



2018-2019 Provider Operations Manual



Call Us At:
1-866-796-0542

Table of Contents

Section 1 - Introduction to Arizona Complete Health-Complete Care Plan	9
1.1 Overview of the Arizona Public Health System	9
1.2 Overview of Arizona Complete Health and Populations Served	9
1.3 Provider Manual	12
1.4 Provider Responsibilities and Expectations	13
1.5 Arizona System Values and Guiding Principles	13
1.6 Provider Services Department Overview	15
1.7 Joining the Arizona Complete Health-Complete Care Plan Provider Network	15
1.8 Arizona Complete Health - Complete Care Plan Organizational Structure	15
1.9 Advertising	16
Section 2 - Covered Services and Related Program Requirements	17
2.1 Covered Health Services Based on Eligibility	17
2.2 Maternity Services	18
2.3 Family Planning for Title XIX/XXI Adults with SMI	25
2.4 Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	31
2.5 Dental Services	43
2.6 Optical Services	52
2.7 Immunization Information	53
2.8 Crisis Intervention Services	54
2.9 Housing Resources for Adults	56
Section 3 – Member Handbook	63
3.1 General	63
3.2 Distribution	63
3.3 Arizona Complete Health-Complete Care Plan Member Handbook Review	64
Section 4 - Medical Management/Utilization Management Requirements	65
4.1 Securing Services and Prior Authorization/Retrospective Authorization	65
4.2 Securing Services that do not Require Prior Authorization	65
4.3 Purpose of Utilization Review Process	68
4.4 Technology	79
4.5 Retrospective Review	80
4.6 Pre-Admission Screening and Resident Review (PASRR)	81
4.7 Inter-Rater Reliability Testing	86
4.8 Care Management and Care Coordination Services	86
4.9 Care Management Team	86

4.10	Disease Management	91
4.11	Out-of-Home Services Requirements	91
4.12	Discharge Planning	92
4.13	Pharmaceutical Requirements	96
4.14	Utilization Data Analysis and Data Management	100
Section 5 - Credentialing and Re-Credentialing Requirements		102
5.1	Introduction and Processes	102
5.2	Delegation of Credentialing	103
5.3	Initial Credentialing Process and Requirements	103
5.4	Additional Credentialing Requirements for Organizational Providers	104
5.5	Hiring Non-Participating Providers	105
5.6	Investigations	106
5.7	Modifications	106
5.8	Provisional Credentialing Process and Requirements	108
5.9	Recredentialing Process and Requirements	109
5.10	Credentialing Approval/Denial Process	109
5.11	Fairness of Process	110
5.12	Notification Requirement	111
5.13	Additional Standards	111
5.14	Provider's Right for Reconsideration	112
5.15	Ongoing Monitoring Process Between Re-Credentialing Cycles	113
5.16	Notice of Requirements (Limited to Providers)	113
5.17	Provider Locations that Accommodate Members with Accessibility Needs	114
Section 6 - Data Systems/Reporting Requirements		117
6.1	Enrollment, Disenrollment and Other Data Submission	117
Section 7 - Finance/Billing		120
7.1	General Information	120
7.2	Claims versus Encounters	120
7.3	Claim or Encounter Submission Requirements	121
7.4	Claim Submission Time Frames	122
7.5	Claim Reimbursement	122
7.6	Remittance Advice and Electronic Funds Transfer (EFT)	125
7.7	Electronic Claim Submission	125
7.8	Reports	125
7.9	Filing a Claim	126

7.10	Overpayment Recovery Procedures	128
7.11	Prior Period Coverage	129
7.12	Professional Claim Editing	129
7.13	Remittance Advice	129
7.14	Specific Billing Requirements	130
7.15	Vaccines for Children Billing Procedures	130
7.16	Claim Coding Policies	131
7.17	Billing AHCCCS Recipients	135
7.18	Resubmissions, Replacements and Voids	136
7.19	Submissions for Non-Title XIX/XXI Enrolled Persons	136
7.20	Pseudo Identification Numbers for Non-Title XIX/XXI Eligible Persons	136
7.21	Provider Preventable Conditions and Fraud Waste and Abuse Edits	136
7.22	Copayments	137
7.23	Third Party Liability and Coordination of Benefits	141
7.24	Transportation	148
7.25	Refunds or Overpayments on Services Rendered	149
7.26	Financial Sanctions and Notice to Cure	149
Section 8 - Grievance and Appeal System		151
8.1	Member Grievance and Provider Complaint Process	152
8.2	The Health Plan Grievance Resolution Process	153
8.3	Grievances and Investigations Concerning Persons with Serious Mental Illness (SMI)	154
8.4	Notice Requirements and Appeal Process (Title XIX/XXI)	156
8.5	Notice Requirements and Appeal Process (SMI and GMH/SA Non-Title XIX/XXI)	162
8.6	Provider Claim Disputes	170
Section 9 - Compliance		174
9.1	Member Rights	174
9.2	Cultural Competence System of Care Requirements	175
9.3	Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits	179
9.4	Reporting Discovered Violations of Immigration Status	182
9.5	Duty to Report Abuse, Neglect or Exploitation	184
9.6	Duty to Warn	186
9.7	Confidentiality	187
9.8	Fraud, Waste and Program Abuse Reporting	204

9.9	Provider Corporate Compliance Program	207
9.10	Encounter Validation Studies	211
9.11	Provider Reporting of Moral Or Religious Objection	212
Section 10 - Quality Management Requirements		212
10.1	Advance Directives	212
10.2	Medical Record Standards	215
10.3	Member Surveys	228
10.4	Performance Improvement Projects	229
10.5	Evidenced Based Practices and Practice Protocols	230
10.6	Peer Review	232
10.7	Quality of Care Concerns	234
10.8	Medical Institution Reporting of Medicare Part D	238
10.9	Seclusion and Restraint Reporting	239
10.10	Reporting of Incidents, Accidents and Deaths	242
10.11	Health Home Quality Management Plan Requirements	246
Section 11 - Physical Health Provider		248
11.1	Primary Care Physician (PCP) Assignment	248
11.2	Primary Care Provider (PCP) Requirements	249
11.3	PCP After-Hours Access Guidelines	252
11.4	Conditions of PCP Practice Closure	253
11.5	Covering and Collaborating Physicians	253
11.6	Additional Referral Requirements for SMI Members	254
11.7	Social Determinants of Health	254
11.8	Referrals to Entities Where Providers Have a Financial Relationship	257
11.9	Appointment Requirements Applicable to Physical Health Providers (Non-Hospitalized Persons)	257
11.10	Audiology Coverage	258
11.11	PCP Treatment and Referrals	258
11.12	Breast Reconstructive Surgery after Mastectomy	260
11.13	Conscious Sedation Coverage	260
11.14	Hemodialysis and Peritoneal Dialysis Coverage	260
11.15	Durable Medical Equipment Coverage	261
11.16	Foot and Ankle Services	262
11.17	Flu Shots/Immunizations	264
11.18	Hospital Observation Services	264
11.19	Skilled Nursing Facilities	265

11.20	Polysomnography-Inpatient and Outpatient	267
11.21	Telemedicine Services	268
11.22	Transplants	271
11.23	Emergency Transportation Services	274
11.24	Genetic Testing Provisions	275
11.25	Radiology Services	276
Section 12 - Behavioral Health Network Provider Service Delivery Requirements		276
12.1	Eligibility Screening For AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program	276
12.2	Appointment Standards and Timeliness of Service	282
12.3	Referral and Intake Process	289
12.4	Outreach, Engagement, Re-Engagement, and Closure	296
12.5	Assessment and Service Planning	302
12.6	SMI Eligibility Determination	309
12.7	General and Informed Consent to Treatment	315
12.8	Psychotropic Medication: Prescribing and Monitoring	321
12.9	Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment	325
12.10	Special Populations	346
12.11	Special Assistance for Members Determined to Have a Serious Mental Illness	355
12.12	Arizona State Hospital	358
12.13	Out-of-State Placements for Children and Young Adults	364
12.14	Cultural Competence for the Behavioral Health System Requirements	365
12.15	Business Continuity/ Recovery Plan and Emergency Response/ Pandemic Plan / Heat Plan Requirements	366
12.16	Behavioral Health Home Requirements	368
12.17	Laboratory Provider Requirements	390
12.18	Specialty Provider Requirements	391
12.19	Requirements for Service Delivery on the Tohono O’odham Nation	399
12.20	Requirements of Organizations Providing Employment Services	400
Section 13 - Health Plan Coordination of Care Requirements		402
13.1	Transition of Persons	402
13.2	Inter-RBHA/MCO Coordination of Care	407
13.3	Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers	415
13.4	Coordination of Care with Other Governmental Entities	423

13.5	Partnerships with Families and Family-Run Organizations in the Children's Behavioral Health System	432
13.6	Warm Line Provider Program	432
Section 14 - Specific Behavioral Health Program Requirements		433
14.1	Urgent Engagement (UE) Program Requirements	433
14.2	Comprehensive Medical and Dental Plan (CMDP) Eligible Children Involved with Department of Child Safety (DCS)	435
14.3	Behavioral Health Respite Home Requirements	439
14.4	Birth To Five Provider Program Requirements	439
14.5	Brief Intervention Provider Program Requirements	439
14.6	Consumer Operated Provider Program Requirements	440
14.7	Crisis Line Provider Program Requirements	440
14.8	Crisis Mobile Team Provider Program Requirements	446
14.9	Crisis Stabilization/Crisis Living Room Provider Program Requirements	449
14.10	Crisis Transportation Provider Program Requirements	450
14.11	Health Education, Health Promotion And Counseling Program Requirements Related To Human Immunodeficiency Virus (HIV)	451
14.12	Home Care Training to Home Care Client (HCTC) Services to Children – Program Requirements	452
14.13	Substance Use Disorder Treatment Requirements	452
14.14	Program Requirements for Providers of Services to Adolescents Who Act Out Sexually	456
14.15	Program Requirements for Providers of Services to Adults Who Act Out Sexually	456
14.16	Community Observation Centers	457
14.17	ACT (Assertive Community Treatment)	459
14.18	Agencies Contracted to Employ Engagement Specialists	459
Section 15 - Training and Peer Support Supervision Requirements		461
15.1	Purpose	461
15.2	Training	461
15.3	Annual and Ongoing Training	462
15.4	Required Training Specific to Professional Foster Homes Providing HCTC Services	463
15.5	Required Training Specific to Community Service Agencies	463
15.6	Training Request	464
15.7	Training Contact Person	464
15.8	Workforce Development Plan and Implementation Progress Report	464

15.9	Monitor Provider Workforce Development Activities	464
15.10	Peer Support/Recovery Support Training, Certification and Supervision Requirements	465
15.11	Parent/Family Support Training, Certification and Supervision Requirements	468
Section 16 - Deliverable Requirements		473
Section 17 - References		481
17.1	Statutory And Regulatory References	481
17.2	Reference Documents	481
17.3	Clinical Guidance Documents	481
Section 18 - Provider Manual Forms & Attachments		482
18.1	FORMS	482
18.2	ATTACHMENTS	484
Section 19 - Definitions & Acronyms		486
19.1	PART I: Definitions Pertaining to All AHCCCS Contracts	486
19.2	Part 2: Definitions Pertaining to One or More AHCCCS Contracts	506
19.3	The Health Plan Definitions	514
19.4	Acronyms	524

Contract services are funded in part under contract with the State of Arizona.

Section 1 - INTRODUCTION TO ARIZONA COMPLETE HEALTH-COMplete CARE PLAN

Health Net Access Inc. dba Arizona Complete Health-Complete Care Plan (The Health Plan) is an Arizona-based, locally-operated Managed Health Services company dedicated to our mission: **“Transforming the health of our community, one person at a time”**. We seek to ensure that Members receive ready access to high quality, effective and culturally responsive care. The Health Plan recognizes that the needs of each community and county are uniquely based on each community’s and county’s challenges and resources. The Health Plan tailors services to meet the needs of each community and supports local community-based efforts to effectively coordinate care, and promote health and wellness.

1.1 Overview of the Arizona Public Health System

The Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid Agency that provides funding to administer health care benefits for persons who are Title XIX/XXI eligible and manages grants to serve special populations. AHCCCS contracts with Managed Care Organizations to secure a network of providers, clinics, and other appropriate facilities and services to deliver behavioral health and physical health services to eligible Members within contracted geographic service areas. In addition, Arizona state law requires AHCCCS to administer community-based treatment services for adults who have been determined to have a Serious Mental Illness (see [AAC R9-21](#)).

AHCCCS is responsible for the oversight of the administration of behavioral health services for several populations funded through various state and federal sources. These programs include Arizona state funded crisis services and services to Non-Title XIX adults with a SMI designation, Governor’s office grants serving residents with Opioid Use Disorders, state and federal housing grants and the Substance Abuse and Mental Health Services Administration (SAMHSA) funded grants. SAMHSA provides funding to the State through two block grants:

- The Substance Abuse Block Grant (SABG) supports a variety of substance abuse services in both specialized addiction treatment and more generalized behavioral health settings, as well as primary prevention and HIV Early Intervention and Testing.
- The Mental Health Block Grant (MHBG) supports Non-Title XIX/XXI services to children determined to have Serious Emotional Disturbance (SED) and adults determined to have a Serious Mental Illness (SMI).

More information about AHCCCS programs is available online at <https://www.azahcccs.gov/>.

1.2 Overview of Arizona Complete Health and Populations Served

The Health Plan in collaboration with its parent company, Centene Corporation, is committed to bringing the best care possible to vulnerable populations through a focus on innovative programs and services delivered through Medicaid (Title XIX), Medicare, CHIP (Title XXI), and other programs for uninsured and under-insured adults and families.

The Health Plan monitors provider performance to verify Members are receiving timely access to quality services that support recovery, resiliency and wellness. For more information about The Health Plan and its services, please visit our website at www.azcompletehealth.com.

The Health Plan's network structure is designed to promote recovery, resiliency and wellness through maximizing Member "voice and choice." The Health Plan wants Members to have a choice of providers and services and be in charge of their individual service plans. The Health Plan's network is designed to remove barriers that prevent people from reaching their wellness and recovery goals and help Members lead productive lives in their communities.

The Health Plan Members can elect to receive services from any Primary Care Provider or Health Home in The Health Plan network based on their benefit plan. The Health Plan serves the following populations and manages the associated benefit plans assigned to The Health Plan for each population.

1.2.1 AHCCCS Enrolled Title XIX/XXI Adults with SMI (Integrated Physical Health and Behavioral Health Services)

The Health Plan serves AHCCCS enrolled Title XIX Adults with SMI in eight Arizona counties—Pima, La Paz, Yuma, Santa Cruz, Cochise, Greenlee, Graham, and Pinal Counties. The Health Plan manages a full array of AHCCCS approved behavioral health and physical health services to meet the whole person health care needs of the Members. The AHCCCS Title XIX benefit plan coverage for these members is outlined in Section 12 of this Provider Manual.

1.2.2 AHCCCS Enrolled Non-Title XIX Adults with SMI (Behavioral Health Services Only)

The Health Plan serves AHCCCS enrolled Non-Title XIX Adults with SMI in eight Arizona counties—Pima, La Paz, Yuma, Santa Cruz, Cochise, Greenlee, Graham, and Pinal Counties. The Health Plan manages a limited array of AHCCCS approved behavioral health services to meet the behavioral health care needs of these members. The AHCCCS Non-Title XIX behavioral health benefit plan coverage for these members is outlined in Section 12 of this Provider Manual.

1.2.3 AHCCCS Enrolled Title XIX/XXI Adults and Children, excluding Adults with SMI (Integrated Physical Health and Behavioral Health Services)

The Health Plan serves AHCCCS enrolled Title XIX/XXI Children and Adults (excluding adults with SMI in ten Arizona counties—Maricopa, Gila, Pima, La Paz, Yuma, Santa Cruz, Cochise, Greenlee, Graham, and Pinal Counties). The AHCCCS Title XIX/XXI benefit plan coverage for these members is outlined in Section 12 of this Provider Manual.

1.2.4 Behavioral Health Services to Children enrolled in the AHCCCS Comprehensive Medical and Dental Plan (CMDP) or Members enrolled in the Arizona Department of Economic Security/Division of Developmental Disabilities (Behavioral Health Services Only)

Comprehensive Medical and Dental Plan (CMDP) or the Arizona Department of Economic Security/Division of Developmental Disabilities Members who live in Cochise, Graham, Greenlee,

La Paz, Pima, Pinal, Santa Cruz, Yuma, County or on the San Carlos Apache Reservation and are assigned to The Health Plan have access to the full array of AHCCCS covered behavioral health services described in this Provider Manual. The AHCCCS Title XIX behavioral health benefit plan coverage for these members is outlined in Section 2 and 12 of this Provider Manual.

1.2.5 Health Care Services to American Indians

American Indians have a choice about what Plan manages their services. American Indians can elect to enroll with the AHCCCS American Indian Health Program, an AHCCCS Arizona Complete Care Plan in their Geographic Service Area or a Tribal Regional Behavioral Health Authority in their Geographic Service Area, if available. The Health Plan works with Tribal Communities to educate tribal members about their options. American Indians can access Indian Health Services providers, Tribal 834 providers and Urban Indian Health providers for services as well. The Health Plan will provide services to American Indians based on member benefit plans for members in our assigned Geographical Service Area with a Serious Mental Illnesses, Children in Foster Care/CMDP, and Members served by the Department of Economic Security/Division of Developmental Disabilities.

1.2.6 Grant Funded Mental Health, Opioid Use Disorder and Substance Use Disorder Services

The Health Plan offers Mental Health, Opioid Use Disorder and Substance Use Disorder treatment services to uninsured and underinsured residents living in Pinal, Graham, Greenlee, Cochise, Santa Cruz, Pima, Yuma or LaPaz Counties funded through state and federal grant funds. For questions about how members can access these services, please call the Provider Services number at 888-796-0542.

1.2.7 Crisis Services to Arizona Residents

All residents of Arizona have access to crisis services 24 hour a day, 7 days a week. Crisis intervention services are funded through state and federal funds and include crisis telephone services, 23-hour facility-based crisis stabilization services, community based crisis mobile team services and similar stabilization and support services.

Southern Region Residents (Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, Yuma, County or on the San Carlos Apache Reservation): can access The Health Plan crisis services by calling 866-495-6735.

Maricopa County Residents: can access The Health Plan crisis services by calling 800-327-9254.

Pinal County Residents: can access The Health Plan crisis services by calling 866-495-6735.

Gila County Residents: can access The Health Plan crisis services by calling 877-756-4090.

1.2.8 Documents Incorporated By Reference

The Health Plan developed this Provider Manual in support of our AHCCCS Complete Care contract, provider contractual agreements and in conformance with Arizona Health Care Cost Containment System (AHCCCS) policies. The AHCCCS Contractor Operation Manual (ACOM) is

located at <https://www.azahcccs.gov/shared/ACOM/> and the AHCCCS Medical Policy Manual (AMPM) is located at <https://www.azahcccs.gov/shared/MedicalPolicyManual/>. All these documents and provisions are incorporated by reference and the associated obligations and requirements are considered part of these Provider Manual requirements as applicable.

1.2.9 Terminology

Consistent terminology throughout The Health Plan's Provider Manual is used to the extent possible. Persons receiving services are generally referred to as "Members"; however, Members are sometimes referenced as "participants," "individuals," or simply as "persons."

The Health Plan's Provider Manual is applicable to all defined populations that may access services through The Health Plan as defined in this Provider Manual and documents incorporated by reference.

1.2.10 Revisions to Arizona Complete Health - Complete Care Plan Provider Manual

The Arizona Complete Health Complete Care Plan Provider Manual is an extension of the provider Contract and contains contractually required provider obligations. The Provider Manual is updated once a month, if changes are necessary. All sections of The Health Plan Provider Manual are reviewed annually. The Health Plan issues Provider Manual Clarification Memoranda to contracted providers and posts them to The Health Plan's website at www.azcompletehealth.com. In addition, AHCCCS issues Policy Clarification Memoranda and posts them on the AHCCCS website at: <https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html>. The Health Plan incorporates these changes upon receipt and as appropriate into The Health Plan Provider Manual.

Providers, stakeholders, and others may provide comments and request for revisions to The Health Plan Provider Manual by contacting the Contracts Department at 866-796-0542. The most current revision to the Provider Manual can be obtained at www.azcompletehealth.com.

The Health Plan has no policies that prevent providers from advocating on behalf of Members as specified in 42 CFR 438.102.

1.3 Provider Manual

Documents Incorporated By Reference

The Health Plan developed this Provider Manual in support of our AHCCCS Complete Care contract, provider contractual agreements and in conformance with Arizona Health Care Cost Containment System (AHCCCS) policies. The AHCCCS Contractor Operation Manual (ACOM) is located at <https://www.azahcccs.gov/shared/ACOM/> and the AHCCCS Medical Policy Manual (AMPM) is located at <https://www.azahcccs.gov/shared/MedicalPolicyManual/>. All these documents and provisions are incorporated by reference and the associated obligations and requirements are considered part of these Provider Manual requirements as applicable.

1.4 Provider Responsibilities and Expectations

AHCCCS has contracted with The Health Plan to provide integrated behavioral health and physical health care to Medicaid eligible adults and children; including adults with a Serious Mental Illness (SMI). This includes coordinating Medicare and Medicaid benefits for dual-eligible Members. Integrating the delivery of behavioral and physical health care is essential to improving the overall health and wellness of adults and children. From a Member perspective, this integrated care approach will improve individual health outcomes, enhance Coordination of Care and increase Member satisfaction. From a system perspective, it will increase efficiency, reduce administrative burden, and foster transparency and accountability.

Providers are responsible to facilitate whole person integrated care for our members, coordinating care effectively between and among disciplines.

Providers are obligated to adhere to and comply with all terms and conditions of The Health Plan Provider Manual, the provider's contractual agreement with The Health Plan, and all applicable federal and State laws and regulations. In addition, providers are obligated to understand and comply with all Arizona Health Care Cost Containment System requirements. Please refer to: AHCCCS ACOM located at <https://www.azahcccs.gov/shared/ACOM/> and AHCCCS AMPM <https://www.azahcccs.gov/shared/MedicalPolicyManual/> for additional information regarding State requirements.

Primary Care Providers and Health Homes are responsible for providing clinical intakes, assessments, service planning, and coordination of care; verifying Members are receiving the services they need to live safely and successfully in their communities; and verifying Members reach their recovery, resiliency and wellness goals.

Specialty Providers are responsible for delivering specialty services and programs as authorized and identified on individualized service plans, regularly reporting progress to Primary Care Providers and/or Health Homes and coordinating services with Primary Care Providers and/or Health Homes. Many specialty provider services require prior authorization. Reference **Provider Manual Section 12.18 Specialty Provider Requirements** for additional information.

1.5 Arizona System Values and Guiding Principles

The following values, guiding system principles, and goals are the foundation of the public health system. Providers are required to follow the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems and The Arizona Vision-Twelve Principles for Children Service Delivery.

1.5.1 Adult Service Delivery Nine Guiding Principles

AHCCCS requires that providers implement adult services consistent with the [AHCCCS Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems](#). Those nine guiding principles are listed below:

1. Respect;
2. Persons in recovery choose services and are included in program decisions and program development efforts;
3. Focus on individual as a whole person, while including and/or developing natural supports;
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure;
5. Integration, collaboration, and participation with the community of one's choice;
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust;
7. Persons in recovery define their own success;
8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences; and
9. Hope is the foundation for the journey towards recovery.

1.5.2 The Arizona Vision-Twelve Principles for the Children's Service Delivery

The State requires that services be delivered to all children consistent with the "Arizona Vision" and according to the twelve Arizona Children's Principles. Reference AHCCCS AMPM policy: <https://www.azahcccs.gov/PlansProviders/Downloads/GM/ClinicalGuidanceTools/ChildFamilyTeam/ChildFamilyTeam.pdf>

The Twelve Principles for Children Service Delivery are:

1. Collaboration with the child and family;
2. Functional outcomes;
3. Collaboration with others;
4. Accessible services;
5. Evidenced-Based Best Practices;
6. Most appropriate setting;
7. Timeliness;
8. Services tailored to the child and family;
9. Stability;
10. Respect for the child and family's unique cultural heritage;
11. Independence; and
12. Connection to natural supports.

1.6 Provider Services Department Overview

The Health Plan Provider Engagement Specialists are responsible to receive and track all provider inquiries and verify timely responses. Provider Engagement Specialists are available 8:00 AM to 5:00 PM Monday through Friday to provide immediate responses to provider inquiries. The Health Plan seeks to resolve each request for information and assistance during the initial call. If additional information is needed to respond to the provider's inquiry, the call will be logged and routed to the subject matter expert best able to answer the provider's question. The Health Plan provider engagement team tracks all inquiries referred to subject matter experts to verify timely responses and satisfaction with the responses. The Health Plan will acknowledge all provider calls within three (3) business days of receipt and will communicate the final resolution to the provider within thirty (30) business days of receipt (including provider referrals from AHCCCS). If you ever feel like you are not receiving the assistance you need, please escalate your request by calling the supervisor of your Provider Engagement Specialist. The name and phone number of the Provider Engagement Specialist supervisor is located on the Provider Engagement Specialist email signature line. Please call Customer Service at 866-796-0542 for assistance with any questions and/or identifying the assigned Provider Engagement Specialist and the supervisor contact information.

1.7 Joining the Arizona Complete Health-Complete Care Plan Provider Network

The process to join The Health Plan Provider Network begins with the submission of an application to join the network submitted through our Network Development Department. Applications to join The Health Plan Network are available on our website at www.azcompletehealth.com. All applications are reviewed at The Health Plan Prospective Provider Committee. The Committee reviews the application and the needs of the Network and issues a determination, which may include approval to move forward, denial, or pended for more information. If approved, the application request is given to the Contracts Department to work with the applicant to start the credentialing process and prepare and execute the contract.

1.8 Arizona Complete Health - Complete Care Plan Organizational Structure

The Health Plan's organizational structure has been established to facilitate consistent communication with providers for all product lines, effective integration of behavioral, physical and social determinants of health, promote wellness and recovery, maximize member and family voice and promote continuous quality improvement. The leadership team, led by the Medicaid President, is responsible for care management and medical management, integrated services including social determinants of health, quality management, network management, operations, compliance and finance. The Chief Medical Officer is accountable for clinical oversight and decisions. Providers are encouraged to contact their Provider Engagement Specialist for immediate assistance and problem resolution. The Medicaid President and other key members of the leadership team serve as points of contact for critical Health Plan communication and decision making.

1.9 Advertising

All advertising bearing any Arizona Complete Care Completed Care Plan name, mark or logo must be approved by the Arizona Department of Insurance (ADOI) or Arizona Health Care Cost Containment System (AHCCCS) before use. The Centers for Medicaid and Medicare Services (CMS) and accreditation entities have additional restrictions and requirements. Providers must submit any advertising bearing an Arizona Complete Care-Completed Care Plan name, mark or logo to Arizona Complete Care-Completed Care Plan prior to use in order to secure regulatory approval.

Section 2 - COVERED SERVICES AND RELATED PROGRAM REQUIREMENTS

2.1 Covered Health Services Based on Eligibility

Arizona Health Care Cost Containment System (AHCCCS) has developed a comprehensive array of covered health services to meet the individual needs of eligible persons. Covered services assist and encourage each person to achieve and maintain the highest possible level of health and self-sufficiency. The type of service covered is contingent on each person's current eligibility status and, for some persons, is based on available funding. All health services are required to be medically necessary, based upon the needs of the person. Providers are required to operate within their scope of practice.

The AHCCCS Medical Policy Manual and the AHCCCS Covered Behavioral Health Services Guide contain information regarding each of the covered services that are available through the publicly funded health care system including: a definition of each service; the requirements of individuals or agencies providing the service; and any limitations to using or billing for the service. Providers must deliver covered services in accordance with the AHCCCS Medical Policy Manual, the AHCCCS Covered Behavioral Health Services Guide, the AHCCCS Policy and Procedures Manual, The Health Plan Policies and Procedures, the AHCCCS Contractor Operations Manual, and the requirements of any other funding source (i.e., Medicare Advantage requirements for dual eligible Members).

2.1.1 Covered and Non-Covered Services

For covered medical benefits, details service descriptions, exclusions, limitations for physical and behavioral health services, refer to the AHCCCS Medical Policy Manual (AMPM):

[AMPM Chapter 300](#) Medical Policies for Covered Services

[AMPM Chapter 300](#), Exhibit 300-1, AHCCCS Covered Services Acute Care

[AMPM Chapter 300](#), Exhibit 300-2A, AHCCCS Covered Services Behavioral Health

[AMPM Chapter 300](#), Exhibit 300-2B, AHCCCS Covered Services Behavioral Health Non-Title XIX-XXI Persons

2.1.2 Eligibility Requirements

Providers must screen individuals for AHCCCS eligibility and, as applicable, assist individuals with applying for AHCCCS and/or enrolling in Medicare Part D **Section 12.1 — Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program**).

Services for Non-Title XIX/XXI persons determined to have a Serious Mental Illness (SMI) are subject to available funding, as appropriated by the Arizona Legislature. Tribal and Health Plans are required to verify that Non-Title XIX/XXI funding allocated by the State for each geographic service area is available for services throughout the fiscal year.

Decisions made with respect to the coverage and provision of services are subject to **Section 8.5 — Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX/XXI)**.

Services must be provided in collaboration with other agencies to coordinate the culturally appropriate delivery of covered behavioral health services with other services provided to the person and the person's family.

Covered behavioral health services may be available to family members of Title XIX/XXI eligible persons enrolled within a Tribal and/or Health Plan to the extent that services are provided in support of the treatment goals of the identified eligible or enrolled person.

2.1.3 Medicare Part D Prescription Drug Coverage

Persons eligible for Medicare Part D must access the Medicare Part D prescription drug coverage by enrolling with a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD). Persons eligible for both Medicare Part D and Title XIX/XXI (AHCCCS) will continue to have coverage of the following excluded Part D drugs through Title XIX/XXI, if not included in the PDP or MA plans' formulary:

- Benzodiazepines;
- Barbiturates; and
- Certain over the counter drugs.

2.2 Maternity Services

Maternity care services include, but are not limited to, pregnancy identification through the submission of **Provider Manual Form 2.3.2 Notification of Pregnancy** form (can be obtained by calling the Provider Services Call Center at 866-796-0572), prenatal services, treatment of pregnancy related conditions, labor and delivery services, postpartum depression screening, and postpartum care. In addition, related services such as outreach and family planning services are provided ([AHCCCS AMPM Policy 420](#) – Maternity Care Services), whenever appropriate, based on the member's current eligibility and enrollment.

2.2.1 Maternity Care Provider Standards

Providers must confirm that members who are receiving physical health care services and who are pregnant have a designated maternity care provider for the duration of the Member's pregnancy and postpartum care. [AHCCCS AMPM Policy 410](#) (Maternity Care Services) provides detailed descriptions of maternity care requirements and expectations. Members have a choice to be assigned a Primary Care Provider that provides obstetrical care consistent with the freedom of choice requirements for selecting health care professionals so as not to compromise the Member's continuity of care. For anticipated low-risk deliveries, Members may elect to receive labor and delivery services in their home from their maternity provider and may also elect to receive prenatal care, labor and delivery, and postpartum care by certified nurse midwives or licensed midwives.

Members will receive up to 48 hours of inpatient hospital care after a routine vaginal delivery and up to 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the member, may discharge the member prior to the minimum

length of stay. According to American College of Obstetricians and Gynecologists guidelines, cesarean section deliveries must be medically necessary. Inductions and cesarean section deliveries prior to 39 weeks must be medically necessary. Cesarean sections and inductions performed prior to 39 weeks that are not found to be medically necessary based on nationally established criteria are not eligible for payment.

For Members receiving maternity services from a certified nurse midwife or a licensed midwife, The Health Plan will assign a Primary Care Provider (PCP) to provide other health care and medical services. A certified nurse midwife may provide those primary care services that they are willing to provide and that the Member elects to receive from the certified nurse midwife. Members receiving care from a certified nurse midwife may also elect to receive some or all of their primary care from the assigned PCP. Licensed midwives may not provide any additional medical services as primary care that are not within their scope of practice.

All physicians and certified nurse midwives who perform deliveries are required to have OB hospital privileges or a documented hospital coverage agreement for those practitioners performing deliveries in alternate settings. Licensed midwives perform deliveries only in the Member's home. Physicians, certified nurse practitioners, and certified nurse midwives within the scope of their practice may provide labor and delivery services in the Member's home.

Upon identification of Member pregnancy, all Maternity Care Providers are required to submit the **Provider Manual Form 2.3.2 Notification of Pregnancy Form (NOP)** (can be obtained by calling the Provider Services Call Center at 866-796-0542) and coordinate care with the member's Health Care Coordinator and behavioral health treatment team throughout the pregnancy, delivery and postpartum treatment. This includes identified difficulties with navigating the health care system, evidenced by missed visits, transportation difficulties, or other perceived barriers. Particular attention should be given to the screening, assessment and treatment of perinatal mood disorders, to include post-partum depression.

Members who transition to a new Contractor or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS-registered provider, regardless of contractual status, to ensure continuity of care. Inform newly-assigned Members and those currently under the care of a non-network provider, that they have the opportunity to change Contractors to ensure continuity of prenatal care.

2.2.2 General Obstetrical Standards of Care

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

- Use of a standardized prenatal medical record and risk assessment tool, such as the ACOG Form, documenting 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. Providers are required to screen all pregnant members through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling must be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.

In addition, providers must educate Members about healthy behaviors during pregnancy, including proper nutrition, effects of alcohol, drugs, prescription opioid use, tobacco cessation, the physiology of pregnancy, screening for sexually transmitted infections, the process of labor and delivery, breast feeding, dangers of lead exposure to mother and child, and other infant care information. Providers are also required to educate Members about elective deliveries prior to 39 weeks and/or Cesarean-sections (C-Sections) unless medically necessary; signs and symptoms of preterm labor; effects of smoking, diabetes, hypertension on pregnancy and/or fetus/infant; prenatal and postpartum visits. Providers are required to offer Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) testing and confidential post testing counseling to all Members. In the event where a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.

Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referral made if a positive screening is obtained.

2.2.3 Maternity Appointment Standards

Maternity care appointments for initial prenatal care for pregnant SMI Members:

- First trimester: within fourteen (14) calendar days of request;
- Second trimester: within seven (7) calendar days of request;
- Third trimester: within three (3) business days of request; and
- High risk pregnancies as expeditiously as the member's health condition requires and no later than three (3) business days of a maternity care provider's identification of high risk or immediately if an emergency exists.

2.2.4 Newborns

A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48 or 96 hour stay. However, for payment purposes, inpatient limits will apply to the extent consistent with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

The newborn may be covered under The Health Plan. Prior to the birth of the baby, the mother will be asked to select a PCP for the newborn. The newborn is assigned to the pre-selected PCP after delivery. The mother may elect to change the assigned PCP at any time.

2.2.5 Special Policies

Covered related services with special policy and procedural guidelines include, but are not limited to:

- Routine circumcision of newborn male infants, which is not a covered service unless it is determined to be medically necessary (ARS 36-2907(b));
- Inpatient hospital stays;
- Home uterine monitoring - Medically necessary home uterine monitoring technology for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization, is a covered benefit;
- Labor and delivery services provided in freestanding birthing centers;
- Services rendered in a freestanding birthing center must be provided by a physician (the member's primary care physician (PCP) or obstetrician with hospital admitting privileges) or by a registered nurse midwife who is accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services;
- Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a freestanding birthing center
- Labor and delivery services provided in a home setting:
 - o Only members with an anticipated uncomplicated prenatal course and a low-risk labor and delivery should deliver in the member's home, and
 - o Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.

2.2.6 Licensed Midwife Services

Licensed midwife services may only be provided to members for whom an uncomplicated prenatal course and a low-risk labor and delivery is anticipated. The age of the member must be included as a consideration in the risk status evaluation;

Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution

2.2.7 Medical Food

The Health Plan covers medical foods when medically necessary for members 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
- 3-methylcrotonyl CoA carboxylase deficiency
- isovaleric acidemia
- methylmalonic acidemia
- propionic acidemia
- arginosuccinic acidemia
- tyrosinemia type I
- HMG CoA lyase deficiency
- cobalamin A, B, C deficiencies

Medical foods are metabolic formula or modified low-protein foods produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is covered for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and KidsCare members diagnosed with galactosemia and only until they are able to eat solid lactose-free foods.

Upon completion of the member's initial consultation with a genetics physician and metabolic nutritionist, and the determination that metabolic formula and/or low-protein foods are necessary to meet the member's nutritional needs, providers forward the request for metabolic nutrition to the Health Plan's Prior Authorization unit for review and processing. All approvals and payments for medical foods are the responsibility of The Health Plan.

2.2.8 Neonate Transfers Between Acute Care Facilities

Acutely ill neonates may be transferred from one acute care center to another, given certain conditions. The chart that follows provides the levels of care, conditions appropriate for transfer, and criteria for transfer.

Level of Care		Transfer Criteria
From	To	
Primary	Secondary	<ol style="list-style-type: none"> The nursing and medical staff of the sending hospital cannot provide: <ul style="list-style-type: none"> The level of care needed to manage the infant beyond stabilization to transport The required diagnostic evaluation and consultation services needed Transportation orders specify the type of transport, the training level of the transport crew and the level of life support
	Tertiary	Same as above
Secondary	Tertiary	Same as above
	Primary	Same as above

Tertiary	Tertiary (rare)	<ol style="list-style-type: none"> 1. The sending and receiving neonatologists (and surgeons, if involved) have spoken and agreed that the transfer is safe. 2. The infant is expected to remain stable, considering the period of time required for the distance to be traveled. 3. Transport orders specify the type of transport and training level of the transport crew.
	Secondary	Same as above
	Primary	Same as above

2.2.9 High Risk Maternity and Perinatal Care Management

The Health Plan Integrated Care Managers, together with providers, identify pregnant women who are at risk for adverse pregnancy outcomes. The Health Plan assists providers in managing the care of at risk pregnant Members due to medical conditions, social determinants, severe mental illness or non-compliant behaviors. The Health Plan evaluates At Risk Members for ongoing follow up during their pregnancy.

The Health Plan's perinatal care management provides comprehensive care management services to high risk pregnant Members, for the purpose of 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 Integrated Care Managers take a collaborative approach in working with Health Home Health Care Coordinators and PCPs and OB/GYNs to engage high risk pregnant Members 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:

- A history of preterm labor before 37 weeks of gestation;
- Bleeding and blood clotting disorders;
- Chronic medical conditions;
- Polyhydramnios or oligohydramnios;
- Placenta previa, abruption or accreta;
- Cervical changes;
- Multiple gestation;
- Teenage mothers;
- Hyperemesis;
- Poor weight gain;
- Advanced maternal age;
- Substance abuse;
- Prescribed psychotropic drugs;
- Domestic violence; and
- Non-adherence with Obstetrics appointments.

2.2.10 Reporting High Risk and Non-Adherent Behaviors in Pregnant Women

Health Home Health Care Coordinators, obstetrical physicians and practitioners must refer all “at risk” pregnant Members to The Health Plan. The following types of situations must be reported to The Health Plan 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.
- 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 Health Plan.

2.2.11 Outreach, Education and Community Resources for Pregnant Members

The Health Plan is committed to maternity care outreach. Maternity care outreach is an effort to identify currently enrolled pregnant individuals and to enter them into prenatal care as soon as possible, but no later than within the first trimester or 42 days after enrollment. Health Home Health Care Coordinators, PCPs, OB/GYNs and other treating providers are expected to ask about pregnancy status when Members call for appointments, to report positive pregnancy tests to The Health Plan through submission of **Provider Manual Form 2.3.2 Notification of Pregnancy form (NOP)**, (can be obtained by calling the Provider Services Call Center at 866-796-0542) and to provide general education and information about prenatal care, when appropriate, during Member office visits.

The Health Plan 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 Women, Infants and Children (WIC) Nutritional Program. Please encourage Members to enroll in this program in order to support healthy pregnancy outcomes. Various other services are available in the community to help pregnant individuals and their families. Please call The Health Plan 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 Health Care Cost Containment System (AHCCCS) Hot Line at 800-833-4642.

2.2.12 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 The Health Plan if they are

aware that a pregnant Member is about to lose or has lost eligibility. The Health Plan Member Services 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 888-788-4408 to report eligibility changes for pregnant Members.

2.3 Family Planning for Title XIX/XXI Adults with SMI

The Health Plan covers family planning services in accordance with the [AHCCCS AMPM Policy 420](#) (Family Planning) for all Members who choose to delay or prevent pregnancy. Services include, but are not limited to, contraceptive counseling, medication and supplies (such as oral and injectable contraceptives, Long-Acting Reversible Contraceptives, subdermal implantable contraceptives, intrauterine devices, diaphragms, condoms, foams and suppositories), medical and laboratory examinations, treatment of complications resulting from contraceptive use (including emergency treatment), natural family planning education and referrals to health professionals, and post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (RU 486 is not a post-coital emergency oral contraception). Screening and treatment for Sexually Transmitted Infections are covered services for all Members.

Family planning services do not include infertility services, pregnancy termination counseling, pregnancy terminations, or hysterectomies.

2.3.1 Requirements for Providing Family Planning Services

Providers are required to collaborate with The Health Plan to implement effective family planning services which includes:

1. Notifying Members of reproductive age of the specific covered family planning services available and how to request them. Notification must be in accordance with ARS § 36.2904(L). The information provided to Members should include, but is not limited to:
 - a. A complete description of covered family planning services available;
 - b. Information advising how to request/obtain these services;
 - c. Information that assistance with scheduling is available; and
 - d. A statement that there is no charge for these services.
2. Provide family planning services that are:
 - a. Provided in a manner free from coercion or behavioral/mental pressure;
 - b. Available and easily accessible to Members;
 - c. Provided in a manner which assures continuity and confidentiality;
 - d. Provided by, or under the direction of, a qualified physician or practitioner; and
 - e. Documented in the medical record. In addition, documentation must be recorded that each Member of reproductive age was notified verbally or in writing of the availability of family planning.

3. Provide translation/interpretation of information related to family planning in accordance with the requirements of the cultural competency policy. (See **Section 9.2—Cultural Competence**).
4. Have a process for ensuring prior to insertion of intrauterine and subdermal implantable contraceptives, the family planning provider has provided proper counseling to the eligible Member to minimize the likelihood of a request for early removal. 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.
5. Establish procedures for referral of those Members who may lose AHCCCS eligibility to low-cost/no-cost agencies for family planning services.

In addition, providers are responsible for the following:

- Making appropriate referrals to health professionals who provide family planning services.
- Keeping complete medical records regarding referrals.
- Verifying and documenting a Member's willingness to receive family planning services.
- Providing medically necessary management of Members with family planning complications.
- Notifying Members of available contraceptive services and making these services available to all Members of reproductive age using the following guidelines:
 - Information for Members between 18 and 55 years of age must be provided directly to the Member or legal guardian. Whenever possible, contraceptive services should be offered in a broad-spectrum counseling context, which includes discussion of mental health and sexually transmitted diseases, including HIV/AIDS.
 - Members of any age whose sexual behavior exposes them to possible conception or Sexually Transmitted Diseases (STDs) should have access to the most effective methods of contraception.
 - Every effort should be made to include partners in such services.
- Providing counseling and education to Members of all genders that is age appropriate and includes information on prevention of unplanned pregnancies.
- Counseling should include the following:
 - The Member's short- and long- term goals;
 - Spacing of births to promote better outcomes for future pregnancies; and
 - 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 diseases, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.

Contraceptives should be recommended and prescribed for sexually active Members. Providers 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 diseases (including AIDS). Such discussions must be documented in the Member's medical record.

2.3.2 Sterilization

The Health Plan requires all participating providers to comply with the informed consent forms and procedures for sterilization as specified in the AHCCCS Specifications Manual (42 CFR Part 441, Sub-part B). The following criteria must be met for consent:

- The Member is at least 21 years of age at the time the consent is signed.
 - For Members under the age of 21, the provider must be able to demonstrate medical necessity for the procedure with supporting documentation including Prior Authorization. The medical necessity prior authorization and supporting documentation must be submitted to AHCCCS with the Monthly Sterilization Report;
- Mental competency is determined;
- Voluntary consent was obtained without coercion; and
- Thirty (30) days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

Any Member requesting sterilization must sign an [AHCCCS AMPM, Chapter 400, Exhibit 420 Attachment A](#), (AHCCCS Consent to Sterilization Form), with a witness present when the consent is obtained. Suitable arrangements must be made to ensure that the information in the consent form is effectively communicated to Members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds, as well as Members with visual and/or auditory limitations. Prior to signing the consent form, a Member must first have been offered factual information that includes all of the following:

- Consent form requirements;
- Answers to questions asked regarding the specific procedure to be performed;
- Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits; A description of available alternative methods;
- Advice that the sterilization procedure is considered to be irreversible,
- A thorough explanation of the specific sterilization procedure to be performed,
- A description of available alternative methods
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

- A full description of the advantages or disadvantages that may be expected as a result of the sterilization; and
- Notification that sterilization cannot be performed for at least 30 days post consent.

Sterilization consents may NOT be obtained when a Member:

- Is in labor or childbirth;
- Is seeking to obtain, or is obtaining, a pregnancy termination; or
- Is under the influence of alcohol or other substances that affect the Member's state of awareness.

The Health Plan submits a Monthly Sterilization Report to AHCCCS which documents the number of sterilizations performed for all Members under the age of 21 years of age during the month. If no sterilizations were performed for Members under the age of 21 years of age during the month, the monthly report must still be submitted to attest to that information.

Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. At the end of the three months, confirmatory testing, a hysterosalpingogram, will be performed confirming that the Member is sterile and reported on the monthly sterilization report.

2.3.3 Medically Necessary Pregnancy Termination for Title XIX/XXI Adults With SMI

Prior authorization is required for pregnancy termination except in emergency situations where the life of the mother is threatened. In these situations, authorization may be sought post procedure. Prior authorization must be obtained before the services are rendered or the services will not be eligible for reimbursement. Pregnancy termination services are covered when one of the following occurs:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- The pregnancy is a result of incest;
- The pregnancy is a result of rape; or
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant Member by:
 - Creating a serious physical or mental health problem for the pregnant Member;
 - Seriously impairing a bodily function of the pregnant Member;
 - Causing dysfunction of a bodily organ or part of the pregnant Member;
 - Exacerbating a health problem of the pregnant Member; or

- Preventing the pregnant Member from obtaining treatment for a health problem.

For medical necessary pregnancy terminations, providers must submit [AHCCCS AMPM Chapter 410 Attachment D](#) – (AHCCCS Verification of Diagnosis by Contractor for a Pregnancy Termination Request) to The Health Plan Medical Director including a written explanation describing why the procedure is medically necessary, a copy of the Member’s medical record and written informed consent from the Member. The provider is required to obtain the written informed consent and retain it in the Member’s medical record for all pregnancy terminations. For pregnant Members younger than 18 years of age, or those 18 or older and considered incapacitated, providers must secure a dated signature of the pregnant Member's parent or legal guardian or a certified copy of a court order indicating approval of the pregnancy termination procedure.

In addition, if the pregnancy termination is requested as a result of incest or rape, providers must include identification of the proper authority to which the incident was reported. This must include the name of the agency, the report number, and the date that the report was filed.

Additional Considerations Related to the Use of Mifepristone

Mifepristone (also known as Mifeprex or RU-486) is not a post-coital emergency oral contraceptive. The administration of Mifepristone, for the purposes of inducing intrauterine pregnancy termination, is covered by AHCCCS when a minimum of one AHCCCS required criterion is met for pregnancy termination, as well as conditions specific to Mifepristone, see [AHCCCS AMPM Chapter 400](#) (Medical Policy for Maternal and Child Health) for additional criteria. When it is administered, the following documentation is also required: duration of pregnancy in days, the date Intrauterine Device (IUD) was removed if the Member had one, the date Mifepristone was given, and documentation that pregnancy termination occurred.

2.3.4 Prior Authorization Requirements for Sterilization and Pregnancy Termination.

Prior authorization is required for sterilization of Members under the age of 21 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 sterilization, complete the applicable forms:

- For sterilization: [AHCCCS AMPM, Chapter 400, Exhibit 420-A](#) (Consent for Sterilization Form) and [AHCCCS AMPM, Chapter 800, Exhibit 820-1](#) (Hysterectomy Consent and Acknowledgement Form) found at <https://www.azahcccs.gov/shared/MedicalPolicyManual/>

To obtain authorization for pregnancy termination, except in cases of medical emergencies, the provider shall obtain a Prior Authorization from The Health Plan Medical Director. A completed [AHCCCS AMPM Section 410 Attachment C](#) (Certificate of Necessity for Pregnancy Termination) and the [AHCCCS AMPM Section 410 Attachment D](#) (Verification of Diagnosis by Contractor for

Pregnancy Termination Request) forms shall be submitted with the request for Prior Authorization, along with the lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination. The Health Plan Medical Director or designee will review the Prior Authorization request and supporting documentation and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination.

In cases of medical emergency, the provider must submit all documentation of medical necessity to The Health Plan within two working days of the date on which the pregnancy termination procedure was performed.

For pregnancy termination: A completed [AHCCCS AMPM Section 410 Attachment C](#) (Certificate of Necessity for Pregnancy Termination) is required.

2.3.5 Annual Preventative Care

An annual 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. An annual well-person preventative care visit is a covered benefit for members to obtain the recommended preventive services, including preconception counseling. Providers are responsible for having a process to inform members about preventative health services annually and within 30 days of enrollment for newly enrolled members. The information must be provided in a second language, in addition to English, in accordance with the requirements of the AHCCCS Division of Health Care Management (DHCM) "Cultural Competency" policy available in the [AHCCCS Contractors Operations Manual \(ACOM\) Section 405](#).

As such, the annual preventative care visit is inclusive of a minimum of the following:

1. A physical exam (well exam) that assesses overall health;
2. Clinical breast exam (if/as necessary);
3. Pelvic exam (if/as necessary, according to current recommendations and best standards of practice);
4. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors. NOTE: Genetic screening and testing is not covered;
5. Screening and counseling is included as part of the well-person preventive visit and is focused on maintaining a healthy lifestyle and minimizing health risks. Screening and counseling addresses at a minimum the following:
 - a. Proper nutrition;
 - b. Physical activity;
 - c. Elevated BMI indicative of obesity;
 - d. Tobacco/substance use, abuse, and/or dependency;
 - e. Depression screening;
 - f. Interpersonal and domestic violence screening that includes counseling involving elicitation of information from members of all ages 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;

- g. Sexually transmitted infections;
 - h. Human Immunodeficiency Virus (HIV); and
 - i. Family planning counseling.
6. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
- a. Reproductive history and sexual practices;
 - b. Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake;
 - c. Physical activity or exercise;
 - d. Oral health care;
 - e. Chronic disease management;
 - f. Emotional wellness;
 - g. Tobacco and substance use (caffeine, alcohol, marijuana and Other drugs), including prescription drug use; and
 - h. Recommended intervals between pregnancies;

NOTE: Preconception counseling does not include genetic testing.

- i. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified;
- j. Immunizations – The Health Plan will cover the Human Papilloma Virus (HPV) vaccine for members 11 to 26 years of age. Providers must coordinate with The Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) aged members less than 19 years of age. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. Refer to the CDC website at www.cdc.gov/vaccines/schedules/index.html where this information is included.

Providers must enroll and re-enroll annually with the VFC program, in accordance with AHCCCS contract requirements in providing immunizations for EPSDT aged members less than 19 years of age, and must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIS) registry. The VFC program must be used for members under 19 years of age.

2.4 Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health conditions for AHCCCS members under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid members in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members under 21 years of age. EPSDT services include screening services, vision

services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in Federal Law 42 USC 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. Members receiving EPSDT and Oral Health services through the RBHA are only covered for members 18 to 21 years of age. All members age out of Oral Health & EPSDT services at age 21. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services described below, as well as referenced EPSDT Periodicity Schedule (AMPM Exhibit 430- and AHCCCS Dental Periodicity Schedule ([AHCCCS AMPM Exhibit 431-1](#))).

2.4.1 EPSDT Coverage

EPSDT coverage includes the following:

- Organ and Tissue Transplantation Services (refer to chapter 300 of the AMPM for detailed coverage);
- Cochlear and Osseointegrated Implantation;
- Conscious Sedation;
- Behavioral Health Services;
- Religious Non-Medical health care Institution Services;
- Care Management Services;
- Chiropractic Services;
- Personal care;
- Incontinence Briefs;
- Medically Necessary Therapies.

In addition, federal and State law govern the provision of EPSDT services for Members under the age of 21 years. The provider is responsible for providing these services to pregnant Members under the age of 21, unless the Member has selected an Obstetrics (OB) provider to serve as both the OB and Primary Care Provider. In that instance, the OB provider must provide EPSDT services to the pregnant Member.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do 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.

2.4.2 PCP EPSDT Regulatory Requirements

PCPs are required to comply with EPSDT regulatory requirements, including the following:

- Provide EPSDT services in accordance with Section 42 USC 1396d (a) and (r), 1396a (a) (43), 42 C.F.R. 441.50 et seq. and AHCCCS rules and policies;
- Providers must complete a Developmental screening (using an AHCCCS-approved developmental screening tool) for members ages 9, 18 and 24 months;
- Document immunizations within 30 days of administration of an immunization into the Arizona State Immunization Information System (ASIIS);
- Enroll every year in the Vaccines for Children (VFC) program;
- Providers must use and complete all applicable elements of the EPSDT Tracking forms as required by the [AHCCCS Medical Policy Section 430](#) (or an electronic equivalent that includes all components from the hard-copy form);
- Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules;
- Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services;
- If appropriate, document in the medical record the member's or legal guardian's decision not to utilize EPSDT services or receive immunizations;
- Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and provide health counseling/education at initial and follow up visits;
- Ensure all infants receive both the first and second newborn screening tests;
- Send copies of the completed EPSDT tracking forms to the health plan's Quality Management Department by secure fax at (844)266-5339;
- Providers must verify that Members receive EPSDT services in compliance with the AHCCCS EPSDT periodicity schedule and the AHCCCS Dental Periodicity Schedule ([AHCCCS AMPM Exhibit 430-1](#));
- Schedule the next appointment at the time of the current office visit for children ages 24 months and younger;
- Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier;
- Refer members to Children's Rehabilitative Services (CRS) when they have conditions covered by the CRS program;
- Initiate and coordinate referrals to ALTCS, Audiology, DDD, Dental, Occupational Therapy, Physical Therapy, Speech, Developmental, behavioral health, Women, Infants and Children (WIC), the Arizona Early Intervention Program (AzEIP) and Head Start as necessary.

2.4.3 An EPSDT Well-Child Basic Elements

A Well-Child exam includes the following elements:

- Comprehensive health and developmental history, including growth and development screening (includes physical, nutritional and behavioral health assessments);
- Developmental screening (using an AHCCCS-approved developmental screening tool) for members ages 9, 18 and 24 months;
- A comprehensive unclothed physical examination;
- Provide appropriate immunizations according to age and health history;
- Laboratory tests appropriate to age and risk for blood lead, tuberculosis skin testing, anemia testing and sickle cell trait;
- Health education, counseling, chronic disease self-management, counseling about child development, healthy lifestyles and accident and disease prevention;
- An oral health screening must be part of an EPSDT screening conducted by a Primary Care Provider; however, it does not replace the need for examination through direct referral to a Dentist;
- Fluoride varnish application every six months (by providers who have completed training) for members' age 6-24 months with at least one tooth eruption;
- Provide appropriate vision and hearing/speech testing;
- Nutritional assessment;
- Obesity screening using the body mass index (BMI) percentile for children;
- Behavioral health screening, referrals and services;
- Tuberculin skin testing as appropriate to age and risk. Children at increased risk of Tuberculosis (TB) include those who have contact with persons:
 - Confirmed or suspected as having TB,
 - In jail or prison 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.
- Provide Anticipatory Guidance;
- Vision exam appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule; and
- Documentation of the member's AHCCCS Identification number on the EPSDT tracking forms or electronic medical record.

2.4.4 Sick Visit Performed in Addition to an EPSDT Visit

Billing of a "sick visit" (CPT Codes 99201-99215) at the same time as an EPSDT if a separately billable service if:

1. 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 E/M service.
2. The “sick visit” is documented on a separate note.
3. History, Exam, and Medical Decision Making components of the separate “sick visit” already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215).
4. The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service.

2.4.5 Developmental Screening Tools

Primary care providers (PCPs) must be trained in the use and scoring of developmental screening tools. Training resources may be found at Arizona Department of Health Services website at <http://www.azdhs.gov/clinicians/training-opportunities/developmental/index.php>

The following developmental screening tools are available for members at their 9-, 18- and 24-month EPSDT visit:

- Ages and Stages Questionnaires™ Third Edition (ASQ) is a tool used to identify developmental delays in the first five years of a child’s life. The sooner a delay or disability is identified, the sooner a child can be connected with services and support that make a real difference. The tool is available online at www.agesandstages.com .
- Ages and Stages Questionnaires®: Social-Emotional (ASQ: SE) is a tool used to identify developmental delays for social-emotional screening. The tool is available at www.agesandstages.com .
- The Modified Checklist for Autism in Toddlers (M-CHAT) used only as a screening tool by a PCP, for members ages 16 to 30 months, to screen for autism when medically indicated. The tool is available online at www.m-chat.org .
- The Parents’ Evaluation of Developmental Status (PEDS) used for developmental screening of EPSDT-aged members. The tool is available online at www.pedstest.com or www.forepath.org

Payment for use of screening tools is covered when the following criteria are met:

- The member’s EPSDT visit is at 9, 18, or 24 months;
- Prior to providing the service, the provider must complete the required training for the developmental screening tool being utilized and submit a copy of the training certificate to the Council for Affordable Quality Healthcare (CAQH);
- The code is appropriately billed (96110-EP). Providers must retain copies of the completed tools in the member’s medical record and submit it to the health plan with the completed EPSDT Tracking Form.

2.4.6 PCP Application of Fluoride Varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit.

Application of fluoride varnish may be billed separately from the EPSDT visit using CPT Code 99188. Fluoride varnish is limited in a primary care provider's office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age.

2.4.7 Blood Lead Screening

EPSDT covers blood lead screening. Required blood lead screening for children under six year of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

- Children living in a targeted high-risk zip code: All children living in a high risk zip code as identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning.
- Children living outside of the targeted high-risk zip codes: Children living in Arizona, but not in a targeted high-risk zip code must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the Arizona Department of Health Services Targeted Lead.
- Providers must report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS (A.A.C. R9-4-302).

2.4.8 Missed/No-Show EPSDT Appointments

Providers are expected to follow up with members who miss or no-show their EPSDT appointments and notify the health plan when a member has missed or cancelled three or more visits. Providers may utilize the health plan's Missed/No-Show Log. Providers are encouraged to use the recall system in order to reduce the number of missed or cancelled appointments.

2.4.9 Arizona Early Intervention

Program (AzEIP) Procedures AHCCCS and AzEIP jointly developed procedures for the coordination of services under Early Periodic Screening, Diagnostic and Treatment (EPSDT) and AzEIP to ensure the coordination and provision of EPSDT and AzEIP services.

2.4.10 PCP-Initiated Services

When concerns about a child's development are initially identified by the child's primary care physician (PCP), the PCP requests an evaluation and, if medically necessary, approval of services from the health plan.

Evaluation/Services: The Health Plan may pend approval for services until the evaluation has been completed by the provider and may deny services if the PCP determines there is no medical need for services based on the results of the evaluation.

- Requests for services from PCPs, licensed providers or the AzEIP service coordinator based on the Individual Family Service Plan (IFSP) must be reviewed for medical necessity prior to authorization and reimbursement.
- If services are approved, The Health Plan authorizes the services with The Health Plan participating provider, whenever possible, and notifies the PCP (requesting provider if other than the PCP) that (a) the services are approved, and (b) identifies the provider that has been authorized, the frequency, duration, and the service begin and end dates.
- The Health Plan follows the Code of Federal Regulation 42 438.210 for completion of prior authorization requests.

The Health Plan provides a decision as expeditiously as the member's health condition requires, but not later than 14 calendar days following the receipt of a standard authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if The Health Plan justifies a need for additional information and the delay is in the member's best interest.

In the event that a provider indicates or The Health Plan determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the health plan makes an expedited authorization decision and provide notice as expeditiously as the member's health condition requires no later than three business days following the receipt of the authorization request (date of receipt of request), with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the health plan justifies a need for additional information and the delay is in the member's best interest.

Referral to AzEIP: After completing the evaluation, the provider who conducted the evaluation submits an evaluation report to the PCP (requesting provider if other than the PCP) and the Health Plan's Prior Authorization Department for authorization of medically necessary services.

If the evaluation indicates that the child scored two standard deviations below the mean, which generally translates to AzEIP's eligibility criteria of 50 percent developmental delay, the child continues to receive all medically necessary EPSDT covered services through the health plan. The health plan's EPSDT Coordinator refers the child to AzEIP for non-medically necessary services that are not covered by Medicaid, but are covered under IDEA Part C. If the evaluation report indicates that the child does not have a 50 percent developmental delay, the EPSDT Specialist continues to coordinate medically necessary care and services for the child.

The Health Plan and AzEIP continue to coordinate services for Medicaid children who are eligible for and enrolled in both AzEIP and Medicaid. The EPSDT Coordinator assists the parent or caregiver in scheduling the EPSDT covered services, as necessary or as requested. The EPSDT services are provided by the health plan's participating provider (or AzEIP service provider reimbursed by the health plan) until the services are determined by the PCP and provider to no longer be medically necessary.

2.4.11 AzEIP-Initiated Service Requests

When concerns about a Medicaid enrolled child's development are initially identified by AzEIP:

- If an EPSDT-eligible child is referred to AzEIP, AzEIP screens and, if needed, conducts an evaluation to determine the child's eligibility for AzEIP. AzEIP obtains parental consent to request and release records to and from the health plan and the child's PCP;
- The PCP reviews all AzEIP documentation and determines which services are medically necessary based on review of the documentation;
- The PCP takes no longer than 10 business days from the date the EPSDT Specialist faxes the documentation to the PCP to determine which services are medically necessary and returns the signed AzEIP AHCCCS Member Service Request form (Exhibit 430-4) to the EPSDT Coordinator.

The PCP will determine the requested services are medically necessary:

- Within two business days, the EPSDT Coordinator sends the completed AzEIP AHCCCS Member Service Request form (Exhibit 430-4) to the AzEIP service coordinator and PCP advising them that: (a) the services are approved, and (b) identifying the provider that has been authorized, the frequency, duration, and the service begin and end dates;
- The Health Plan authorizes services with a participating provider whenever possible;
- AzEIP providers may only be reimbursed (a) if they are AHCCCS registered and (b) for the categories of services for which they are registered and that were provided. Billing must be completed in accordance with AHCCCS guidelines;
- When services are determined by the PCP and service provider to be no longer medically necessary, the AzEIP service coordinator implements the process for amending the IFSP, which may include (a) non medically necessary services covered by AzEIP, and (b) changes made to IFSP outcomes and IFSP services, including payer, setting, etc;
- The AzEIP service coordinator, family and other IFSP team members review the IFSP at least every six months or sooner if requested by any team member. If services are changed (deleted or added) during an annual IFSP or IFSP review, the AzEIP service coordinator notifies the EPSDT Coordinator and PCP within two business days of the IFSP review. If a service is added, the AzEIP service coordinator's notification to the EPSDT coordinator initiates the process for determining medical necessity and authorizing the service as outlined above.

2.4.12 Children's Rehabilitative Services (CRS) Program

The Provider shall notify The Health Plan when a child is potentially in need of services related to CRS qualifying conditions, as specified in A.A.C. R9-22 Article 13, and A.R.S. Title 36. See [AHCCCS ACOM Policy 426](#) for the referral process to obtain a CRS designation. In addition, the Provider shall notify the member, or their parent/guardian/authorized representative, and The Health Plan when a referral to a specialist for an evaluation of a CRS condition is being made.

Reference [AHCCCS ACOM Policy 426](#) for the processes used to process referrals for a CRS designation. The Provider is responsible for notifying The Health Plan of the date when a member with a CRS designation is no longer in need of treatment for the CRS qualifying condition(s) as specified in Section F, Attachment F3, Contractor Chart of Deliverable and [AHCCCS ACOM Policy 426](#). The notification requirements described above are applicable only to members under 21 years of age. The Provider shall consider members with a CRS qualifying condition as members with special health care needs. Refer to Section D, Paragraph 10, Special Health Care Needs.

Many children with Special Health Care Needs, including children with CRS-qualifying medical conditions typically require complex care and are medically fragile. For these children, CRS Providers must provide health care service delivery that involves multiple clinicians, covering the entire continuum of care. In addition to a primary care provider, these children may receive services from subspecialists who manage care related to their condition(s) and coordinate with other specialty services including but not limited to behavioral health, pharmacy, medical equipment and appliances, therapies, diagnostic services, and telemedicine visits.

Comprehensive care includes a multi-disciplinary team made up of subspecialists and caregivers such as pulmonologists, cardiologists, nutritionists, psychologists, and therapists. Because of the complexity of the needs of these children requiring multiple surgeries, hospitalization, and clinical care it is imperative that there be integrated health information and care coordination for the member. Services shall be provided using an integrated family-centered, culturally competent, multi-specialty, interdisciplinary approach that includes the following elements:

1. A process for using a centralized, integrated medical record that is accessible to The Health Plan and service providers consistent with Federal and State privacy laws to facilitate well-coordinated, interdisciplinary care;
2. A process for developing and implementing a Service Plan accessible to The Health Plan and service providers that is consistent with Federal and State privacy laws that contains the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation; and
3. Collaboration with individuals, groups, providers, organizations and agencies charged with the administration, support or delivery of services for persons with special health care needs.

Providers shall ensure that members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring have an individualized physical and behavioral treatment or service plan. In addition, the Provider shall conduct multi-disciplinary staffings for members with challenging behaviors or health care needs [42 CFR 438.208(c)(3)].

For members with special health care needs determined to need a specialized course of treatment or regular care monitoring, The Health Plan will allow members to directly access a specialist (for example through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs [42 CFR 438.208(c)(4)]. The minimum performance standard established by AHCCCS for the initial visit for CRS-Identified Members is to occur within 30 days.

Multi-Specialty Interdisciplinary Clinics (MSICs): For members with special health care needs, including members with CRS conditions who could benefit from a multi-disciplinary approach, covered services shall be delivered through a combination of established Multi-Specialty Interdisciplinary Clinics (MSICs), Field Clinics, Virtual Clinics, and in community settings. The Provider shall coordinate care for members that includes allowing members with a CRS designation turning 21 the choice to continue being served by an MSIC that is able to provide services and coordinate care for adults with special healthcare needs.

COPAYMENTS

Members with a CRS qualifying condition are currently exempt from mandatory and optional copayments.

2.4.13 Body Mass Index

Primary care providers (PCPs) should calculate each child's body mass index (BMI) starting at age 2 until the member is age 21. BMI is used to assess underweight, overweight and those at risk for overweight. BMI for children is gender and age specific. PCPs are required to calculate the child's BMI and percentile. Additional information is available at the Centers for Disease Control and Prevention (CDC) website regarding BMI.

The following established percentile cutoff points are used to identify underweight and overweight in children:

≥ 95th percentile	Obese
85th to < 95th percentile	Overweight
5th to < 85th percentile	Healthy Weight
< 5th percentile	Underweight

Nutritional Assessment and Nutritional Therapy

Nutritional assessments are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for the health plan's members under age 21, whose health status may improve with nutrition intervention. Nutritional therapy is covered for EPSDT-eligible health plan members for the below 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.

- Enteral nutritional therapy –
Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube Parenteral nutritional therapy -
Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength.
- Commercial oral supplemental nutritional feedings

Provides nourishment and increases caloric intake as a supplement to the member's intake of other age- appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription

The Health Plan covers the following for members with a medical condition described in the section above:

- Special Supplemental Program for Women, Infants and Children (WIC)-eligible infant formulas, including specialty infant formulas;
- Medical foods;
- Parenteral feedings; and
- Enteral feedings.

Refer to the Medical Foods section for the health plan's members with a congenital metabolic disorder, such as phenylketonuria, homocystinuria, maple syrup urine disease, or galactosemia.

2.4.14 Nutritional Assessment and Nutritional Therapy – Members Ages 21 and Older

Nutritional assessments and nutritional therapy is provided for members whose health status may improve with nutrition intervention. Arizona Health Care Cost Containment System (AHCCCS) covers nutritional therapy on an enteral, parenteral and oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake.

Nutritional assessments and nutritional therapy are covered benefits for members ages 21 and older when all of the following apply:

- The member is currently underweight with a BMI of less than 18.5 presenting serious health consequences for the member, or the member has demonstrated a medically significant decline in weight within the past three months (prior to the assessment).
- The member is able to consume no more than 25 percent of their nutritional requirements from typical food sources.
- The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions or psychosocial problems, or endocrine or gastrointestinal problems).
- The member has had a trial of higher caloric foods, blenderized foods or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. After this trial, there is clinical documentation and other supporting evidence indicating that higher caloric foods would be detrimental to the member's overall health.

2.4.15 Referrals for Nutritional Assessment

Nutritional assessments are conducted to assist members whose health status may improve with nutritional intervention. The health plan covers the assessment of nutritional status, as determined necessary and as a part of health risk assessment and screening services provided by the member's primary care provider (PCP).

Nutritional assessment services provided by a registered dietitian are covered when ordered by the member's PCP.

To initiate a referral for a nutritional assessment, complete the health plan's referral form and fax it to the health plan's Prior Authorization Department.

The assessment of a member's nutritional status is covered as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program specified in the Arizona Health Care Cost Containment System (AHCCCS) EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member's primary care physician (PCP). This includes members who are under or overweight. A PCP may perform the nutritional assessment or may refer the member to a registered dietitian.

2.4.16 Prior Authorization for Nutritional Therapy

Prior authorization is always required for nutritional therapy. Providers must submit all clinically relevant information for medical necessity review and prior authorization requests. To obtain prior authorization for enteral or parenteral nutritional therapy, providers must complete and submit a Request for Prior Authorization form to the health plan's Prior Authorization Department.

Prior authorization is required for commercial oral supplemental nutritional feedings, including specialty infant formulas, unless the member is also currently receiving nutrition through enteral or parenteral feedings. Prior authorization is not required for the first 30 days if the member requires commercial oral nutritional supplements on a temporary basis due to an emergent condition. An example of a nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder.

The primary care physician (PCP) or attending physician must determine medical necessity on an individual basis for commercial oral nutritional supplements.

For prior authorization on commercial oral supplemental nutritional feedings, the member's PCP or attending physician must complete and submit the Arizona Health Care Cost Containment System (AHCCCS)-approved Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form to the health plan's Prior Authorization Department.

The PCP or attending physician must have documentation that nutritional counseling was provided as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and specify alternatives that were tried in an effort to boost caloric intake and change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.

The PCP or attending physician must indicate on the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements form which criteria were met when assessing medical necessity of providing commercial oral nutritional supplements. The member must meet at least two of the following criteria:

- At or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more;
- Reached a plateau in growth and/or nutritional status for more than six months (prepubescent);

- Already demonstrated a medically significant decline in weight within the past three months (prior to the assessment);
- Able to consume/eat no more than 25 percent of their nutritional requirements from age-appropriate food sources;
- Has absorption problems as evidenced by emesis, diarrhea, dehydration, and weight loss; and intolerance to milk or formula products has been ruled out;
- Requires nutritional supplements on a temporary basis due to an emergent condition; such as post- hospitalization (prior authorization is not required for the first 30 days);
- At high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition.

2.5 Dental Services

The Health Plan has a comprehensive dental network for members. To serve the needs of its members, the health plan partners with Envolve Dental who administers the health plan's dental benefits. Dental Providers must submit claims and prior authorizations to Envolve Dental, <https://dental.envolvehealth.com/providers.html> 844-876-2028.

The Health Plan offers dental services for:

- Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment aged members
- Preventive dental services for EPSDT Members under the age of 21 years
- Therapeutic Dental Services For members under 21
- Emergency Dental Coverage for members under 21
- Emergency Dental Coverage for Members 21 Years Of Age And Older
- PCP Fluoride Varnish Application for children less than 2 years of age

Eligible EPSDT Members under the age of 21 years old have comprehensive dental service benefits which include preventive, therapeutic and emergency dental services. All members age out of the Oral Health & EPSDT program and services at age 21.

If a member does not qualify under their dental eligibility and a medical condition is present, medical necessity is determined by the health plan. Medical documentation is required and must be submitted directly to the health plan for review and prior authorization determination.

Dental Providers should include parent/guardian or caregivers in all consultations and counseling of members regarding preventive oral health care and the clinical findings.

The Health Plan adheres to the Deental Uniform Prior Authorization List and the Uniforms Warranty List as outline in [AMPM Policy 431](#).

2.5.1 Oral Health Care for Early and Periodic Screening, Diagnosis and Treatment aged members

As part of the physical examination, the physician, physician's assistant or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist must be made as outlined in the Contract:

- EMERGENT-Within 24 hours of request
- URGENT-Within three days of request
- ROUTINE-Within 45 days of request

PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member's medical record.

EPSDT Members may select a dentist within the health plans contracted network and receive preventive dental services without a referral.

2.5.2 PCP Application of Fluoride Varnish

Physicians who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visit for recipients who are at least age six months, with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until the recipient's second birthday, are also reimbursed.

AHCCCS recommended training for fluoride varnish application is located at the Smiles for Life website under Training Module 6 that covers caries risk assessment, fluoride varnish and counseling. Upon completion of the required training, providers should upload a copy of their certificate to the Council for Affordable Quality Healthcare (CAQH) site. This certificate is used in the credentialing process to verify completion of training necessary for reimbursement. An oral health screening must be part of an EPSDT screening conducted by a PCP; however, it does not substitute for examination through direct referral to a dentist. PCPs must refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member's medical record.

2.5.3 Preventive Dental Services

Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule ([AHCCCS AMPM Exhibit 431-1](#)), including but not limited to:

- Diagnostic services includes comprehensive and periodic examinations. The Health Plan allows two oral examinations and two oral prophylaxis and fluoride treatments per

member per year (one every six months) for members ages 12 months until members 21 years of age;

- Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth X-rays, supplemental bitewing X-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry (AAPD); and
- Panorex films are covered as recommended by AAPD, up to three times maximum per provider for children between ages 3 to members 21st birthday. Additional panorex films needed above this limit must be deemed medically necessary through the health plan prior authorization process.

Preventive services, including:

- Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/ legal guardian;
- Application of topical fluoride varnish. The use of a prophylaxis paste containing fluoride or fluoride mouth rinses do not meet the AHCCCS standard for fluoride treatment;
- Dental sealants for first and second molars are covered every three years up to age 15, with a two- time maximum benefit. Additional applications must be deemed medically necessary and require prior authorization through The Health Plan;
- Space maintainers when posterior primary teeth are lost and when deemed medically necessary through The Health Plan prior authorization process.

2.5.4 Therapeutic Dental Services

All therapeutic dental services will be covered when they are considered medically necessary and cost effective, but may be subject to PA by the health plan or AHCCCS Division of Fee-For-Service Management for FFS members.

These services include, but are not limited to:

- a. Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery;
- b. Crowns:
 - i. When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth; or
 - ii. Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 to 21 years of age.
- c. Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar);

- d. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is 18 to 21 years of age and has had endodontic treatment;
- e. Restorations of anterior teeth for children under the age of five, when medically necessary. Children, five years and over with primary anterior tooth decay should be considered for extraction, if presenting with pain or severely broken down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider;
- f. Removable dental prosthetics, including complete dentures and removable partial dentures; and
- g. Orthodontic services and orthognathic surgery are covered only when these services are necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

Examples of conditions that may require orthodontic treatment include the following:

- a. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services;
- b. Trauma requiring surgical treatment in addition to orthodontic services; or
- c. Skeletal discrepancy involving maxillary and/or mandibular structures.

2.5.5 Emergency Dental Coverage for Members under 21 Years Of Age

EPSDT covers the following dental services:

Emergency dental services including:

- a. Treatment for pain, infection, swelling and/or injury;
- b. Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic); and
- c. General anesthesia, conscious sedation or anxiolysis (minimal sedation, members respond normally to verbal commands) when local anesthesia is contraindicated or when management of the member requires it. (See [AHCCCS AMPM Policy 430](#), Section C, Item No. 9 regarding conscious sedation.)

2.5.6 Dental Services Not Covered For EPSDT Age Members

Orthodontic treatment and extraction of non-symptomatic teeth are generally not covered services. This includes third molars.

Services or items furnished solely for cosmetic purposes are not covered.

2.5.7 Emergency Dental Coverage for Members 21 Years Of Age And Older

Medically necessary emergency dental care and extractions are covered for persons age 21 years and older who meet the criteria for a dental emergency. A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

AHCCCS covers the following dental services provided by a licensed dentist for members who are 21 years of age or older:

1. Emergency dental services up to \$1000 per member per contract year (October 1st to September 30th) as a result of A.R.S. §36-2907. The emergency dental services are described in subsection A;
2. Medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician (A.A.C. R9-22-207);
3. These services must be related to the treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction [TMJ] pain), infection, or fracture of the jaw. Covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma. Services described in this paragraph are not subject to the \$1000 adult emergency dental limit;
4. Limited dental services as a prerequisite to AHCCCS covered transplantation services may be performed under State law by either a physician or by a dentist and he services would be considered physician services if furnished by a physician and when they are in preparation for radiation treatment for certain cancers.

The following services and procedures are covered as emergency dental services:

- Emergency oral diagnostic examination (limited oral examination – problem focused);
- Radiographs and laboratory services, limited to the symptomatic teeth;
- Composite resin due to recent tooth fracture for anterior teeth;
- Prefabricated crowns, to eliminate pain due to recent tooth fracture only;
- Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;
- Pulp cap, direct or indirect plus filling;
- Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;
- Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;

- Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition,
- Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;
- Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment);
- Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods;
- Preoperative procedures and anesthesia appropriate for optimal patient management; and
- Cast crowns limited to the restoration of root canal treated teeth only.

Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the \$1000 limit.

2.5.8 Limitations

Adult Emergency Dental Services Limitations for Persons age 21 Years and Older.

Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.

Diagnosis and treatment of temporomandibular joint dysfunction (TMD or TMJ) is not covered except for the reduction of trauma.

Routine restorative procedures and routine root canal therapy are not emergency dental services and are not covered.

Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presences of active infection.

Fixed bridgework to replace missing teeth is not covered.

Dentures are not covered.

Exceptions for Transplants and Members with Cancer

I. Transplant Cases

For members who require medically necessary dental services as a pre-requisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease. Covered dental services are limited to the following:

- Dental cleaning(Prophylaxis);
- Treatment of periodontal disease;
- Medically necessary extractions;
- Simple restorations. A simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns.

The health plan covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. These services are not subject to the \$1000 adult emergency dental limit.

II. Members with Cancer

Covered dental services are limited to the following:

- Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is also covered. These services are not subject to the \$1000 adult emergency dental limit.

2.5.9 Charging of Members

Emergency dental services of \$1000 per contract year are covered for AHCCCS member's age 21 years and older. Billing of AHCCCS members for emergency dental services in excess of the \$1000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 (for acute members) and A.A.C. R9-28-701.10 (for ALTCS members).

In order to bill the member for emergency dental services exceeding the \$1000 limit, the provider must first inform the member in a way s/he understands, that the requested dental service exceeds the \$1000 limit and is not covered by AHCCCS. Before providing the dental services that will be billed to the member, the provider must furnish the member with a document to be signed in advance of the service, stating that the member understands that the dental service will not be fully paid by AHCCCS and that the member agrees to pay for the amount exceeding the \$1000 emergency dental services limit, as well as services not covered by AHCCCS.

The member must sign the document before receiving the service in order for the provider to bill the member. It is expected that the document contain information describing the type of service to be provided and the charge for the service

2.5.10 Informed Consent

A written consent is needed for an exam or reversible procedure and is updated every six months.

A separate written consent is needed for any irreversible service.

Members must receive copies of their treatment plans.

2.5.11 Facility and Anesthesia Charges

Adult members requiring general anesthesia in an ambulatory service center or outpatient hospital the general anesthesia are subject to the \$1000 emergency dental limit.

Dentist performing general anesthesia on adult emergency members must bill dental codes that count towards the \$1000 adult emergency benefit.

Physicians performing general anesthesia on adult emergency members for a dental procedure must bill medical codes and it will count towards the \$1000 emergency dental limit.

2.5.12 Dental Referrals

Dental services may be initiated by a Primary Care Provider (PCP) through referral to a participating dental provider, the member or member's legal guardian. No referral is required for an eligible member to make a dental appointment or receive dental care from one of the contracted health plan dental providers. Prior authorizations may be required for therapeutic services.

The AHCCCS EPSDT Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services must be provided. Depending on the results of the oral health screening, a referral to a dentist must be made.

PCP Providers must:

- Encourage Members who call for a dental referral to obtain any routine or follow up care and document all referrals in the Member's medical record.
- Identify appropriate dental services based on needs
- Document evidence of referrals on the EPSDT tracking form or in the member's electronic medical records;
- Refer members for a dental assessment if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional according to the AHCCCS EPSDT Dental Periodicity Schedule.
- Encourage eligible Members to see a dentist regularly;
- Obtain appropriate prior authorization before rendering non-emergency dental services.

Although the AHCCCS Dental Periodicity Schedule identifies when routine referrals begin, PCP's may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to dentists who are in the health plan provider network.

2.5.13 Dental Home Assignment for EPSDT age Members under the age of 21

The American Academy of Pediatric Dentistry (AAPD) defines the dental home as the ongoing relationship between dentist and the member, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home must include:

- Comprehensive oral health care, including acute care and preventive services in accordance with the Arizona Health Care Cost Containment System (AHCCCS) Dental Periodicity Schedule;
- Comprehensive assessment for oral diseases and conditions;
- Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment;

- Anticipatory guidance about growth and development issues (such as teething, digit or pacifier habits);
- Plan for acute dental trauma;
- Information about proper care of the child's teeth and gingivae. This would include the prevention, diagnosis and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function and esthetics of those structures and tissues;
- Dietary counseling; and
- Referrals to dental specialists when care cannot directly be provided within the dental home.

Members must be assigned to a dental home by age one and seen by a dentist for routine preventive care according to the AHCCCS Dental Periodicity Schedule ([AHCCCS AMPM Chapter 400, Exhibit 431](#)) - Members must also be referred for additional oral health care concerns requiring additional evaluation and/or treatment.

2.5.14 Provider Request for Dental Home Re-assignment of an EPSDT Age Member

Dental home providers can request that a covered member be removed from their panel by issuing the person a written notice and allowing up to 60 days for assignment to a new dental home provider.

2.5.15 Preventive Care For Title XIX/XXI Eligible Adults with SMI 21 Years of Age & Older with added Employment Benefit

Preventive dental services are covered benefits for Title XIX/XXI Eligible adults with SMI 21 years of age and older enrolled with the health plan and who meet the eligibility criteria outlined above. In general, these include:

- Diagnostic services: two oral examinations per year and x-rays.
- Two oral prophylaxis and fluoride treatments per year.

2.5.16 Therapeutic Dental Services For Title XIX/XXI Eligible Adults with SMI 21 Years of Age & Older with added Employment Benefit

Therapeutic dental services require prior authorization by Envolve Dental, dental administrator for the health plan. Crowns: covered crowns include porcelain/ceramic substrate, porcelain fused to metal. Teeth covered: front teeth # 6-11 and #22-27.

Extraction of symptomatic (including pain), infected and non-restorable primary and permanent teeth, as well as retained primary teeth (extractions are limited to teeth which are symptomatic).

General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it.

2.5.17 Dental Services Not Covered For Title XIX/XXI Eligible Adults with SMI 21 Years of Age or Older with Added Employment Benefit

Dental Services not covered for Title XIX/XXI eligible adults with SMI 21 years of age or older with added employment benefits includes:

- Orthodontic treatment;
- Extraction of non-symptomatic teeth are generally not covered services. This includes third molars; and
- Services or items furnished solely for cosmetic purposes are not covered.

2.6 Optical Services

The Health Plan covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on Member age and eligibility.

Emergency eye care, which meets the definition of an emergency medical condition, is covered for all Members. For Members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for Members under the EPSDT program and for adults when medically necessary following cataract removal. Cataract removal is covered for all eligible Members under certain conditions. For more information, visit the AHCCCS website under Medical Policy for AHCCCS Covered Services.

2.6.1 Coverage for EPSDT aged members

Appropriate vision screenings are covered during an EPSDT visit. EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision requirements provided in a PCP's office during an EPSDT visit, are considered part of the EPSDT visit and are not a separately billable services. Ocular photoscreening with interpretation and report, bilateral (CPT code 99177) is covered for children ages three to five as part of the EPSDT visit due to challenges with a child's ability to cooperate with traditional vision screening techniques. Ocular photoscreening is limited to a lifetime coverage limit of one. This procedure, although completed during the EPSDT visit, is a separately billable service.

Coverage for EPSDT members includes:

- Medically necessary emergency eye care, vision examinations, prescriptive lenses and treatments for conditions of the eye;
- PCPs are required to provide initial vision screening in their office as part of the EPSDT program. Vision exams provided in a PCP's office during an EPSDT visit are not a separately billable service;

- Members 18-20 years of age with vision screening of 20/60 or greater should be referred to the contracted vision provider for further examination and possible provision of glasses;
- Replacement of lost or broken glasses is a covered benefit;
- Contact lenses are not a covered benefit.

Vision CPT codes with the EP modifier must be listed on the claim form in addition to the preventive medicine CPT codes for visit screening assessment. With the exception of CPT code 99177, no additional reimbursement is allowed for these codes.

2.6.2 Emergency Eye coverage for members 21 Years And Over

- Emergency care for eye conditions when the eye condition meets the definition of an emergency medical condition; for cataract removal and/or medically necessary vision examinations; and for prescriptive lenses if required following cataract removal.
- Routine eye exams and glasses are not a covered service for adults.
- Adults 21 years of age and older should be referred to Envolv Vision (The Health Plan's Managed Optical Care Vendor) for the diagnosis and treatment of eye diseases as well.

2.7 Immunization Information

Primary care providers (PCPs) are responsible for immunizing members and maintaining all immunization information in the member's medical record. Local health departments (LHDs) may also immunize the health plan's members. PCPs must be available to administer immunizations during routine office hours. It is the PCP's responsibility to update the immunization record card or other form of immunization record, and enter all immunizations into the Arizona State Immunization Information System (ASIIS) registry. At each visit, the PCP should inquire whether the patient has received immunizations from another provider. The PCP should also educate members regarding their responsibility to inform the PCP if they receive immunizations elsewhere (such as from an LHD or nonparticipating provider). This information is necessary for documentation and for the member's safety.

The EPSDT Program covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. The health plan will cover the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 to 21 years of age. The health plan will cover members nine and ten years of age, if the member is deemed to be in a high-risk situation. All appropriate immunizations must be provided to establish and maintain up-to-date immunization status for each member based on their age. Refer to the CDC website at www.cdc.gov/vaccines/schedules/index.html for current immunization schedules.

For adult immunization coverage, refer to [AHCCCS AMPM Chapter 300, Policy 310-M](#) for AHCCCS Covered Services, or to the CDC website at

<https://www.cdc.gov/vaccines/schedules/hcp/adult.html> for adult immunization recommendations.

2.7.1 Vaccine for Children (VFC)

Through the Vaccines for Children (VFC) Program, the federal and State governments purchase, and make available to providers at no cost, vaccines for Medicaid eligible members under age nineteen (19). Members, 18 years of age, are eligible to receive VFC vaccines.

- Providers must coordinate with the Arizona Department of Health Services Vaccines for Children (VFC) program in the delivery of immunization services.
- Providers must enroll and re-enroll annually with the VFC program in accordance with AHCCCS Contract requirements.
- Providers will not utilize AHCCCS funding to purchase VFC vaccines for members over 19 years of age.
- Providers shall maintain a sufficient supply of vaccines for EPSDT aged members.
- Immunizations must be provided according to the Advisory Committee on Immunization Practices (ACIP) Recommended Schedule or when medically necessary for the member's health.
- Providers are encouraged to offer simultaneous administration of all vaccines for which a member 18 years of age is eligible at the time of EPSDT visit.
- Providers must enroll with and document EPSDT member's immunizations in the Arizona State Immunization Information System (ASIIS) and maintain the ASIIS immunization records of each EPSDT member in ASIIS in accordance with A.R.S. Title 36, Section 135.
- The ADHS ASIIS immunization registry can be accessed by the providers to obtain accurate immunization records for EPSDT members.

More information is available in the Vaccines for Children (VFC) Program Operations Guide 2016 per AHCCCS or visit <https://azdhs.gov/documents/preparedness/epidemiology-disease-control/immunization/vaccines-for-children/exhibits/operations-guide.pdf>

2.7.2 Arizona State Immunization Information System (ASIIS)

Providers must document each EPSDT age member's immunizations in the Arizona State Immunization Information System (ASIIS) registry within 30 days of administering an immunization. In addition, providers must maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. Title 36, Section 135.

2.8 Crisis Intervention Services

Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in a variety of settings, such as hospital emergency departments, face-to-face at a person's home, over the telephone, or in the community. These intensive and time limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessing, evaluating or counseling to

stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to verify stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation.

At the time behavioral health crisis intervention services are provided, a person's enrollment or eligibility status may not be known. However, crisis intervention services must be provided, regardless of enrollment or eligibility status.

Any person presenting with a behavioral health crisis in the community, regardless of Medicaid eligibility or enrollment status. Collaboration agreements between Health Plans and local law enforcement/first responders address continuity of services during a crisis, jail diversion and safety, and strengthening relationships between first responders and providers.

2.8.1 Overview of Crisis Intervention Services

To meet the needs of individuals in communities throughout Arizona, The Health Plan provides the following crisis services:

- Telephone crisis intervention services provided by The Health Plan contracted Crisis Call Center available 24 hours per day, seven days a week:
 - Southern Region Residents (Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, Yuma, County or on the San Carlos Apache Reservation): can access The Health Plan crisis services by calling 866-495-6735.
 - Maricopa County Residents: can access The Health Plan crisis services by calling 800-327-9254.
 - Pinal County Residents: can access The Health Plan crisis services by calling 866-495-6735.
 - Gila County Residents: can access The Health Plan crisis services by calling 877-756-4090.
- Mobile crisis intervention services, available 24 hours per day, seven days a week;
 - If one person responds, this person shall be a Behavioral Health Professional or a Behavioral Health Technician; and
 - If a two-person team responds, one person may be a Behavioral Health Paraprofessional, including a peer or family member, provided they have supervision and training as currently required for all mobile team members.
- Crisis stabilization/observation services, including detoxification services;
 - The Health Plan provides crisis stabilization and detoxification services through Behavioral Health Inpatient Facilities, Behavioral Health Hospital Facilities, and Substance Abuse Transitional Facilities.
 - If you live in Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, Yuma County or on the San Carlos Apache Reservation, you can access crisis services by calling 866-495-6735.
 - If you live in Pinal County, you can access crisis services by calling 866-495-6735
 - If you live in Maricopa County, you can access crisis services by calling the Maricopa County Crisis Line 1-602-222-9444 or 800-327-9254.
 - If you live in Gila County, you can access crisis services by calling 877-756-4090
- Up to 72 hours of additional crisis stabilization as funding is available for mental health

and substance abuse related services.

For program requirements related to The Health Plan Crisis Intervention Services, see **Section 14 — Specific Behavioral Health Program Requirements**.

2.8.2 Management of Crisis Services

The Health Plan maintains availability of crisis services in each county served. The Health Plan utilizes the following in managing crisis services:

- The Health Plan allocates and manages funding to maintain the availability of required crisis services for the entire fiscal year;
- The Health Plan works collaboratively with local hospital-based emergency departments to determine whether a The Health Plan -funded crisis provider should be deployed to such locations for crisis intervention services;
- The Health Plan works collaboratively with local Behavioral Health Inpatient Facilities to determine whether and for how many hours such locations are used for crisis observation/stabilization services; and
- When Non-Title XIX/XXI eligible individuals are receiving crisis services and require medication, The Health Plan uses the generic medication formulary identified in the Non-Title XIX/XXI SMI benefit (see **Section 4.13 — Pharmaceutical Requirements**).

The Health Plan seeks to ensure Members receive crisis services on a timely basis and, when appropriate, in their homes and communities. Crisis mobile teams are available to help Members obtain the appropriate crisis services. The Health Plan discourages providers from sending Members to emergency rooms for non-medical reasons.

2.9 Housing Resources for Adults

State-Funded Housing for Adults

State-funded housing rules are outlined within The Health Plan Provider Manual and [ACOM Policy 448](#). For members who are experiencing or are at-risk of homelessness and are able to live independently, The Health Plan funds a number of programs to support independent living. This includes supported housing programs, provider owned or leased homes and apartment complexes that combine housing services with other covered services (<http://AZAHCCCS.gov> and <http://www.samhsa.gov>).

2.9.1 Cooperation with Arizona Complete Health Complete Care Plan and other Agencies

Providers must cooperate with The Health Plan, HMIS, State, ADOH, the Arizona State Auditor General and other appropriate monitoring activities, including record review training sessions, and site-visits. Providers must cooperate with The Health Plan staff, clinical teams, support service contractors, Adult Probation, Vocational Rehabilitation, and others for the overall acquisition/construction and success of the Housing Program and the Members participating in the program.

2.9.1.1 Access to Facilities and Audit of Funds

Provider Agencies are required to respond promptly to calls from The Health Plan and/or AHCCCS and report Member information as requested. When member activity is affecting housing eligibility, tenancy status, or is indicative of a clinical problem, then the provider shall cooperate with and initiate, as necessary, an individualized service planning process or a staffing for any Member who may be jeopardizing their housing eligibility. Providers must attend meetings, including grievance, appeal and Service Plan hearings. Appropriate notice shall be given to provider agencies requested to attend these meetings.

Providers must grant The Health Plan and any other appropriate agents of the State or Federal government, or any of their duly authorized representatives, access to the provider's facilities for the purpose of inspecting facilities and reviewing records. Providers must allow The Health Plan to inspect, audit, monitor, and evaluate the Housing Assistance funds received and expended pursuant to The Health Plan Contract during the term of the agreement, and within 365 days after the termination of the agreement.

Providers must make available to The Health Plan, HUD or State copies of all requested Housing Assistance Records within five (5) business days of any request at no charge. The Health Plan, the State, ADOH and HUD shall have full and complete rights to analyze, reproduce, duplicate, adapt, distribute, display, disclose and otherwise use all reports, information, data and material prepared by the Provider Agency.

2.9.2 Permanent Supportive Housing

AHCCCS has adopted the SAMHSA model for permanent supportive housing programs. Housing providers are required to maintain fidelity to the SAMHSA Supportive Housing Elements. (<http://www.azahcccs.gov> and <http://www.samhsa.gov>)

2.9.3 General Housing Requirements

Providers must collaborate with community system partners, State agency partners, federal agencies and other entities to identify, apply for or leverage alternative funding sources for housing programs. <https://www.azahcccs.gov> and <http://www.samhsa.gov>

2.9.4 Staffing (Staff Training)

Providers are required to have professional staff dedicated to overseeing the housing program. Housing programs must employ separate housing management and service delivery staff.

Property management staff are responsible for signing and renewing of leases, collection of rent and completion of maintenance requests. Housing Specialist Providers are responsible for ensuring Housing Quality Standard Inspections (HQS) are conducted by a Certified HQS Inspector. Service delivery staff are responsible for ensuring the delivery of services a member needs in order to meet their treatment goals, including but not limited to, living independently and adhering to stipulations outlined in the rental agreement/lease.

Providers must annually train housing staff on the following topics: property acquisition, maintaining units to Housing Quality Standards, Fair Housing Laws, and the Arizona Residential

Landlord Tenant Act. Providers will be required to demonstrate that annual trainings on these topics is provided to housing staff.

Clinical and Administrative Directors/Managers shall demonstrate: Knowledge of the basic concepts found in the Federal Fair Housing Law and the Arizona Landlord Tenant Act as they apply to members and their contracted providers by passing a posttest conducted after an orientation session.

Behavioral Health Professionals, Behavioral Health Technicians, & Behavioral Health Paraprofessionals shall demonstrate competency, by passing a post-test after training, in the following areas: Knowledge of basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords, the general rights of members afforded by these laws, and the principles and availability of Housing support services.

Health Care Coordinators shall demonstrate the basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws that describe the rights of tenants and landlords. Health Care Coordinators shall explain:

- Lease requirements and rights of tenancy to members in a language they understand and can act upon;
- Visit members and schedule service appointments at their homes consistent with the law;
- Determine eviction risk and arrange for skill and or support service assistance to members in coordination with Housing Providers;
- Document and involve the member in investigating complaints originated by the Member or Landlord; and
- Pass a posttest conducted after training and thereafter annually.

Housing Specialists and Health Care Coordinators shall also demonstrate that they can capably conduct and use the current and emerging tools and best practices such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) by passing a post test conducted after Specialized Training program and thereafter during routine clinical Supervision.

2.9.5 Property Management

All housing programs/units must be managed by a separate property management department or company. The property management department/company must be staffed and operated separate and apart from the delivery of housing support services as outlined in the SAMSHA Permanent Supported Housing Evidence-Based Practice Guidelines.

2.9.6 Accounting

Providers must develop and maintain an automated electronic accounting system with software that records all financial data, including but not limited to the provider's income and expense data, cost allocations, payments and expenditures which also equitably allocates common expenses between funding sources and housing units in substantial compliance with Generally Accepted Accounting Principles. The provider's accounting system must provide a detailed audit trail that allows reported financial data to be verified. The accounting system must maintain a segregation of revenue and expenditures by fund source. Allocation of costs to fund sources shall be consistently applied among fund sources in accordance with the provider's accounting system.

2.9.7 Grievance and Appeals

Providers must assist in the resolution of grievances and appeals of members, including appeals, submitted through The Health Plan, HUD, Arizona Department of Housing (ADOH), and AHCCCS. <https://www.azahcccs.gov>

2.9.8 Compliance with Laws, Rules, Regulations, and Policies

2.10.8.1 Non-Discrimination

Providers must not illegally or unconstitutionally discriminate against or segregate any person or group of persons on account of gender, marital status, race, age, disability, color, religion, creed, national origin or ancestry in the sale, lease, sublease, transfer, use, occupancy, tenure or enjoyment of property herein conveyed, nor shall provider establish or permit any such practice or practices of discrimination or segregation, location, number, use or occupancy of tenants, lessees, subtenants or vendees in the property.

2.9.9 AHCCCS Property Acquisition Rehabilitation

Prior Approval

Providers must notify and obtain The Health Plan approval prior to program implementation, property acquisition, or placing members with Serious Mental Illness in a residential program that occupies more than eight (8) adults or where more than twenty-five percent (25%) of an apartment complex houses Members with SMI.

Property Requirements

In August 2000, the State developed a permanent housing property acquisition program that allowed The Health Plans and their non-profit partners to purchase property for the first time in the history of Arizona, specifically for persons determined to have a SMI (HB 2003).

Providers must ensure any housing units acquired or constructed with HB 2003 funds are used for the benefit of persons with SMI. Providers must comply with the applicable terms and conditions of any contracts, deeds, and declarations of covenant conditions and restrictions executed in connection with the acquisition or construction of housing units. Members must not be required to move when treatment/rehabilitation goals are achieved and will not be evicted solely based on substance use or dependence. Housing options obtained through HB 2003 implementation must be sustained without additional funding appropriations for a period of fifteen (15) years.

Providers must submit prior to the purchase of any new property leveraged with funds provided by The Health Plan a **Provider Manual Form 2.10.1, AHCCCS Property Acquisition Rehab Application** (can be obtained by calling the Provider Services Call Center at 866-796-0542), which is required to include the following:

- The funding source used to purchase the property, specifically whether the purchase is to be made with funds provided under the provider's agreement with The Health Plan or other funds. The financing arrangements made prior to purchase of the property;
- Prior approval from The Health Plan if the property is purchased with funds provided under the provider's agreement with The Health Plan;
- A deed containing the use restrictions and covenants, conditions, or restrictions, or another legal instrument that verifies the property is used solely for the benefit of members and that failure to comply with the use restrictions allows the State to take title to the property or otherwise enforce the restrictions.

The Health Plan and Arizona Department of Housing (ADOH) retain the right of prior approval and refusal on all housing units proposed to be purchased by the provider using funds awarded through ADOH or the State. Providers must demonstrate that for real property, housing for members, or buildings and improvements purchased by the provider with funds provided by The Health Plan (excluding net profits earned) the following exists:

- A use restriction in the deed, and Covenants, Conditions and Restrictions, or
- Another legal instrument subject to prior written approval by The Health Plan that requires the property to be used solely for the benefit of members; and an application for funding consisting of an intended use plan.

2.9.10 The Health Plan State Set-Aside Housing Programs and Requirements

The Health Plan housing programs include state set-aside housing units to meet the needs of persons determined to have a SMI who are difficult to house in the community partly due to crime free/drug free ordinances and specific behavioral health related service needs.

2.9.10.1.1 Rental Agreements

The Rental Agreement is required to comply with the provisions of the Arizona Residential Landlord and Tenant Act and thereafter enforce and administer the Rental Agreement for the benefit of The Health Plan enrolled individuals. Providers must ensure that the total monthly rental payment under a Rental Agreement shall not exceed the Fair Market Rent (established annually by HUD). The Rent payable by the member to the provider or landlord must be 30 % of their gross income. Providers must inform each Member of their rent and/or utility payments and allowances, and must charge a member a security or utility deposit in accordance with Arizona Residential Landlord Tenant Act.

Providers must not charge applicants for costs associated with accepting and processing applications or verifying income and eligibility, including application fees, credit report charges, or other costs associated with these functions. Providers may collect damage and key deposits in accordance with Arizona law and may invoice a member for a check returned for insufficient funds only for the amount the bank charges for processing the returned check.

Providers may charge a member a fee (not to exceed \$100.00) if a member wishes to move from a Housing Unit to another Housing Unit before the expiration of the Rental Agreement term. This fee is incurred for breakage of the Rental Agreement and is required to be utilized solely to offset any expenses the provider incurs in turning the Housing Unit.

2.9.10.1.2 Notice of Termination of Rental Services

Property Management must provide all notices and documents required by the Arizona Residential Landlord Tenant Act to The Health Plan regarding evictions. Additionally, prior to initiating any eviction proceeding, the members' clinical team must be notified and a staffing must be held. Providers must be represented at that staffing. Finally, all evictions notices must be submitted to The Health Plan Housing Department at least three (3) days prior to the potential eviction.

2.9.10.1.3 Grievances of Damages

Providers must operate an informal and formal hearing process for the resolution of member matters handled by The Health Plan. Providers must maintain copies of The Health Plan grievance procedures and make them available to any applicant or member who has indicated dissatisfaction with the services of the provider.

2.9.10.1.4 Participant Housing Record

Providers must maintain a complete housing file on each member referred to the provider and are required to maintain a file on each housing unit under a rental agreement. Housing Providers must make any and all housing records available to The Health Plan for review upon request.

2.9.11 Housing Maintenance Policies and Other Compliance

Housing Providers must maintain a Housing Maintenance Policy, including a provision for 24-hour or other on-call availability to member, Administrators, Housing Managers and Health Care Coordinators regarding housing emergencies for housing units. Providers must maintain the property or properties in compliance with city, county and/or state zoning ordinances and with any ordinance relating to real property maintenance, health and safety.

Housing Providers must ensure that all member based rental agreements, housing assistance payment contracts, occupancy agreements, and sponsor based rental agreements are executed, maintained, and performed in compliance with approved The Health Plan policies. Housing Providers may implement any modifications to the housing programs, whether program wide or specific to an individual member, only as mutually agreed upon with The Health Plan.

Housing must be safe, stable, and consistent with the member's recovery goals and be the least restrictive environment necessary to support the Member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation. The Health Plan and its providers must not actively refer or house individuals in a shelter, licensed supervisory care home, unlicensed board and care home, or other similar facilities.

2.9.12 Housing Quality Standards

Housing Quality Standards

Providers must conduct regular inspections of housing units including tenant living situations to determine whether the Member has access to basic needs and whether the living environment is safe, secure, and the least restrictive environment consistent with the treatment goals in the Member's Individualized Service Plan. Providers must conduct or arrange for Housing Quality Standards (HQS) inspections at least annually and upon renting the unit to a new tenant.

Providers must maintain at least one person on staff:

- Certified as a Section 8 Housing Choice Voucher (HCV) Housing Quality Standards Specialist by Nancy McKay and Associates, Inc. and NMA University; and
- Performs the HQS inspections within seventy-two (72) hours of request, and within twenty-four (24) hours of the request in the event of priority move-ins.

In the event the provider does not have a qualified person on staff, the provider must receive an exemption from The Health Plan and must arrange for HQS inspections within the required time frames. The provider must maintain records of the results of walk through inspections of the property and all housing units. In addition, providers must conduct randomly selected inspections of units each year and maintain all State funded housing programs in accordance with standards of the local planning and zoning authorities and standards in the AHCCCS Housing Desktop Manual.

2.9.13 Coordination with Federally Funded Housing: VI SPDAT and HMIS Requirements

Arizona Complete Health Complete Care Plan requires that Providers complete a homeless assessment using the Vulnerability Index Service Prioritization Decision Assistance Tool (VI SPDAT) for all members experiencing homelessness, at risk of homelessness, or request assistance with housing. The Provider must then enter the VI SPDAT assessment for each member into the Continuum of Care (CoC) Homeless Management Information System (HMIS) database referring the member to The Health Plan Coordinated Entry Housing list. Provider is responsible to ensure accurate and reliable information is input into HMIS and receive passing grades for this element as provided by HMIS.

Members meeting the HUD definition of homelessness will also be entered into the CoC Coordinated Entry List. This step will open housing opportunities beyond the state-funded and The Health Plan housing programs for members experiencing homelessness, assist providers in maintaining contact with those members, and ensure heightened coordination and collaboration with the full network of homeless and housing services available in local communities.

The Health Plan works in collaboration with the Arizona Department of Housing (ADOH) and AHCCCS and the five Continuums of Care to ensure the revised requirements of the HEARTH Act are met, allowing Arizona to maximize the HUD Continuum of Care Homeless Assistance Programs awarded throughout the State.

Section 3 – MEMBER HANDBOOK

The purpose of this section is to establish the responsibility of providers to notify new enrollees and all health plan enrolled Members receiving health care services about the availability of Member handbooks.

The Health Plan Member Handbook is intended to provide information to Members and potential enrollees regarding the availability of services in the public health care system. The Health Plan Member Handbook provides information regarding how to obtain services, what services are available, what service limitations exist for Title XIX and Non-Title XIX persons, ACC members, and Member rights and responsibilities, among other topics. This information is imperative in verifying that services are accessible.

For providers serving Department of Developmental Disabilities (DDD) and Comprehensive Medical and Dental Plan (CMDP) members can obtain a member handbook and other materials by accessing the Arizona Complete Health website (www.azcompletehealth.com) or by contacting Member Services at 888-788-4408.

3.1 General

The Health Plan produces the Member Handbook. It is printed in a type-style and size which can easily be read by Members with varying degrees of blindness or low vision, such as large print and other alternative formats included by not limited to audio and/or Braille.

3.2 Distribution

Member handbooks will be made available to Health Plan members upon enrollment. Members will receive notification of how to obtain a handbook in accordance with timelines in [AHCCCS ACOM Policy 400 Chapter 406](#). The notification will be provided within the member welcome packet.

Upon request, copies must be made available to Member and family advocacy organizations and other human service organizations. Provider must have a process in place to monitor the delivery of the Member Handbook to its members.

Persons receiving services have the right to request and obtain a Member Handbook at least annually. The Health Plan is required notify persons of their right to request and obtain a Member Handbook at least annually by publishing this information using Health Plan communications such as the health plan webpage, newsletter, welcome packet, etc.

AHCCCS may require the Health Plan to revise the Member Handbook and distribute it to all current enrollees if there is a significant program change. AHCCCS determines if a change qualifies as significant.

3.3 Arizona Complete Health-Complete Care Plan Member Handbook Review

Member Handbooks are reviewed annually, and if needed, updated by AHCCCS and the Health Plan. Any approved revisions or updated versions of the Member Handbook will be posted to the Health Plan website by the effective date of such revisions or updates. Providers can help members obtain the Member Handbook by referring the member to the Health Plan website.

Section 4 - MEDICAL MANAGEMENT/UTILIZATION MANAGEMENT REQUIREMENTS

4.1 Securing Services and Prior Authorization/Retrospective Authorization

The Health Plan Utilization Management (UM) program is designed to ensure members receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible members across all product types, age categories, and range of diagnoses. The UM program incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, and ancillary care services.

Our UM initiatives are focused on optimizing each member's health status, sense of well-being, encouraging self-management skills, productivity, and access to quality health care, while at the same time actively managing cost trends. The UM program aims to provide Covered Services that are medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Utilization Management program goals include:

- Monitoring utilization patterns to guard against over-or under-utilization;
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction;
- Identification and provision of Care and/or disease management for members at risk for significant health expenses or ongoing care;
- Development of an infrastructure to ensure that all Health Plan members establish a relationship with their Primary Care Provider (PCP) to obtain preventive care;
- Implementation of programs that encourage preventive services and chronic condition self-management;
- Creation of partnerships with members/providers to enhance cooperation and support for UM goals.

4.2 Securing Services that do not Require Prior Authorization

It is important that persons receiving services have timely access to the most appropriate services. It is also important that limited resources are allocated in the most efficient and effective ways possible.

The clinical team (Health Home), or Primary Care Provider (PCP) in coordination with the clinical team, is responsible for identifying and securing the service needs of each behavioral health or integrated member through the assessment and service planning processes. During the treatment planning process, the clinical team may use established tools and nationally recognized standardized criteria to guide clinical practice and to help determine the types of services and supports that will result in positive outcomes for the member. Clinical teams should make decisions based on a member's unique and individual identified needs and should not use these tools as criteria to deny or limit services. Rather than identifying pre-determined services, the clinical team should focus on identifying the underlying needs of the behavioral

health or integrated member, including the type, intensity, and frequency of support and treatment needed.

As part of the service planning process, it is the clinical team's responsibility to identify available resources and the most appropriate provider(s) for services using The Health Plan's network of participating healthcare providers. This is done in conjunction with the clinical team, the PCP (as needed), the behavioral health member, family, and/or natural supports. If the service is available through a contracted provider the member can access the services directly. If the requested service is only available through a non-contracted provider, the clinical team is responsible for coordinating with The Health Plan to obtain the requested services as outlined below.

Prior authorization is not required for the following physical health services:

- Emergency Services;
- Medical Observation stays.

4.2.1 Securing Services with a Non-Contracted Outpatient Provider

In cases where The Health Plan does not have a contracted participating healthcare provider and it is necessary to secure services through a non-contracted provider in order to provide the needed, covered, medically necessary physical or behavioral health service or to fulfill a clinical team's request. Non-contracted service requests are prior authorized and a member may be referred if:

- The services required are not available within The Health Plan network.
- The Health Plan prior authorized the services.

In order to prior authorize the service, a provider must be AHCCCS registered in order to receive reimbursement for service delivery. The Health Plan is not required to offer services outside the contracted provider network if the service is available within the contracted network.

If non-contracted 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 The Health Plan policies. Both referring and receiving providers must comply with The Health Plan's policies, documents, and requirements that govern referrals (paper or electronic), including prior authorization. If the clinical team has made all attempts to find a contracted provider for a medically necessary service and is unable to secure the service within the required timeframes, the clinical team may submit a Single Case Agreement to The Health Plan for the service.

The Health Plan requires the following information in order to process the prior authorization request:

- Requested services, including covered service codes and units;
- Provider information, including name, license, address, phone number, and AHCCCS ID. If the provider does not have an AHCCCS ID, they can be directed to the AHCCCS Provider Registration website for instructions on how to apply;
- Copy of the service plan indicating needed services have been documented;
- Reason for going to a non-contracted provider (i.e., specialty no available in network);

- Timeframes for processing the request:
 - Expedited Prior Authorization request – A decision is made within 72 hours after receipt of the request. Extension of 14 calendar days may be granted if it is in the best interests of the member;
 - Standard Prior Authorization request – A decision is made within 14 calendar days after receipt of the request. Extension of 14 calendar days may be granted if it is in the best interests of the member.

The process for securing behavioral health and physical health services through a non-contracted provider is as follows:

- Authorization requests have to be made no more than 60 days before the intended service date;
- If a needed covered outpatient service is unavailable within The Health Plan's contracted provider network, the provider submits a completed **Provider Manual Form 10.1.15 Out Of Network Request Attachment** (can be obtained by calling the Provider Services Call Center at 866-796-0542) to The Health Plan's Medical Management Department. This form is submitted as an attachment to the completed prior authorization forms;
- A completed Request contains pertinent clinical information on the Member, the requested out-of-network service(s) and the requested out-of-network provider. The request must be accompanied by the current service plan and/or any relevant clinical records, including reasons why a contracted provider cannot provide the requested services;
- All requested providers must be licensed by the applicable Arizona licensing board. All providers must have an AHCCCS Provider ID Number and a National Provider ID (NPI) Number, failure to have an AHCCCS provider ID will result in denial of the request. All non-contracted providers must agree to provide the requested services, possess appropriate insurance, and agree to The Health Plan-approved reimbursement rates. If for any reason The Health Plan's Contracts Department is unable to establish a single case agreement with an authorized but non-contracted provider. The Health Plan's Contracts Department will notify Medical Management of an approved single case agreement or unapproved. The Medical Management Department will notify the requesting Provider and/or clinical team;
- The clinical team will then meet to consider alternative services. The clinical team is responsible for ensuring that a similar level of equivalent services is in place for the Member;
- The Health Plan secures services through and provides payment to non-contracted providers through single case agreements. If a provider applies for an AHCCCS provider ID, the request for provided services will be reviewed retrospectively; and
- The Health Plan notifies the requesting provider and the servicing provider of prior authorization approvals. The requesting provider is expected to notify the member of the approval of the service(s).

In the event that a request to secure covered services through a non-contracted provider is denied, The Health Plan will provide notice of the decision in accordance with **Section 8.4 -**

Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons, and Section 8.5 - Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX).

Claims are not eligible for payment (does not apply to emergency services) unless the single case agreement is in place and the authorization has been obtained.

4.3 Purpose of Utilization Review Process

The purpose of the prior authorization function is to monitor the use of designated services before services are delivered in order to confirm they are:

- Provided in an appropriate level of care and place of service;
- Included in the defined benefits,
- Appropriate, timely and cost effective;
- Coordinated as necessary with additional departments such as Quality Management;
- Accurately documented in order to facilitate accurate and timely reimbursement

Prior authorization processes are used to promote appropriate utilization of physical and behavioral health services while effectively managing associated costs. Except during an emergency situation, The Health Plan requires prior authorization before accessing inpatient services in a licensed inpatient facility and for accessing medications reflected as requiring prior authorization on The Health Plan's Behavioral Health Drug List (for non-integrated members) or The Health Plan's Comprehensive Drug List (for integrated members). In addition, The Health Plan also requires prior authorization of covered physical and behavioral health services other than inpatient services.

- Prior authorization (PA) is a request to The Health Plan Utilization Management (must be obtained prior to the delivery of certain elective and scheduled services. Authorizations can be submitted through the secure web portal or by use of a fax form available on our website under Provider Resources. **Prior authorization should be requested at least five (5) business days before the scheduled service delivery date or as soon as need for service is identified.** Most services that require The Health Plan's authorization are listed in the following table. The Health Plan website offers a pre-screen tool that provides authorization requirements at the billing code level. (Please seek further information in this Manual for authorization requirements for home health, physical, occupational and speech therapy prior authorization information.

When it is determined that a person is in need of a physical and/or behavioral health service requiring prior authorization, a utilization management professional applies the designated medical necessity criteria to approve the provision of the covered service. When appropriate, The Health Plan will provide a consultation with the requesting provider to gather additional information to make a determination. A decision to deny a prior authorization request must be made by The Health Plan's Chief Medical Officer, physician or Dental Medical Director designee. In addition, when system partners, including guardians, disagree with a treatment decision, resulting in the denial of a prior authorized level of care, the provider is obligated to send the

request to The Health Plan Medical Management department. The request must include the provider's recommendation and supporting evidence.

4.3.1 Emergency Situations

Definition of Emergency Medical Condition

The Health Plan defines *emergency medical condition* as follows: Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant individual, the health of the individual or their unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part. (42 CFR. 1396-u2(b)(2)(C), as amended).

Members may access emergency services at any time without prior authorization or prior contact with The Health Plan. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Provider (PCP) and/or The Health Plan's 24 hour Nurse Line, NurseWise at 1-866-534-5963 for assistance. However, this is not a requirement to access emergency services.

Emergency services are covered by The Health Plan when furnished by a qualified provider, including non-network providers, and will be covered until the member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by The Health Plan. Emergency services will be covered and will be reimbursed regardless of whether the provider is in The Health Plans provider network.

The Health Plan will not deny payment for treatment obtained under either of the following circumstances:

1. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or
2. A representative from the Plan or NurseWise instructs the member to seek emergency services.

Once the member's emergency medical condition is stabilized, The Health Plan requires notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this handbook.

4.3.2 Prior Authorization Process

Authorizations are not a guarantee of payment, the member must be eligible on the date the service is provided and the services provided must be aligned with the prior authorized service request. Prior authorization seeks to ensure that persons are treated in the most appropriate, least restrictive and most cost effective setting, with sufficient intensity of service and

supervision to safely and adequately treat the person's physical and/or behavioral health condition. Failure to obtain authorization may result in administrative claim denials. The Health Plan providers are contractually prohibited from holding any The Health Plan member financially liable for any service administratively denied by The Health Plan for the failure of the provider to obtain timely authorization.

4.3.3 Accessing services that require prior authorization

Prior authorization seeks to ensure that persons are treated in the most appropriate, least restrictive and most cost effective setting, with sufficient intensity of service and supervision to safely and adequately treat the person's physical and/or behavioral health condition. When a clinical team initiates a request for a service requiring prior authorization, the request must immediately be forwarded to the personnel responsible for making prior authorization decisions. Authorizations are not a guarantee of payment.

4.3.4 Availability of Prior Authorization

The Health Plan has appropriate utilization management professionals, including licensed nurses and physicians available 24 hours a day, seven days a week to receive requests for any service that requires prior authorization.

4.3.5 Prior Authorization Decisions Making

The Health Plan utilization management professional is required to prior authorize services unless it issues a decision to deny. A decision to deny a service is required to be made by a The Health Plan physician or physician designee.

The Health Plan has Arizona licensed prior authorization staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply The Health Plan's medical criteria or make medical decisions.

4.3.6 10.3.6 Criteria Used in Prior Authorization Decisions

The Health Plan uses nationally recognized standardized criteria through McKesson's InterQual, the American Society of Addiction Medicine (ASAM), adopted practice guidelines and/or other AHCCCS approved criteria to make determinations for prior authorizations of services. The Health Plan's Medical Management Committee reviews medical necessity criteria at least annually.

4.3.7 10.3.7 Prior Authorization When The Health Plan is not the Primary Payer

The Health Plan does not require prior authorization when The Health Plan is not the primary payer. Providers are required to pursue payment and submit the EOB (explanation of benefits) from all primary payers prior to billing The Health Plan any co-pays and deductibles. In instances when the member has exhausted the primary payer's benefit, a provider may submit prior authorization to The Health Plan for primary coverage. All Health Plan prior authorization requirements are required. The provider MUST submit evidence of the member's primary benefits being exhausted.

4.3.8 10.3.8 Timeframes for Decisions

Decisions to prior authorize services must be made according to these guidelines:

- **Standard Requests:** A decision must be made as expeditiously as the member's health condition requires, but not later than fourteen (14) calendar days after the receipt of the authorization request. A possible extension of up to fourteen (14) calendar days can be requested by the member or provider, or if The Health Plan justifies a need for additional information and the delay is in the member's best interest. The Health Plan or the provider may determine that using the standard timeframe could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function, in this case the authorization can be changed to an expedited request.
- **Expedited Requests:** A decision must be made as expeditiously as the member's health condition requires, but not later than three (3) business days after the receipt of the authorization request. A possible extension of up to fourteen (14) calendar days can be requested by the member or provider, or if The Health Plan justifies a need for additional information and the delay is in the member's best interest. If The Health Plan receives an expedited request for authorization and the requested service is not of an urgent medical nature, The Health Plan may downgrade the expedited request to a standard request. Prior to the request being downgraded, The Health Plan will contact the provider immediately to discuss the authorization being downgraded to a standard request. If the provider agrees with the downgrade it is documented in the authorization request and changed to a standard request. If the provider disagrees with the downgrade and supplies additional information regarding the urgent nature of the request it is documented in the authorization request and processed as an expedited request.

4.3.9 Authorization procedures for providers contracted by The Health Plan

4.3.9.1.1 Services that must be authorized

Providers are encouraged to access the Pre-Authorization Check Tool online for the most current services, procedures and equipment requiring prior authorization for The Health Plan. The Pre-Authorization Check Tool can be found on the Provider Section of the website at www.azcompletehealth.com.

Reimbursement is based on the accuracy of the information received with the prior authorization request, on whether the service is substantiated through concurrent and medical review, and/or on whether the claim meets claim submission requirements. All other coverage requirements must also be met in order for a claim to be eligible for payment.

- **Acute Inpatient Hospital Services:** Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;

- Sub-acute services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- Behavioral Health Inpatient Facility (BHIF) residential treatment services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- Behavioral Health Residential Facility (BHRF) (excluding BHRFs for Substance Use Disorder (SUD) treatment) services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- BHRF for SUD treatment services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- BHRF and HCTC services: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- Initiation and continuation of Out of Network inpatient, observation and outpatient services;
- Skilled Nursing Facilities, Long Term Acute Care Facilities and Rehabilitation Facilities: Notification of Admission and continued stay, pre-scheduled admissions must be approved by Prior Authorization at least 5 days prior to the admission;
- Physical Health Service authorizations may be required for a number of ancillary services, facility services, pharmaceuticals, physician services, radiology and laboratory services, surgeries and other procedures and Out of Network (OON) services. To identify services requiring prior authorizations please go to www.azcompletehealth.com.

4.3.10 Notice of Admission

All facilities are required to send a notification of admission to The Health Plan within 1 business day of the admission. The notice of admission must include the member's name, date of birth, AHCCCS ID#, facility name, NPI of facility, date of admission, admitting diagnosis and level of care admitted to. The notice of admission can be completed by any of the following means:

- Enter the admission via The Health Plan Web Portal;
- Fax a facesheet to 1-866-796-0542;
- Fax a Notice of Admission form, **Provider Manual Form 10.1.3 Notice of Admission** to the above fax numbers. Providers are directed to call the Provider Service Center to obtain a copy of this form, if needed, at 1-866-796-0542.
- A CON (Certificate of Need) can be submitted as notice of admission but it **MUST** be received within 1 business day of the admission. The form must be signed by a treating provider and have appropriate clinical documentation regarding the need for admission.

A Certificate of Need (CON) must be completed within 72 hours of an admission for members age 21 and older and within 14 days of admission for members under the age of 21 years. A notice of admission **MUST** be received within 1 business day of the admission to the facility.

A CON must be completed if a member applies for Medicaid Assistance (AHCCCS) while in the hospital, before Medicaid (AHCCCS) funding is authorized. The facility MUST notify The Health Plan of the admission as soon as the member receives AHCCCS eligibility. If the member is still hospitalized when eligibility starts, notification of admission to The Health Plan must occur immediately so medical review and discharge planning can be initiated. In cases where eligibility confirmation occurs after discharge, the facility may submit for retrospective review, these requests must be received within 30 days of the eligibility determination.

Prior authorization will never be applied in an emergency situation. A retrospective review may be conducted after the person's immediate health needs have been met. If upon review of the circumstances, the physical and/or behavioral health service did not meet admission authorization criteria, payment for the service may be denied. The provider must notify The Health Plan within 1 business day of an inpatient admission or demonstrate why timely notification was not possible. If the provider fails to timely notify The Health Plan of admission or demonstrate why it was not possible, a request for retrospective review may be denied. The test for appropriateness of the request for emergency services must be whether a prudent layperson, similarly situated, would have requested such services.

4.3.10.1 Certification of Need (CON) for Services

- A CON is a certification made by a physician that inpatient services are or were needed at the time of the person's admission. Although a CON must be submitted prior to a person's admission (except in an emergency), a CON is not an authorization tool designed to approve or deny an inpatient service, rather it is a federally required attestation by a physician that inpatient services are or were needed at the time of the person's admission. The decision to authorize a service is dependent on the individualized clinical documentation meeting the medical necessity criteria for admission. Providers must use **Provider Manual Form 10.1.1, Certification of Need (CON) for Level I Facilities**. Providers are directed to call the Provider Service Center to obtain a copy of this form, if needed, at 1-866-796-0542.

In the event of an emergency, the CON must be submitted:

- For persons age 21 or older, within 72 hours of admission; and
- For persons under the age of 21, within 14 calendar days of admission.

4.3.10.2 Re-certification of Need (RON) for Services

- A RON is a re-certification made by the treating physician, nurse practitioner or physician assistant. The RON must recertify for each applicant or beneficiary that inpatient services are needed. A RON must be completed at least every 60 days for a person who is receiving services in an inpatient facility. An exception to the 60-day timeframe exists for inpatient services provided to persons under the age of 21. The treatment plan (individual plan of care) for persons under the age of 21 in an inpatient facility must be completed and reviewed every 30 days. The completion and review of the treatment plan in this circumstance meets the requirement for the re-certification of need. Providers must use **Provider Manual Form 10.1.2, Re-Certification of Need**

(RON). Providers are directed to call the Provider Service Center to obtain a copy of this form, if needed, at 1-866-796-0542.

4.3.10.3 ***Documentation on a CON or RON for Behavioral Health Services***

Providers must utilize The Health Plan CON and RON forms for Behavioral Health Inpatient Facility and Licensed Hospital Services requests. The following documentation is needed on a CON and RON:

- Proper treatment of the person's health condition requires services on an inpatient basis under the direction of a physician;
- The service can reasonably be expected to improve the person's condition or prevent further regression so that the service will no longer be needed;
- Outpatient resources available in the community do not meet the treatment needs of the person;
- CONs must have a dated physician's signature; and
- RONs must have a dated signature by a physician, nurse practitioner or physician assistant.

Additional CON requirements:

- If a person becomes eligible for Title XIX/XXI (AHCCCS) services while receiving inpatient services, the CON must be completed and submitted to The Health Plan's Medical Management Department prior to the authorization of payment; and
- Federal rules set forth additional requirements for completing CONs when persons under the age of 21 are admitted to, or are receiving inpatient psychiatric services in a Behavioral Health Inpatient Facility. These requirements include the following:
 - For an individual who is Title XIX/XXI eligible when admitted, the CON must be completed by the clinical team that is independent of the facility and must include a physician who has knowledge of the person's situation and who is competent in the diagnosis and treatment of mental illness, preferably child psychiatry;
 - For emergency admissions, the CON must be completed by the team responsible for the treatment plan within 14 days of admission. This team is defined in 42 CFR §441.156 as "an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in the facility"; and
 - For persons who are admitted and then become Title XIX/XXI eligible while at the facility, the team responsible for the treatment plan must complete the CON. The CON must cover any period of time for which claims for payment are made.

4.3.11 **Continued Stay When Medically Necessary Services are not available at Discharge**

If a person receiving hospital or sub-acute services no longer requires such services under the direction of a physician, but services suitable to meet the person's physical and/or behavioral

health needs are not available or the person cannot return to the person'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 and is documented daily. In these instances, the facilities may request "Administrative Days". The request must be made while the member is still hospitalized, all requests MUST be made to The Health Plan UM reviewer who will review for approval with The Health Plan Medical Director. The Health Plan contracts team will negotiate a payment rate comparable to the level of care the member's condition requires. Upon approval of the "Administrative Days" the initial authorization will be terminated and a new authorization will be issued for "Administrative Days", Providers must bill separately for these services.

4.3.12 Issuance of a Notice of Action

For Title XIX/XXI covered services requested by persons who are Title XIX/XXI eligible or persons with SMI, The Health Plan provides the person(s) requesting services with a Notice of Action as described in **Provider Manual Section 8**.

4.3.13 Further Considerations for Denials of Requested Services

Inpatient Facilities Denials for Unplanned Admission or Continued Stay - After The Health Plan notifies a facility of a denial for an unplanned admission or a continued stay, the requesting clinician has the opportunity to contact The Health Plan physician to discuss the decision. This request should occur within 24 hours of the issuance of the denial but providers are encouraged to contact The Health Plan as soon as possible. The Health Plan will ensure 24 hour access to a delegated physician for any denials of hospital admission.

Providers may obtain the criteria used to make a specific adverse determination by contacting the Medical Management department at 866-796-0542. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. Please call the number on the denial notice to set up a 'peer to peer' discussion.

After this collaboration, The Health Plan physician may rescind the denial or let the denial stand. If the denial is not rescinded, the requesting provider may appeal the decision as outlined in **Section 8 of the Provider Manual**.

Outpatient Authorizations and Planned Admissions - After The Health Plan notifies a provider of the decision to deny a requested authorization the requesting provider has several options.

- The provider can resubmit another authorization request with additional clinical documentation to substantiate the request;
- The provider can request reconsideration either in writing or via a peer to peer with The Health Plan physician who issued the denial; and/or
- The provider can appeal the denial as outlined in Section 8.4.

Special Instructions for submitting documentation to support medical necessity.

The Health Plan must receive individualized clinical documentation of the member's status in

order to conduct clinical review for medical necessity.

Supporting documentation includes:

Behavioral Health and Physical Health Inpatient/Sub-Acute Admissions

- Notice of Admission – facesheet, Notification of Admission form Provider Manual or CON;
- Admission notes that support the current level of care;
- Progress notes, including supporting labs, radiology reports, etc.;
- Case management activities, including discharge planning, CFT/ART notes;
- Any other supporting relevant clinical information.

Initial inpatient stays are based on the adopted criteria, the member's specific conditions, and the projected discharge date. Reviews will occur on a schedule dictated by the member's diagnosis and condition. Emergency initial concurrent reviews are completed within one (1) business day of The Health Plan receipt of notification of admission. Subsequent reviews will be determined based on the member's specific condition. Providers are notified of the next review date and are responsible for providing updated clinical information on the scheduled review date (last covered day).

Behavioral Health Residential Facilities:

- Notice of Admission – facesheet, Notification of Admission form Provider Manual or CON;
- Admission notes that support the current level of care;
- The most current behavioral health individual service plan;
- Documentation showing member's most recent intense outpatient treatments (90 days) and the results of the services rendered;
- Most recent psychiatric evaluation and progress notes;
- Case management and CFT progress notes;
- Psychological or psycho-educational evaluations;
- Hospital or residential discharge summaries;
- Any other relevant clinical information.

Initial behavioral health stays are based on the adopted criteria, the member's specific conditions, and the projected discharge date. Reviews will occur on a schedule dictated by the member's diagnosis and condition. Initial concurrent reviews are completed within one (1) business day of The Health Plan receipt of notification of admission. Subsequent reviews will be determined based on the member's specific condition. Providers are notified of the next review date and are responsible for providing updated clinical information on the scheduled review date (last covered day).

For requests for continued stay, RONS are submitted as outlined above:

- Hospital, sub-acute service and residential BHIF providers submit additional clinical information to The Health Plan's Medical Management Department verbally at 866-495-6738 or by secure fax.

Skilled Nursing Facility (SNF);

The Health Plan provides medically necessary skilled nursing facility services for integrated members receiving physical healthcare services, including when the member has ALTCS pending. On-going reviews of members in skilled nursing facilities are conducted on a schedule dictated by the members' diagnosis and condition, not to exceed 7 days. Providers are notified of the next review date and are responsible for providing updated clinical information on the scheduled review date.

The Health Plan tracks the number of SNF days utilized by a member in a contract year and will only be responsible for reimbursement during the time the member is enrolled with The Health Plan and if the member becomes ALTCS eligible and is enrolled with an ALTCS contractor before the end of the maximum ninety (90) days per contract year. The ninety (90) days per AHCCCS contract year limitation is monitored and will be applied for nursing facility services. AHCCCS is notified electronically when a member has been residing in a nursing facility for forty-five (45) days and ninety (90) days.

Only the information necessary to certify the length of stay, frequency or duration of services, or continued stay in authorized services will be collected and will be accepted from any reasonably reliable source that can assist in the authorization process.

The Health Plan makes a decision to authorize or deny coverage of these services based on available clinical information utilizing the policies and procedures developed for determining medical necessity for ongoing institutional care.

The Medical Management team will ensure a process to share all clinical information on individuals in hospital, BHIF, BHRF, Skilled Nursing Facility (SNF) and HCTC services among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from consumers and providers, exceptions include substance use and HIV information. The Health Plan bases concurrent review determinations solely on the medical information obtained by the reviewer at the time of the review determination. The Health Plan verifies that the frequency of reviews for the extension of the initial determinations is based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity but will also meet the prescribed review timelines according to InterQual® criteria. Authorization for hospital and institutional stays will have a specified date by which the need for continued stay will be reviewed and this will be documented in and relayed to the requesting provider to ensure coordination and understanding of when additional member condition updates are required. Admission reviews must be conducted within one business day after notification is provided to the Contractor by the hospital or institution (this does not apply to pre-certifications) (42 C.F.R. 456.125).

For members being transferred for respite or other reasons, a notice of transfer must be submitted within three (3) business days of the admission.

Providers are directed to call the Provider Service Call Center to obtain a copy of these forms, if needed, at 1-866-796-0542.

Attachments:

Provider Manual Attachment 10.1.1 Admission Psychiatric Acute Hospital & Sub-Acute Criteria,
Provider Manual Attachment 10.1.2 Continued Psychiatric Acute or Sub-Acute Facilities Authorization Criteria,
Provider Manual Attachment 10.1.3 Prior Authorization Criteria for Admission and Continued Stay for Behavioral Health Residential Facilities,
Provider Manual Attachment 10.1.3a BHRF Substance Abuse Treatment Placement FAQs,
Provider Manual Attachment 10.1.4 Prior Authorization Criteria for Admission and Continued Stay for Behavioral Health Supportive Homes,
Provider Manual Attachment 10.1.5 Prior Authorization Criteria for Continued Stay for HCTC
Provider Manual Attachment 10.1.6 Authorization Criteria for Behavioral Health Inpatient Facilities
Provider Manual Attachment 10.1.15 Prior Authorization Criteria for HCTC

Forms:

Provider Manual Form 10.1.1 Certificate of Need (CON)
Provider Manual Form 10.1.2 Recertification of Need (RON)
Provider Manual Form 10.1.3 Notice of Admission to ALL LEVELS OF CARE
Provider Manual Form 10.1.6 Out-of Home Admission
Provider Manual Form 10.1.8 Out-of-Home Concurrent Review
Provider Manual Form 10.1.10 Inpatient Discharge Summary
Provider Manual Form 10.1.11 Request for Expedited Authorization
Provider Manual Form 10.1.12 Outpatient Medicaid Prior Authorization Fax Form
Provider Manual Form 10.1.13 Inpatient Medicaid Prior Authorization Fax Form
Provider Manual Form 10.1.14 Intensive Staffing
Provider Manual Form 10.1.15 Out-of-Network Request
Provider Manual Form 10.1.16 Notice of Temporary Placement MASTER
Provider Manual Form 10.1.17 Notice of Transfer Out-of-Home Facilities MASTER

4.3.14 Prior Authorizing Medications

The Health Plan has developed drug lists for use by all providers. These lists denote all drugs which require prior authorization. These prior authorization criteria have been developed and approved by the AHCCCS pharmacy and therapeutics committee and/or the Arizona Complete Health pharmacy and therapeutics committee and must be used by The Health Plan's providers. For specific information on medications requiring prior authorization, see **Section 4.13.4 – The Health Plan's Drug Lists**. The approved prior authorization criteria are posted on The Health Plan Provider Portal. The prior authorization requirements for provision of Notice are the same as those outlined for prior authorized services. For pharmacy prior authorization requests, a decision or request for more information will be provided within 24 hours. If additional information is requested, a decision will be rendered within 7 business days of the request. The Health Plan and providers must assure that a person will not experience a gap in access to

prescribed medications due to a change in prior authorization requirements. The Health Plan and providers are required to ensure continuity of care in cases in which a medication that previously did not require prior authorization is now required to be prior authorized.

4.3.15 Notification of Prior Authorization Changes

The Health Plan makes every effort to give providers at least thirty days' notice, when possible, of changes in authorization processes or criteria through monthly Essential Provider Communication Meetings. Updated materials are posted to The Health Plan website for provider and Member access.

4.4 Technology

The Health Plan reviews and considers adoption of new technologies and/or adoption of new uses to existing technologies utilizing evidence-based research and guidelines. The process includes evaluation of the Food and Drug Administration (FDA) approved use, evidence based research, guidelines and analyses of related peer reviewed literature published in the United States. Peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

New technologies include new delivery systems of medications if that delivery system is a device. Newly developed non-delivery systems (such as microspheres, oral dissolving systems) are not considered new technologies and aren't subject to these requirements.

Providers may initiate a request for The Health Plan coverage of new approved technologies including the usage of new applications for established technologies by submitting the proposal in writing to The Health Plan's Medical Director for review. The proposals shall include:

- FDA approval of the new technology and the approved indication;
- Medical necessity criteria and supporting documentation;
- A cost analysis including the financial impact to the provider for the new technology;
- Peer reviewed literature indicating the efficacy of the new technology or the modification in usage of the existing technology, if available; and
- Relevant coverage decisions made by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.

The Health Plan will participate in the review of newly requested technologies, including the usage of new applications for established technologies through The Health Plan Pharmacy and Therapeutics (P&T) Committee and the Medical Management Committee. The Health Plan will consider coverage rules, practice guidelines, payment policies and procedures, utilization management, and oversight that allows for the individual member's medical needs to be met during this review.

The Health Plan will review requests for the use of a new technology at the quarterly Pharmacy and Therapeutics Committee meeting following the request. The Health Plan Providers are informed of AHCCCS approval of new technology and any applicable prior authorization criteria

through the AzCH website, the monthly Essential Provider Communication Call, and pharmacy webinar. Discussion reflecting consideration of a new FDA approved technology, including the usage of a new application for established technology and The Health Plan's determination of coverage will be documented in the P&T Committee meeting minutes and the Medical Management Committee meeting minutes.

Consideration for systemic implementation of the coverage of the technology will be prioritized for consideration by AHCCCS based on member needs, utilization trends, financial considerations, and the meta-analysis of peer reviewed literature.

4.5 Retrospective Review

The Health Plan completes retrospective reviews (review after services have initiated or been provided) in response to a provider request for authorization of services after the initiation of services or after services have been rendered or to investigate quality of care concerns. Services eligible for retrospective review are outlined below:

- All services rendered during a member's Prior Period Coverage when the request is received within 30 days of the Add-on Date;
 - Post-discharge physical health or behavioral health hospital services ("hospital services") and behavioral health inpatient facility sub-acute facility services ("BHIF-SAF services") when The Health Plan received timely notification of admission (within 72 hours) and when the request is received no later than 30 days after the date of discharge;
 - Continuation of hospital services or BHIF-SAF services (pre-discharge) when The Health Plan did not receive timely notification of admission;
- Outpatient services requiring prior authorization when an authorization is requested after initiation of, but prior to completion of, a course of a treatment when the provider asserts completion of the course of treatment is necessary to ensure continuity of care ("course of treatment outpatient services");
- Post-discharge out-of-home treatment that does not require prior authorization but does require notification of admission when The Health Plan received timely notification of admission and when the request is received no later than 30 days after the date of discharge; and
- Continuation (pre-discharge) of out-of-home treatment that does not require prior authorization but does require notification of admission when The Health Plan did not receive timely notification of admission.

Upon receipt of a written request for retrospective review, The Health Plan will screen the request to determine if it is eligible for retrospective review. If it is not eligible for retrospective review based on the above criteria, a denial letter will be sent to the provider. The denial letter will explain the appeal process.

Upon receipt of a verbal request for retrospective review, The Health Plan will ask the provider to explain the reason for the request and will describe to the provider the circumstances under which The Health Plan will conduct a retrospective review. If The Health Plan believes the request is eligible for retrospective review, the provider will be given instructions about how to

submit the written request. If The Health Plan does not believe the request is eligible for retrospective review, but the provider nevertheless would like to submit a written request, The Health Plan will provide information to the provider about how to submit the request.

Upon determining a request is eligible for retrospective review, The Health Plan will review the submitted records within seven (7) calendar days of receipt to ascertain if The Health Plan has received all clinical information necessary to conduct an adequate review. If the provider fails to submit sufficient information to render an authorization determination, The Health Plan will notify the provider and specifically describe the information needed. The facility will be given up to fourteen (14) calendar days to submit the additional information or to inform The Health Plan why the information cannot be submitted for review. The Health Plan will make a one-time request if clinical information is not sufficient to make a decision.

Review decisions are rendered within 30 days of the initial receipt of request for retrospective review. The Health Plans UM Reviewers can be reached Monday – Friday, 8am to 5pm, for prior authorization, continued stay authorization, and technical assistance at 866-495-6738. After hours, providers may contact The Health Plan at 866-495-6738, 24 hours per day, 365 days per year to request assistance. After hours calls are handled by The Health Plan’s crisis line contractor, NurseWise.

4.6 Pre-Admission Screening and Resident Review (PASRR)

The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those identified with Serious Mental Illness (SMI) and/or Intellectual disability.

- PASRR Level I screenings are used to determine whether the person has any diagnosis or other presenting evidence that suggests the potential presence of SMI and/or intellectual disability.
- PASRR Level II evaluations are used to confirm whether the person indeed has SMI and/or intellectual disability. If the person is determined to have SMI and/or intellectual disability, this stage of the evaluation process determines whether the person requires the level of services in a Nursing Facility (NF) and/or specialized services (inpatient/hospital psychiatric treatment).

Medicaid certified NFs must provide PASRR Level I screening, or verify that screening has been conducted, in order to identify SMI and/or intellectual disability prior to initial admission of persons to a nursing facility bed that is Medicaid certified or dually certified for Medicaid/Medicare.

4.6.1 PASRR Level I Screenings

See [AHCCCS AMPM Exhibit 1220-1](#), PASRR Level I Screening Document and instructions.

PASRR Level I screenings can be performed by the following professionals:

- Arizona Long Term Care System (ALTCS) Pre-Admission Screening assessors, or case managers;
- Hospital discharge planners;

- Nurses;
- Social workers; or
- Other nursing facility staff that have been trained to conduct the Level I PASRR screening and make Level II PASRR referrals.

ALTCS Pre-Admission Screening assessors or case managers may conduct Level I PASRR screenings, but it is the ultimate responsibility of the facility where the Member is located to ensure that the Level I and Level II PASRR is completed prior to the Member being admitted into the receiving nursing facility.

A PASRR Level I screening is not required for readmission of persons who were hospitalized and are returning to the nursing facility, or for inter-facility transfers from another nursing facility, if there has not been a significant change in their mental condition. The PASRR Level I screening form and PASRR Level II evaluation must accompany the readmitted or transferred person.

A PASRR Level I screening is required if a person is being admitted to a nursing facility for a convalescent period, or respite care, not to exceed 30 days. If later it is determined that the admission will last longer than 30 days, a new PASRR Level I screening is required. The PASRR Level II evaluation must be done within 40 calendar days of the admission date.

4.6.1.1 **Review**

Upon completion of a PASRR Level I screening, documents are forwarded to the PASRR Coordinator within the AHCCCS Bureau of Quality Management Operations. If necessary, referrals for a PASRR Level II evaluation to determine if a person has a SMI diagnosis are forwarded to the AHCCCS Office of the Medical Director. Alternatively, referrals for a PASRR Level II evaluation are forwarded to the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) PASRR Coordinator to determine if a person has Intellectual Disability. For dually diagnosed persons (both SMI and intellectual disability), referrals for a PASRR Level II evaluation are forwarded to both ADES/DDD and AHCCCS.

When a PASRR Level I screening is received by AHCCCS, the PASRR Coordinator reviews it and, if needed, consults with the AHCCCS Medical Director or designee (must be a Board-eligible or Board-certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) to determine if a PASRR Level II evaluation is necessary. If it is determined that a PASRR Level II evaluation should be conducted, the PASRR coordinator must:

- Forward copies of the PASRR Level I screening and any other documentation to The Health Plan; and
- Send a letter to the person/legal representative that contains notification of the requirement to undergo a Level II PASRR evaluation.

4.6.2 **PASRR Level II Screenings**

The Health Plan must develop an administrative process for conducting PASRR Level II evaluations and must ensure that:

- They are completed within 5 working days of receipt of the PASRR Level I screening;

- If the person is awaiting discharge from a hospital, the evaluation should be completed within 3 working days; and
- The criteria used to make the decision about appropriate placement are not affected by the availability of placement alternatives.

4.6.2.1 **Criteria**

The PASRR Level II evaluation includes the following criteria:

- The evaluation report must include the components of the [Level II PASRR Psychiatric Evaluation](#) ;
- The evaluation must be performed by a physician who is a Board-eligible or Board-certified psychiatrist and has an unrestricted, active license to practice medicine in Arizona;
- The evaluation can only be performed by a psychiatrist who is independent of and not directly responsible for any aspect of the care or treatment of the person being evaluated;
- The evaluation and notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated;
- The evaluation must involve the individual being evaluated, the individual's legal representative, if one has been designated under state law, and the individual's family, if available and if the individual or the legal representative agrees to family participation;
- Evaluators may use relevant evaluative data, obtained prior to initiation of preadmission screening or resident reviews, if the data are considered valid and accurate and reflect the current functional status of the individual. However, in the case of individualized evaluations, to supplement and verify the currency and accuracy of existing data, the State's PASRR program may need to gather additional information necessary to assess proper placement and treatment.
- Evaluators are to follow AHCCCS Policy 1009:
 - [Pre-Admission Screening and Residential Review LEVEL 1 \(Exhibit 1220-1\) PASRR](#)
 - [Pre-Admission Screening and Psychiatric Review LEVEL II \(Exhibit 1220-2\) PASRR](#)

4.6.2.2 **Review**

The AHCCCS Medical Director or designee reviews all evaluations and makes final Level II placement determinations prior to the proposed/current placement.

AHCCCS must provide copies of the completed PASRR Level II evaluation to the referring agency, Arizona Health Care Cost Containment System, Division of Health Care Management (AHCCCS/DHCM) PASRR Coordinator, facility, primary care provider, and person/legal representative.

4.6.3 Cease Process And Documentation

If at any time in the PASRR process it is determined that the person does not have a SMI, or has a principal/primary diagnosis identified as an exemption in the Level I screening, the evaluator must cease the PASRR process of screening and evaluation and document such activity.

4.6.4 SMI Determination

AHCCCS reviews each person determined to have a SMI on an annual basis, or when a significant change in the resident's physical or mental condition has been noted in order to ensure the continued appropriateness of nursing home level of care and the provision of appropriate behavioral health services.

4.6.5 Reporting

The Health Plan shall report monthly to AHCCCS concerning the number and disposition of residents (1) not requiring nursing facility services, but requiring specialized services for SMI, (2) residents not requiring nursing facility services or specialized services for SMI, and (3) any appeals activities and dispositions of appeal cases.

4.6.6 Discharge

Per 42 C.F.R. 483.118 (1 and 2), AHCCCS will work with the facility to arrange for the safe and orderly discharge of the resident. The facility in accordance with 42 C.F.R. 483.12(a) will prepare and orient the resident for discharge.

Per 42 C.F.R. 483.118 (c) (i-iv), AHCCCS will work with the facility to provide an alternative disposition plan for any residents who require specialized services and who have continuously resided in a NF for at least 30 months prior to the determination as defined in 42 C.F.R. 483.120. AHCCCS, in consultation with the resident's family or legal representative and caregivers, offer the resident the choice of remaining in the facility or of receiving services in an alternative appropriate setting.

4.6.7 Recommendations

The AHCCCS Level II PASRR Psychiatric Evaluation includes the recommendations of services for lesser intensity by the evaluating Psychiatrist as per 42 C.F.R.483.120, 128(h)(i) (4 and 5). The AHCCCS Medical Director or designee (must be a Board-eligible or Board-certified psychiatrist and have an unrestricted, active license to practice medicine in Arizona) will determine if the person requires nursing facility level of care and if specialized services are needed based on individualized evaluations or advance group determinations in accordance with 42 C.F.R. § 483.130-134. Individual evaluations or advance group determinations may be made for the following circumstances:

- The person has been diagnosed with a terminal illness; or
- Severe physical illness results in a level of impairment so severe that the person could not benefit from specialized services. The person will be reassessed when notified by the nursing facility of an improvement in their condition; and
- Other conditions as listed in 42 C.F.R. § 483.130-134.

4.6.8 Appeal and Notice Process Specific To PASRR Evaluations

AHCCCS shall send a written notice no later than three (3) working days following a PASRR determination in the context of either a preadmission screening or resident review that adversely affects a Title XIX/XXI eligible person.

Appeals shall be processed, consistent with the requirements in **Section 8.4 – Notice Requirements and Appeal Processes for Title XIX/XXI Eligible Persons** and **Section 8.5 - Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX/XXI)**.

The Health Plan will provide AHCCCS with any requested information, and will make available witnesses necessary to assist with the defense of the decision on appeal, in the event that a person appeals the determination of the PASRR evaluation.

4.6.9 Retention

The Health Plan will retain case records for all Level II evaluations for a period of 6 years in accordance with A.R.S. § 12-2297.

The Health Plan will permit authorized AHCCCS personnel reasonable access to files containing the reports received and developed.

4.6.10 Training

Training will be provided to psychiatrists and any other medical professionals that conduct Level II evaluations as needed.

4.6.11 Provider Requirements

Providers are required to follow PASRR requirements for Members who require services in a skilled nursing facility. Those requirements are:

- The provider is required to administer the PASRR Residential evaluations as requested and meet required time frames for assessment and submission to The Health Plan.
- The provider is required to determine the appropriateness of admitting persons with mental impairments to Medicaid-certified nursing facilities, to determine if the level of care provided by the nursing facility is needed and whether specialized services for persons with mental impairments are required.
- The provider is required to demonstrate that a licensed physician who is Board-Certified or Board-eligible in Psychiatry conducts PASRR Residential evaluations in accordance with 42 CFR Part 483, Subpart C and the AHCCCS Policy and Procedures Manual section on *Pre-Admission Screening and Resident Review (PASRR)*.
- The provider is required to conduct PASRR Residential evaluations in person where the referred person is located.

4.7 Inter-Rater Reliability Testing

To make utilization decisions, The Health Plan uses written criteria as required by contract with AHCCCS. The Health Plan evaluates the application of Medical Necessity Criteria annually, and maintains and uses a standardized instrument for measuring Medical Management staff's application of the current Medical Necessity Criteria. A different measurement tool will be utilized during each measurement of Inter-Rater Reliability to maintain continuous objectivity in the evaluation.

4.8 Care Management and Care Coordination Services

Care Management and Care Coordination services are available for all Title XIX/XXI Members. Care Management and Care Coordination services are provided by The Health Plan Care Managers and Care Coordinators. These services encompass a variety of coordination of care activities to assist a member in achieving individualized wellness and recovery goals.

Title XIX/XXI members identified as having less acute and less complex physical or behavioral health care needs, receive Care Coordination Services. Care Coordinators are assigned to serve this population. Members in this group typically have been more successful at managing their health care, may require varying needs for support with their psychosocial needs, but may be at risk of developing chronic conditions.

The Health Plan ensures the provision of care management to assist members who may or may not have a chronic disease but have physical or behavioral health needs or risks that need immediate attention. This care coordination assures members get the services they need to prevent or reduce an adverse health outcome. Care management is short term and time limited in nature and may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members' immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention.

Care Managers and Care Coordinators seek to align services with the goals identified by members, goals associated with physical health care ordered by physical health providers and services described in the member's Individual Service Plan in collaboration with the member's Health Home (when applicable). These activities, which can occur both at a clinical and system level, are performed by the member's Care Manager or Care Coordinator in collaboration with the member's treatment team or treating provider, depending on a member's needs, goals, and functional status. This coordination ensures the provision of appropriate services in acute, home, chronic and alternative care settings that meet the member's needs in the most cost-effective manner available.

4.9 Care Management Team

Health Plan Care Management/Care Coordination staff consists of Arizona Licensed nurses and Behavioral Health clinicians; others are unlicensed with behavioral health backgrounds or/and expertise in community case management, but all are cross-trained in behavioral health,

physical health and social determinants of health. Additionally, Care Management teams are comprised of staff that are trained in, and/or have expertise in person-centered care, the provision of self-management-skills coaching, motivational interviewing, implementing Evidence Based Practice modalities such as, Trauma Informed Care, health promotion and literacy, and member advocacy, while navigating complex systems and communicating across disciplines.

4.9.1 Role and Function of Care Management and Care Coordination

The Health Plan Care Management program is designed to help Title XIX/XXI Members achieve their wellness and recovery goals and assist eligible members in receiving appropriate treatment for chronic/non-chronic conditions (both primary and secondary chronic/non-chronic conditions) by providing proactive support to the member, and to the member's treating providers. Care Management involves identifying the health care needs of members, providing clinical support and recommendations to provider agency treatment teams, verifying necessary referrals are made, and appropriate services are provided, maintaining health history, and facilitating access to additional evaluation/diagnosis and treatment when necessary. Care Managers have expertise in member self-management approaches, member advocacy, and are capable of navigating complex systems and communicating with a wide spectrum of professional and lay persons, including family members, physicians, specialists and other health care professionals.

4.9.2 Provider Responsibilities Related to Care Management

Treating providers are required to collaborate effectively with The Health Plan Care Managers and Care Coordinators. This collaboration includes collaborating on the following duties:

- Assisting members in the completion of Health Risk Assessments;
- Identifying members who may qualify for Care Management services;
- Aligning The Health Plan Care Plans with Member Individualized Treatment Plans;
- Assisting members in obtaining necessary physical health and behavioral health services, including specialty care, preventive care, and well person visits;
- Assisting members in achieving medication adherence;
- Verifying members complete lab tests as appropriate;
- Providing or arranging transportation for members to receive medically necessary services;
- Facilitating effective transitions among providers and levels of care;
- Participating in Care Plan Rounds as requested;
- Coordinating and implementing disease management and wellness programs to meet the needs of members in the provider's care;
- Coordinating with 24/7 community based programs to reduce justice system involvement, and unnecessary emergency department utilization and hospitalizations;
- Engaging the member to participate in service planning;
- Monitoring and facilitating adherence to treatment goals including medication adherence;

- Establishing a process to verify coordination of member care needs across the continuum based on early identification of health risk factors or special care needs;
- Monitoring individual health status and service utilization to determine use of evidence-based care and adherence to or variance from the member's Treatment Plan;
- Monitoring member services and placements to assess the continued appropriateness, medical necessity and cost effectiveness of the services;
- Communicating among behavioral and physical health service providers regarding member progress and health status, test results, lab reports, medications and other health care information when necessary to promote optimal outcomes and reduce risks, and duplication of services or errors;
- Monitoring the member's eligibility status for covered benefits and assisting with eligibility applications or renewals;
- Communicating with the member's assigned Care Manager, treatment team members or other service providers to ensure management of care and services including addressing and resolving complex, difficult care situations;
- Participating in discharge planning from hospitals, jail or other institutions and follow up with members after discharge as appropriate;
- Verifying that periodic re-assessment occurs at least annually or more frequently when the member's psychiatric and/or medical status changes.

4.9.3 Care Management

Care Management is essential to successfully improving healthcare outcomes for XIX/XXI members. Care Management is designed to cover a wide spectrum of episodic and chronic, complex health care conditions for members with an emphasis on proactive health promotion, health education, disease management, and self-management resulting in improved physical and behavioral health outcomes. Care Management is an administrative function and not a billable service.

The Health Plan assigns and monitors Care Management to member ratios based upon national standards, consistent with a member's acuity and complexity of need for Care Management and evidence-based outcome expectations.

Members in this group typically include:

- Members at high risk of poor health outcomes and high utilization;
- Members with an acute or chronic diagnosis or condition;
- Members who have struggled unsuccessfully to manage their health care, and require more complex or frequent healthcare and services.

The Health Plan utilizes data from multiple sources to identify members who may benefit from Care Management to meet their individualized needs. These tools allow for members to be stratified into a case registry and their specific risks identified, including chronic co-morbid conditions (both primary and secondary chronic conditions), over utilization of behavioral health and physical health services, adverse events, high costs and specific gaps in care. Members may

be identified through population-based tools (i.e., predictive modeling) and individual-based tools (i.e., Health Risk Assessment). These reports also assist in identifying the appropriate level of Care Management, particularly for those members with the greatest potential for improved health outcomes and an increased utilization of cost-effective treatment.

In addition, members are identified for Care Management through various referral sources from within The Health Plan and through external sources. These referral sources include, but are not limited to, the following:

- Member self-referral;
- Family and/or caregiver;
- Treatment Teams;
- Utilization Management (UM) referral;
- Quality Management (QM) referral;
- Various other The Health Plan departments;
- Discharge planner referral;
- Provider submissions of the American College of Obstetricians and Gynecologists [ACOG] comprehensive assessment tool ;
- Provider submission of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Tracking Form;
- Arizona Health Care Cost Containment System (AHCCCS);
- American Indian Health Program;
- Inpatient facilities, emergency departments, crisis providers; and
- Department of Economic Security (DES)/Division of Developmental Disabilities.

Referrals for Care Management (Title XIX/XXI members with the highest needs) can be made by calling the Care Management Referral Line at (866) 495-6738. Upon receipt of a referral for Care Management, The Health Plan assesses the member's eligibility and provides notification of the decision within 30 days of referral.

4.9.4 Disenrollment From Care Management

Members are dis-enrolled from the Care Management Program when they show successful completion of Care Management goals and a reduction of risk and utilization; when they cease to be willing to actively participate, and at loss of eligibility. Upon dis-enrollment from the Care Management Program, the member's ongoing care is monitored through analysis of claims data. Members are also dis-enrolled from the Care Management when they expire, move out of state, or transfer to another health plan or service area.

4.9.5 Care Management/Care Coordination Team Responsibilities

The Health Plan Care Management Teams under the direction of The Health Plan Health Plan Chief Medical Officer and Chief Clinical Officer performs the following functions:

- Researching claims data and clinical information to identify care gaps and opportunities for better coordination of care, better access to services and better treatment alternatives;
- Communicating findings to treating providers and collaborating with treatment teams to identify opportunities to enhance care and engage members into disease management and other treatment programs;
- Identifying opportunities with the treating providers to assist members in making lifestyle changes that enhance recovery and support wellness;
- Assisting treatment teams in identifying opportunities to improve medication adherence, reduce unnecessary emergency department and inpatient utilization;
- Assisting treating providers in identifying opportunities to decrease and eliminate justice system involvement and arrests, and use of crisis services;
- Facilitating and tracking completion of Health Risk Assessments;
- Reporting program needs to the Integrated Care/Program Development department to facilitate the development of new programs and services;
- Collaborating effectively with all The Health Plan departments, including Quality Management and Network Development;
- Monitoring member transitions from one level of care to another;
- Providing members with the tools to self-manage care in order to safely live, work, and integrate into the community;
- Completing a comprehensive Care Plan review for each member enrolled in the Care Management Program minimally on a quarterly basis. The Care Plan review includes, at a minimum:
 - A medical record chart review;
 - Consultation with the member's treatment team;
 - Review of administrative data such as claims/encounters; and
 - Customer service data.

4.9.6 Care Planning

Care Managers collaborate with the member, the member's physical health and/or behavioral health inpatient and/or outpatient treatment team to develop the care plan, which is designed to prioritize goals that consider the member's and/or caregiver's strengths, treatment needs, recovery and wellness goals, and preferences. All providers participating in the member's care will be given access to the member's Care Plan. The Care Plan is expected to align with the member's Individual Treatment Plan, but will be neither a part of, nor a substitute for the Treatment Plan. The Care Plan describes the clinical interventions recommended and agreed to, by the clinical team and member; identifies the coordination gaps, strategies to improve coordination of care among service providers; and strategies required to monitor referrals and follow-up for specialty care and routine health care services, including medication monitoring.

As part of the care planning process, the Care Manager documents a schedule for follow up with the treatment team and member and convenes Care Plan reviews at intervals consistent with the identified member care needs, and to ensure progress and safety. Care Plan reviews are pre-scheduled and designed to evaluate progress toward Care Plan goals and meeting member

needs. The Care Plan is additionally updated at any point apart from the schedule, based on member progress and outcomes. The Care Plan identifies the next point of review and is saved in the member's electronic record in The Health Plan Care Management business application system.

4.9.7 Interdisciplinary Care Plan Rounds

A member's unique care needs can also be addressed through formal interdisciplinary Care Plan Rounds. In Care Plan Rounds, both treatment and non-treatment staff may present member treatment concerns to their treatment peers and treatment leaders to seek guidance and recommendations on how to best address the member's physical, behavioral and social care needs. Care Plan Rounds typically focus on members who are at high risk, have complex co-morbid conditions and/or have difficulty sustaining an effective working relationship with treatment and/or non-treatment staff. Interdisciplinary Care Plan Rounds are scheduled weekly.

4.10 Disease Management

The Health Plan disease management program is available to Members with high risk and/or chronic conditions. The program includes intervention plans that target chronic behavioral and physical health conditions such as, anxiety, chronic obstructive pulmonary disease, heart failure, chronic pain, and diabetes mellitus.

The goal of the program is to employ strategies such as health coaching and wellness to facilitate behavioral change to address underlying health risks and to increase Member self-management as well as improve practice patterns of providers, thereby improving healthcare outcomes for Members. The Health Plan evaluates the effectiveness of these programs including education specifically related to the identified Member's ability to self-manage disease and measurable outcomes.

4.11 Out-of-Home Services Requirements

Out of Home Services for review should include but not limited to: Necessity of admission and appropriateness of service setting, quality of care, length of stay, how the services meet the member's needs, and discharge needs. Providers providing out-of-home services are required to provide the following additional documentation as identified below to The Health Plan:

- The Admission Face Sheet or Notice of Admission within one business day following admission.
- The Out-of-Home Program Intake Summary within one business day following admission.
- The most recent Psychiatric Evaluation within one business day following the admission.
- Concurrent reviews are completed by paper submission and /or telephonic review depending on your organizational needs. Please submit concurrent review by Fax to 1-855-764-8513 within 7 days prior to the last covered day.
- Discharge Planning begins 24 hours after admission to a residential or inpatient facility. Please follow the [AHCCCS AMPM, Chapter 1000, Section 1020](#) (Discharge

Planning). This includes post follow up appointment with PCP or specialist within 7 days, safe placement with community supports, prescription medicines, and medical equipment if needed.

4.12 Discharge Planning

4.12.1 General Overview

Discharge planning refers to the clinically appropriate process of assessment and preparation for member needs upon discharge from the emergency department, inpatient or out-of-home placements. Discharge planning is a collaborative process involving timely communication between the member/caregiver, inpatient/residential provider, plan care manager, and outpatient providers to ensure a smooth transition of care to the community or another level of care.

Improvements in discharge planning can dramatically improve the outcome for members as they move to the next level of care. Research shows that good discharge planning is instrumental in improving health, and reducing avoidable readmissions when medications are prescribed and given correctly, and the member, their family or caregivers are adequately prepared to take over their care. Members, family, caregivers and providers are all involved in maintaining the health and stability of a member after discharge.

Recommended discharge planning activities:

- Assessment of the member by qualified personnel, including:
 - Member's social determinants of health (SDOH) which will affect their ability to successfully discharge to the community.
 - Barriers/gaps in care that may lead to readmission
 - Member needs upon discharge for services such as physical/behavioral therapy, home health, etc.
 - Needs for DME
 - Member's understanding of medications, or need for education in this area.
 - Past utilization patterns.
- Communication:
 - To the member's Health Plan/outpatient providers about the admission, to request records/treatment history, and to discuss needs for discharge.
 - Discussion with the member about their needs; the type of care that will be required after discharge; what activities they might need assistance with when they go home; information about medications and diet; who will handle meal preparation, transportation and chores.
 - Outreach to member's family/caregivers/natural supports to engage them in member's support and treatment according to member's needs and desires.
 - Include outpatient treatment team in treatment planning with the member where possible.
- Planning for discharge or transfer to another facility:
 - Work with outpatient providers to develop continuing treatment plans if necessary.

- Arrange follow-up appointments with outpatient providers, including medication reconciliation if necessary.
- Arrange appointments for follow up testing if required.
- Ensure access to medications before discharge and member understanding of how to take medications and why.
- Make referrals to specialists, home care agencies and/or appropriate support organizations in the community.
- Arrange for DME, oxygen, etc. according to the member's needs.
- Arrange for caregiver training or other support if it will be needed.

For licensure requirements with regards to discharge planning please check:

http://apps.azsos.gov/public_services/Title_09/9-10.pdf

4.12.1.1 **Best Practice References and Recommendations**

- Care Transitions Model (Coleman Model)
- Transitional Care Model designed to prevent health complications and re-hospitalizations of chronically ill, elderly hospital patients
- Project Re-engineered Discharge (Project Red)
- Project Better Outcomes for Older Adults Through Safe Transitions (Project Boost)
- HSAG Top 10 Intervention Series to Reduce Inpatient Psychiatric Readmissions
- AHRQ Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions/Toolkit
<https://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html>

4.12.1.2 **Administrative Days (formerly known as Avoidable Bed Days)**

The Health Plan will consider administrative days for an acute hospitalized member who no longer meets medical necessity criteria and is ready for the next level of care; and the stay is being denied by the Health Plan Medical Director. In addition, it must be clearly documented in the member's medical record that the inpatient facility has attempted to secure the next level of care but has been repeatedly refused by all network available facilities. Providers must submit daily documentation, including weekends, of reaching out to providers for an available placement for the member. The documentation must be submitted to reviewer every 3 days throughout duration of administrative stay.

1. Discuss with the provider's UM reviewer about the member's lack of disposition per the finding of a facility available at time of discharge and request administrative days.
2. The provider will be notified upon approval.
3. It is the provider's obligation to submit continued information on who is being contacted for bed placement daily, with the name of the facility, phone number, who was spoken with, and reason for not accepting member.
4. Documentation of reaching out to providers for placement, including the information specified above, must be submitted daily, including weekends, and must also be submitted to the reviewer every 3 days throughout duration of administrative stay.

4.12.2 Discharge Planning for American Indian Members In an Out of Home Placement

1. If an American Indian member is currently receiving services from an Outpatient Provider and a Tribal Provider (Tribal and/or IHS), providers are required to work in collaboration with the Tribal Provider.
2. When American Indian members are placed out of home, the provider is expected to include the Tribal provider in ongoing discharge planning and ongoing service planning.
3. If assistance is needed with Tribal providers, contact a member of the Health Plan Tribal Programs Team at AzCHTribalCOC@azcompletehealth.com

4.12.3 Discharge Planning for Behavioral Health Admissions

4.12.3.1 Behavioral Health Hospital Discharge Plan

- Member assessment needs:
 - Use a screening tool to assess Social Determinants of Health (SDOH)
 - Patient Centered Assessment Method (PCAM), which can be found at [https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/Practice%20Centered%20Assessment%20Model%20\(PCAM\).pdf](https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/Practice%20Centered%20Assessment%20Model%20(PCAM).pdf).
 - Health Leads Screening Toolkit (which includes a screening tool), which can be found at <https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/>
 - Hennepin County Medical Center Life Style Overview which can be found at <https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/Hennepin%20Health%20Life%20Style%20Overview.pdf> ,
 - Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE), which can be found at <https://www.azahcccs.gov/PlansProviders/Downloads/TI/CoreComponents/PRAPARE - NACHC.mht>
 - Accountable Health Communities Screening Tool which can be found at <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>
- Communication:
 - Inform the Health Plan and Outpatient Providers of member's admission
 - Request treatment records including: most recent History & Physical, psychiatric evaluation, medication lists from both BHMP and PCP, current service plan and Crisis Plan, anticipated target level of functioning upon discharge from inpatient services.
 - Invite member and outpatient provider participation in discharge planning meetings.
 - Provide discharge summaries to the member's Health Plan and outpatient treatment providers that includes a description of the patient's condition and the services provided to the member.

- Provide the member with documented discharge instructions, and provide a copy to the member's representative/caregiver.
- Treatment Planning:
 - For members with an SMI determination develop an ITDP (Inpatient Treatment Discharge Plan) in collaboration with the outpatient clinical team.
 - Identify the specific needs of the member after discharge.
 - If member is going to need DME, treatment in Behavioral Health Residential Facility (BHRF) or other ongoing treatment, ensure that the appropriate requests for authorization have been submitted to the Health Plan.
 - Provide sufficient medications to cover the member until they are able to meet with their outpatient provider/prescriber.
 - For members with substance dependence issues ensure that services are offered such as: detoxification, opioid treatment, MAT, and referrals to treatment if necessary. If needed also ensure that these members are provided with naloxone.
 - Ensure that post discharge appointments have been scheduled for medication reconciliation or other treatment needs.

For more information see: *ARTICLE 2. HOSPITALS.

https://apps.azsos.gov/public_services/Title_09/9-10.pdf; R9-10-209. Discharge Planning.

ARTICLE 3. BEHAVIORAL HEALTH INPATIENT FACILITIES.

https://apps.azsos.gov/public_services/Title_09/9-10.pdf. R9-10-309. Discharge

4.12.3.2 ***Discharge Planning Activities for Behavioral Health Outpatient Providers:***

- Communication:
 - Provide a packet of clinical information about the member to the Inpatient facility, including: most recent History & Physical, psychiatric evaluation, Medications lists from both BHMP and PCP, current service plan and Crisis Plan, anticipated level of functioning upon discharge.
 - Notify the outpatient clinical team staff of member's current status/discharge plan.
 - Coordinate/facilitate a treatment planning meeting (ART/CFT) with the member while inpatient and invite the Hospital Social Worker/discharge planner, member's guardian, POA, Public Fiduciary, therapist, peer support, member's natural supports, and unit charge nurse.
 - Meet with the member within 48 hours of admission, and prior to discharge.
 - Obtain a copy of the ITDP (developed in collaboration between the Inpatient and Outpatient treatment teams) and distribute to the treatment team.
 - If necessary to develop a safe disposition plan, facilitate a conversation between the BHMP/PCP and the attending psychiatrist.
 - If the member has any barriers to a safe discharge inform the inpatient social worker and the Health Plan UM reviewer/transitions of care CM.
- Treatment Planning:
 - Review the recommendations on the ITDP and plan to implement them.

- Submit any required authorization requests for Behavioral Health placement, and other behavioral health needs on the ISP, including medication prior authorization to the Health Plan for approval.
- Provide the dates for follow-up appointments to the inpatient discharge planner and to the member. The scheduling is:
 - BHMP: Within 7 calendar days of member's discharge from facility for BH condition
 - Primary Care Provider: Within 7 calendar days of member's discharge unless medically indicated to see provider sooner.
- Plan to meet with the member after discharge to ensure member's needs have been met.
- Update the annual assessment, ISP and Crisis plan in the member's EHR, to ensure that all gaps in care have been identified and provided for to reduce the chance that the member will readmit.

4.13 Pharmaceutical Requirements

Providers are required to comply with various pharmaceutical requirements within the AzCH-CCP Provider Manual and [AHCCCS AMPM Policy 310-V](#).

4.13.1 E-Prescribing Software

Utilize e-prescribing software systems to submit prescriptions to pharmacies.

4.13.2 Tamper-Resistant Prescription Pads

Providers are required to ensure that processes are in place for the use of Tamper Resistant Prescription Pads (TRPP) for any non-electronic prescriptions. Written and non-electronic prescriptions are required to contain all three of the following characteristics:

- One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.
- One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber, and
- One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

The tamper resistant requirement does not apply when a prescription is communicated by the prescriber to the pharmacy electronically, verbally, by fax, or in most situations when drugs are provided in designated institutional and clinical settings and paid for as part of a bundled or per diem payment methodology. The guidance also allows emergency fills with non-compliant written prescriptions as long as the prescriber provides a verbal, faxed, electronic, or compliant written prescription to the pharmacy within 72 hours.

4.13.3 Free Samples

Providers must ensure that no "free samples" of brand name medications will be provided to Health Plan Members and that Pharmaceutical Company Representatives are not allowed to provide, or make available, marketing materials of brand name medications to Health Plan Members. The Provider must also ensure that Health Plan Members do not participate in Pharmaceutical Company sponsored activities, such as free lunches or giveaways. In order to prevent drug representatives from having undue influence on prescribing practices, provider staff serving Health Plan Members also are discouraged from participating in Pharmaceutical Company sponsored activities, such as free lunches or giveaways.

4.13.4 The Health Plan Drug Lists (Formulary)

Providers are required to abide by The Health Plan's drug lists (formularies) as applicable, when prescribing medications for Members in accordance with this Provider Manual. Providers are also required to adhere to the requirements of the AHCCCS Psychotropic Medication informed consent requirements in accordance with this Provider Manual.

4.13.5 Prescriber Appointments

Providers must ensure that Members are scheduled for Prescriber appointments in a time frame that ensures that (1) the Member is evaluated for the need for medications so that the Member does not experience a decline in behavioral health status, and (2) the Member does not run out of medication.

4.13.6 Physician Oversight

Providers are required to provide physician oversight when providing medical treatments, including methadone, medications, and detoxification to ensure services are rehabilitative in focus and directed to long-term recovery management, when applicable.

4.13.7 Medication Assisted Treatment

Providers are required to ensure Behavioral Health Medical Professionals assist Members with Substance Use Disorders receive Medication Assisted Treatment when appropriate to support Members' recovery.

4.13.8 Registration with Controlled Substance Prescription Monitoring Program

All medical practitioners are required to register and utilize the Arizona Controlled Substance Prescription Monitoring Program (CSPMP, PMP). Practitioners must obtain a patient utilization report for the preceding 12 months from the controlled substances PMP central database tracking system before prescribing opioid analgesics or benzodiazepines in schedules II-IV. Practitioners are not required to obtain a report if the patient is:

- receiving hospice care or being treated for cancer or cancer-related illness;
- if the practitioner will administer the controlled substance;
- if the patient is receiving the controlled substance during the course of inpatient or residential treatment in a hospital, nursing care facility or mental health facility;
- if the medical practitioner, under specific legislation, prescribed controlled substances for no more than five day after oral surgery, and
- as outlined in [AHCCCS AMPM Chapter 300, Policy 310-FF](#).

Medical practitioners may be subject to liability or disciplinary action for failing to request or receive prescription monitoring data from the PMP, or for acting or failing to act on the basis of the PMP monitoring data provided. Evidence of registration is required to be maintained in personnel records.

4.13.9 The Health Plan Drug Lists

The Health Plan's Drug Lists ensure the availability of safe, cost-effective and efficacious medications for eligible Members. Medications may be added or deleted from the list based on factors such as obsolescence, toxicity, and substitution of superior products or newer treatment options.

Medicare eligible Members, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX), receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs). Prescription drug coverage for Medicare eligible Members enrolled in Part D is based on the Part D plans' drug lists (formularies). There may be an occasion when a Member's prescribed drug is not available through their Part D plan's formulary. This is considered a non-covered Part D drug. The Health Plan and/or providers must make attempts to obtain a drug not on a Part D plan's formulary by requesting an exception from the Part D plan.

To ensure coverage of medications through The Health Plan, providers are required to utilize The Health Plan drug lists. These drug lists can be found on The Health Plan's website at www.azcompletehealth.com or can be requested in hard copy by calling the Pharmacy Service Center at 888-788-4408.

To use the drug list, providers are encouraged to look in the index which lists all of the drugs on the drug list and includes both the brand name and generic name. Abbreviations that may appear in the Drug Tier column on the drug list include: "F" for Formulary which means the drugs are covered by Arizona Complete Health-Complete Care Plan and "NF" or Non-Formulary for drugs that require authorization to be covered.

Title XIX/XXI eligible persons receiving medication(s) have the right to notice and appeal when a decision affects coverage for medication(s), in accordance with **Section 8.4 - Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons**. Non-Title XXI/XXI persons determined to have a SMI have the right to notice and appeal when a decision affects medication coverage, in accordance with **Section 8.5 - Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX)**.

Members with third party coverage, such as Medicare and private insurance, will have access to medications on their health plan's formulary through their third party insurer. If the desired/recommended prescription drug is not included on the health plan's formulary but may be covered by requesting an exception or submitting an appeal, the provider is required to attempt to obtain an exception for the medication or assist the Member in submitting an appeal with the health plan. The Health Plan will cover medications for persons determined to have a SMI, regardless of Title XIX/XXI eligibility, when their third party insurer will not grant an exception for a medication that is a medication on the Behavioral Health Drug List or The Health Plan Drug List.

Applicable copayments must only be collected in accordance with **Section 7.22 - Copayments**. For Persons with Coverage from Third Party Payers, copayments are collected in accordance with **Section 7.24 - Third Party Liability and Coordination of Benefits**.

4.13.10 Prior Authorization

AHCCCS requires The Health Plan to prior authorize coverage of those medications indicated in the AHCCCS Health Plan Drug Lists as requiring prior authorization and those that have age limits. Please see the preferred drug lists (PDLs) for additional information on which medications require prior authorization or have coverage limitations. You may also refer to the health plan web-site for pharmacy forms and criteria: <https://www.azcompletehealth.com/providers/pharmacy.html> or by request by calling provider services.

When these prior authorization criteria are utilized, the requirements outlined in **Section 4.1 - Securing Services and Prior Authorization**, **Section 8.4 - Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons**, and **Section 8.5 - Notice and Appeal Requirements (SMI and GMH/SA Non-TXIX/TXXI)**, must be met.

4.13.11 Input from The Health Plan Pre Contracted Providers

The Health Plan contracted providers can offer suggestions for adding or deleting medications to/from the AHCCCS Health Plan Drug Lists directly with AHCCCS.

To propose additions or deletions to The Health Plan Drug Lists, providers may submit a written request to The Health Plan's Pharmacy Administrator:

Pharmacy Administrator
Arizona Complete Health- Complete Care Plan
333 E. Wetmore Road
Tucson, AZ 85705

Requests for additions must include the following information:

- Medication requested (trade name and generic name, if applicable);
- Dosage forms, strengths and corresponding costs of the medication requested;
- Average daily dosage;
- Indications for use (including pharmacological effects, therapeutic uses of the medication and target symptoms);
- Advantages of the medication (including any relevant research findings if available);
- Adverse effects reported with the medication;
- Specific monitoring required; and
- The drugs on the current formulary that this medication could replace.

Requests for deletions must include a detailed summary of the reason for requesting the deletion.

The Health Plan Pharmacy Administrator or designee will present requests, as determined appropriate, to the AHCCCS Pharmacy and Therapeutics Committee.

The Health Plan will provide specific information for their providers regarding requests and changes to the Preferred Drug Lists on our web-site <https://www.azcompletehealth.com/providers/pharmacy.html> or through fax/e-mail communications or pharmacy webinars. .

4.14 Utilization Data Analysis and Data Management

4.14.1 Compliance with The Health Plan, Agency Requirements and Laws

Providers must comply with various utilization management requirements, including Chapter 1000 of the AMPM, the QM/MM/UM Performance Improvement Specifications Manual, this Provider Manual, The Health Plan's Utilization Management Plan, and Federal utilization control requirements limiting respite services to six hundred (600) hours per Member per year.

4.14.2 Communication of Guidelines

The Health Plan will communicate guidelines, including any admission, continued stay and discharge criteria to all affected providers and to Members when appropriate and to individual Members upon their request. Decisions regarding utilization management, Member and provider education, coverage of services, provision of services, and other areas to which guidelines are applicable must be consistent with 42 CFR 438.230(c) and (d). Providers must also communicate notice of decision requirements as described in this Provider Manual, and federal and State laws and regulations, including federal requirements regarding Utilization Review Plans, Utilization Review Committees, Plan of Care and Medical Care Evaluation studies as prescribed in 42 CFR, Parts 441 and 456.

4.14.3 Emergency Room Utilization

The Health Plan tracks emergency room utilization, including waiting times members are in an emergency room awaiting a behavioral health inpatient placement. The Health Plan tracks emergency department utilization by members and Health Home, providing reports to Health Homes on a monthly basis. Health Homes are required to proactively work with members to minimize unnecessary utilization of emergency rooms by providing members 24/7 access to physicians and developing and utilizing alternative 24/7 community based services to help members manage crises and receive appropriate medical care. The Health Plan reports appropriate and non-appropriate use of emergency departments to Health Homes regarding individual members. Non-appropriate and repeat appropriate use of emergency departments by individual members is reported to providers through the provider portal. Health Homes are required to review the data and help members receive the most appropriate care in the most appropriate settings and facilitate access to preventive care services to reduce the need for emergency department utilization.

4.14.4 Responsibilities of The Health Plan Medical Management/ Utilization Management Committees

The Health Plan convenes Medical Management/Utilization Management (MM/UM) Committee meetings on a regularly scheduled and ongoing basis. The Health Plan discusses data submitted to AHCCCS as part of the MM/UM Committee. The Health Plan's MM/UM Committee is expected to conduct the following Utilization Data Management Activities specific to data that is reported to AHCCCS:

- Review and analyze data to identify trends;
- Interpret variances;
- Review Outcomes;
- Determine, based on the review of data, if action (new or changes to current intervention) is required to improve the efficient utilization of services;
- Develop and/or approve corrective action and interventions based on findings; and
- Review and evaluate the effectiveness/outcomes of the intervention.

Both AHCCCS and The Health Plan's evaluation of findings and interventions must include a review of the impact to service utilization, quality, and outcome.

Both AHCCCS and The Health Plan's intervention strategies are to address both over and under-utilization of services and must be integrated throughout the organization. All strategies must have measurable outcomes and must be reported in MM/UM minutes. The Health Plan must also incorporate its evaluation of over and under-utilization into its annual Medical Management Plan and summarize action taken to correct areas of concern.

Minimum Required Utilization Data Elements include, but are not limited to:

- Over- and Under-utilization of services and costs;
- Avoidable hospital admissions and readmissions, and average length of stay for all psychiatric inpatient stays;
- Follow-up after discharge;
- Court-ordered treatment;
- Emergency Department utilization and crisis services;
- Prior Authorization, denials and notices of action;
- Pharmacy Utilization;
- Lab and diagnostic utilization;
- Medicare Utilization;
- Serious Mental Illness Eligibility Determination; and
- Bed days per 1000 admissions.

Section 5 - CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS

5.1 Introduction and Processes

The credentialing and re-credentialing processes are integral components of The Health Plan quality management program. The credentialing and re-credentialing processes help to verify that qualified providers, who are capable of meeting the needs of the persons who are seeking and/or receiving services, participate in The Health Plan provider network.

Credentialing and re-credentialing is an ongoing review process to assure the current competence of practitioners by validating the training and competence of individual practitioners in particular specialty areas. This level of review is intended to provide verification that the appropriate training, experience, qualifications, and ongoing competence has been demonstrated by individual practitioners for the services they provide.

The credentialing and re-credentialing requirements differ depending on the type of provider. Physicians, nurse practitioners, physician assistants, psychologists and all other health professionals who are registered to bill independently or provide services for which they are licensed to perform must be credentialed prior to providing services to members.

This section applies to providers providing services to persons enrolled in the AHCCCS health system or AHCCCS Health Plan. Provider types subject to credentialing and re-credentialing requirements include, but are not limited to:

- Physicians (MD and DO);
- Doctor of Podiatric Medicine (DPM);
- Licensed Psychologists;
- Nurse Practitioners (Nurse Practitioners must have certifications that align with their Scope of Practice);
- Physician Assistants;
- Licensed Clinical Social Workers;
- Licensed Professional Counselors;
- Licensed Marriage and Family Therapists;
- Licensed Independent Substance Abuse Counselors;
- Board Certified Behavior Analysts (BCBAs);
- Occupational Therapists;
- Speech and Language Pathologists;
- Physical Therapists;
- Behavioral Health Residential Facilities;
- Behavioral Health Outpatient Clinics;
- Free standing psychiatric hospitals;
- Psychiatric and addiction disorder units;
- Hospitals and units in general hospitals;

- Ambulatory Surgical Centers;
- Home Health and Long Term Care Providers;
- Psychiatric and addiction disorder residential treatment centers;
- Non-emergency transportation vendor;
- Laboratories;
- Federally Qualified Health Centers;
- Community/Rural/Mental Health Clinics (Centers);
- Level 1 Sub-Acute Facilities;
- Community Service Agency;
- Integrated Clinics; and
- Any non-contracted provider that is rendering services and sees 50 or more of The Health Plan's The Health Plan members per contract year.

5.2 Delegation of Credentialing

If The Health Plan delegates any of the credentialing/re-credentialing or selection of provider responsibilities, The Health Plan is required retain the right to approve, suspend, or terminate any providers selected and may revoke the delegated function if the delegated performance is inadequate.

5.3 Initial Credentialing Process and Requirements

Providers wishing to join The Health Plan Network must complete the Potential Provider Application for review and approval prior to applying for credentialing, located here: <https://www.azcompletehealth.com/providers/become-a-provider.html> . Initial applications will not start the formal credentialing process unless approved by The Health Plan's Potential Provider Committee.

The initial credentialing process includes verification of information submitted on the credentialing application and a site visit (if applicable), and is completed before the effective date of the initial contract. An application must be complete, signed, and dated. Credentials with expiration dates must be valid at the time of approval. Initial credentialing is completed within 90 calendar days from receipt of a complete application, accompanied by the designated documents, to render a decision for approval or denial.

The Health Plan is required to utilize the Arizona Association of Health Plan's (AzAHP) Credentialing Verification Organization (CVO) as part of the credentialing process. As part of this process, it is required that all individual applicants be enrolled in the Council for Affordable Quality Healthcare (CAQH) and maintain a current CAQH application and attestation in order to be credentialed. Providers must also utilize the AzAHP credentialing data forms. The Health Plan's Credentialing Department reserves the right to specify exceptions to this process to meet network needs.

For organizational provider types not requiring CAQH registration, an AzAHP credentialing application and data form must be completed in its entirety and submitted along with all required documentation. This form can be found on The Health Plan website, here: <https://www.azcompletehealth.com/providers/become-a-provider/credentialing-forms.html>. Credentialing applications should be submitted as indicated on the AzAHP credentialing forms.

Any provider that has changed its NPI or provider type or Organizational Providers who have moved locations, must submit new credentialing applications. Providers that have failed to re-credential timely, must also complete the initial credentialing process.

The initial credentialing process may include verification the following:

- Application Completeness;
- License;
- Work History;
- Insurance Coverage;
- Drug Enforcement Administration (DEA) Certificate (if applicable);
- Controlled Substance Certificate (if applicable);
- Board Certification (if applicable);
- Education;
- Sanction Information;
- Malpractice History;
- Site Survey;
- CLIA License (if applicable);
- Pharmacy License (if applicable);
- W-9;
- Disclosure of Ownership.

5.4 Additional Credentialing Requirements for Organizational Providers

Hospitals and other licensed health care facilities are included in this process. Prior to contracting with an organizational provider, The Health Plan verifies that organizations have been reviewed and approved by a recognized accrediting body or meet The Health Plan's standards for participation, and are in good standing with state and federal agencies. Organizational providers include, at a minimum, hospitals, outpatient treatment centers, home health agencies, skilled nursing facilities, nursing homes, crisis services providers, freestanding surgical centers and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential or ambulatory care setting. Once approved to join The Health Plan's network, the AzAHP credentialing data and application forms must be completed, along with all required documents. This form and detailed submission information can be found here: <https://www.azcompletehealth.com/providers/become-a-provider/credentialing-forms.html>. Credentialing applications should be submitted as indicated on the AzAHP credentialing forms.

The initial credentialing process may include verification the following:

- Application Completeness;
- License;
- Accreditation of JCAHO/CARF/COA/or AOA (If applicable);

- Site Survey not more than 3 years old;
- Insurance Coverage;
- CLIA License (If applicable);
- Pharmacy License (if applicable);
- W-9;
- Disclosure of Ownership.

For organizational providers that are not accredited and do not have a current Center for Medicare and Medicaid Services (CMS) certificate, or do not have an AHCCCS license that denotes a recent Site Survey, an onsite inspection will be done by Provider Relations or a Network Specialist determine the scope of services available at the facility, physical plant safety, review of the quality improvement program for adequate mechanisms to credential practitioners delivering care in the facility, identify and manage situations involving risk, and assess the medical record keeping practices.

Community Service Agencies are subject to additional requirements, for more information see the [AHCCCS AMPM Chapter 900, Policy 950](#).

5.5 Hiring Non-Participating Providers

In an effort to comply with applicable federal and state laws and regulations, all participating providers in The Health Plan's network must comply with the following standards when hiring a non-participating provider to provide services to The Health Plan members.

The Health Plan's participating providers must be able to demonstrate that each non-participating provider has supporting documentation that includes:

- Current, unencumbered state medical license;
- Valid, unencumbered Drug Enforcement Agency (DEA) certificate, as applicable or Chemical Dependency Services (CDS) certificate, as applicable;
- Evidence of adequate education and training for the services the practitioner is contracting to provide;
- Malpractice insurance coverage through their own practice or through the hiring of The Health Plan's participating provider;
- Absent of any sanctions that would not allow them to see a Medicare member.

Additionally, the practitioner must be absent from:

- The Medicare Opt Out report if treating Medicare members The Office of the Inspector General's (OIG) sanctions List of Individuals and Entities (LEIE) if treating Medicaid and Medicare members;
- The System for Award Management's Exclusions Extract Data Package (EEDP) if treating Medicare members;
- The Federal Employee Health Benefits Program Debarment Report if treating federal members.

5.6 Investigations

The Health Plan investigates adverse activities indicated in a practitioner's or provider's initial credentialing or recredentialing application materials or as identified between credentialing cycles. The Health Plan may also be made aware of such activities through primary source verification utilized during the credentialing process or by state and federal regulatory agencies. The Health Plan may require a practitioner or provider to supply additional information regarding any such adverse activities.

Examples of such activities include, but are not limited to:

- State or local disciplinary action by a regulatory agency or licensing board;
- Current or past chemical dependency or substance abuse;
- Health care fraud or abuse;
- Member complaints;
- Substantiated quality of care concerns Impaired health;
- Criminal history;
- Office of Inspector General (OIG) Medicare/ Medicaid sanctions;
- Federal Employees Health Benefits Program (FEHBP) debarment;
- Substantiated media events;
- Trended data;
- At The Health Plan's request, a practitioner or provider must assist in investigating any professional liability claims, lawsuits, arbitrations, settlements, or judgments that have occurred within prescribed time frames.

5.7 Modifications

A request to add new facilities or providers to an existing Provider Participation Agreement (PPA) requires completion of the AzAHP Practitioner Data Form for physicians or AzAHP Organizational Data Form or AzAHP Facility Form for other provider types and a Disclosure of Ownership form for each physician and facility. These forms are located on Arizona Complete Health website www.azcompletehealth.com. New physicians are not permitted to treat The Health Plan's members until all credentialing requirements have been met and the physician has been formally added to the PPA.

Note: Providers must include their National Provider Identifier (NPI) on the Provider Participation Request form they submit to The Health Plan.

Providers participating in The Health Plan must include the Arizona Health Care Cost Containment System (AHCCCS) identification number and NPI. Any subsequent changes to either the AHCCCS identification (ID) number or NPI require the submission of a request for processing. Instructions for these requests are located on www.azcompletehealth.com

Provider data changes include:

- Name changes;
- Tax ID numbers, Group NPI's, or changes or additions of AHCCCS ID numbers;
- Primary address and billing address changes;

- Addition or deletion of locations;
- Provider termination notifications;
- Specialty or sub-specialty changes.

When changing a tax ID number, include a new W-9 and the effective date. Participating providers may be held responsible for Internal Revenue Service fines imposed by The Health Plan associated with incorrect tax IDs if the provider fails to notify The Health Plan in writing prior to the change. The Health Plan is unable to change tax IDs retroactively.

Changes must be submitted in writing to The Health Plan Network Operations Department 30 days prior to the change or as soon as reasonably possible.

The Health Plan must approve any new or modified subcontracts prior to the effective date.

5.7.1 Provider Online Data Verification

Physicians, hospitals, ancillary providers, and medical groups or IPAs are required to provide advance notification to The Health Plan or their medical groups or IPAs with changes to their provider data information. On a monthly basis, providers should validate that their information is reflected correctly on the provider website under Find a Provider.

5.7.2 Provider data Information

Providers' data information should include the following:

- Name;
- Address;
- telephone number;
- fax number;
- office hours;
- languages other than English spoken by the physician handicap accessibility status for parking (P), exterior building (EB), interior building (IB), restroom (R), exam room (ER), and exam table/scale (T) - if accessibility is not yes to all, then indicate no.
-

5.7.3 Notification and Maintenance Requirements

According to the terms of the Provider Participation Agreement (PPA), participating providers are required to provide a minimum of 30 days advance notice of any changes to their information. If the change pertains to the status of accepting new patients, the provider must notify The Health Plan 45 days prior to the decision to no longer accept Covered Persons with respect to a particular product.

Providers directly contracting with The Health Plan must notify The Health Plan of changes by emailing AZProviderData@AZCompleteHealth.com

Providers contracting through a medical group or IPA must notify the medical group or IPA directly of changes, and the medical group or IPA notifies The Health Plan. Medical groups or IPAs must have policies in place that establish and implement processes to collect,

maintain and submit their provider data changes to The Health Plan on a real-time basis. Real-time is within 30 days, as defined by the Centers for Medicare & Medicaid Services (CMS).

5.7.4 AHCCCS Minimum Subcontract Provisions

Providers refer to your Provider Participation Agreement for the latest information on AHCCCS Minimum Subcontract provisions. Any subcontractors must also comply with AHCCCS minimum subcontract provisions. To view the full provision please refer to: <https://www.azahcccs.gov/PlansProviders/HealthPlans/minimumsubcontractprovisions.html>

5.7.5 Terminations

Participating providers terminating a physician, clinician or other entity from an existing Provider Participation Agreement (PPA) must submit the following information:

- Physician's full name;
- Physician's NPI;
- Specialty type (or entity type if facility or ancillary);
- License number;
- Tax ID;
- Group NPI;
- Practice location address;
- Effective date of the change;
- Covering physician;
- Contact name, address and telephone number.

This information must be submitted in writing to The Health Plan Network Operations Department at least 60 days prior to the termination. Upon termination, The Health Plan may invoke a 12-month waiting period before the provider may re-apply for a contract; however, the termination clause varies based on the PPA.

The Health Plan must be notified of participating providers who terminate a subcontract. This information must be submitted in writing to The Health Plan Network Operations Department at least 60 days prior to the termination.

5.8 Provisional Credentialing Process and Requirements

Occasionally, it is in the interest of members to allow practitioners availability in the network prior to completion of the entire initial credentialing process. Provisional credentialing is intended to ensure member service delivery and provider availability in medically underserved areas, based on The Health Plan's network sufficiency.

Practitioner and provider types that may qualify for provisional credentialing include, but not limited to:

- Federally Qualified Health Centers (FQHC);
- FQHC Look-Alike organizations;
- Hospital employed physicians (when appropriate);
- Providers needed in medically underserved areas (determined by network sufficiency);

- Covering or substitute providers providing services during a provider absence.

Provisional credentialing is completed within 14 calendar days from receipt of a complete application accompanied by the designated documents to render a decision regarding temporary or provisional credentialing. Practitioners applying to the network for the first time are eligible for provisional credentialing. A practitioner may only be provisionally credentialed once and practitioners may not be held in a provisional credentialing status for more than 60 calendar days. Providers that are in a provisional status, that do not clear the Initial Credentialing Requirements will be terminated.

5.9 Recredentialing Process and Requirements

The recredentialing of providers is completed every 36 months. As part of the recredentialing process, providers are notified 180 days in advance of the expiration of their credentials. The Credentialing Department will mail, fax or email notifications to the providers at least three times within the notification cycle. In order to avoid a lapse in network participation status, the recredentialing application and required documents must be valid at the time of approval. Any provider that fails to recredential timely, will have to undergo the initial credentialing process. Providers that fail to recredential cannot request provisional credentialing status. The provider will be required to complete and submit applicable credentialing applications, data forms and all required supplemental documentation. The forms and detailed submission instructions can be found here: <https://www.azcompletehealth.com/providers/become-a-provider/credentialing-forms.html>.

The Health Plan is required to utilize the Arizona Association of Health Plan's (AzAHP) Credentialing Verification Organization (CVO) as part of the recredentialing process. As part of this process, it is required that all individual applicants be enrolled in the Council for Affordable Quality Healthcare (CAQH) and maintain a current CAQH application and attestation in order to be credentialed. Providers must also utilize the AzAHP credentialing data forms. The Health Plan's The Health Plan Credentialing Department reserves the right to specify exceptions to this process to meet network needs.

For organizational provider types not requiring CAQH registration, an AzAHP credentialing application and data form must be completed in its entirety and submitted along with all required documentation. This form can be found on The Health Plan's website, here: <https://www.azcompletehealth.com/providers/become-a-provider/credentialing-forms.html>

The recredentialing process includes the verification of all the elements included during initial credentialing, with the addition of member concern/grievances, utilization management, performance improvement, results of medical record audits, and quality of care concerns.

5.10 Credentialing Approval/Denial Process

Completed credentialing and recredentialing requests are presented to the Credentialing Committee Chair, or designee, for review prior to presentation at Credentialing Committee. Initial credentialing files that were not considered adverse, may receive approval during the review. Recredential files and credentialing files that exceed the credentialing standards

(adverse) must be taken to the Credentialing Committee for review and determination. It is the responsibility of the Credentialing Committee to review the issues/concerns and qualifications of each applicant presented and make approval or denial determinations.

All applicants receive notice of their status in writing within 14 calendar days of the Credentialing Committee decision.

When there are extenuating circumstances that preclude the practitioner from meeting minimum participation criteria, but do not preclude the practitioner from providing quality care and service for The Health Plan's Members, the Medical Director/ Credentialing Committee Chair /Credentialing Committee may decide to extend an offer of participation. If such a need exists, each criterion for selection shall be examined on an individual basis taking into account the following:

- Malpractice claims history;
- If there is a history of drug or alcohol abuse, the applicant must be involved in a credible program to correct impairment with concurrent and present monitoring by the medical society or state board. There should be no evidence of recidivism;
- Previous sanction activity: the nature of the sanction and remedy; and
- Office site visit: a plan to remedy any deficiencies with provisional approval until the remedy is achieved.

If the Credentialing Committee requires additional information prior to making a determination, the application will be pended in order to obtain additional information or clarification for the Credentialing Committee. Once the requested information has been obtained, the file will be presented to the Credentialing Committee at a future Credentialing Committee meeting. The Credentialing Committee will review and grant exceptions on an individual basis, depending on the outcome of the review.

5.11 Fairness of Process

The Health Plan or its designee shall maintain fair credentialing and re-credentialing processes which:

- Do not discriminate against a provider solely on the basis of the professional's license or certification; or due to the fact that the provider serves high-risk populations and/or specializes in the treatment of costly conditions;
- Afford the provider the right to review information gathered related to their credentialing application and to correct erroneous information submitted by another party. The organization is not required to reveal the source of information if the information is not obtained to meet organization credentialing verification requirements or if disclosure is prohibited by law;
- Notify the provider when the information obtained through the primary source verification process varies substantially from what the provider provided;
- Verify credentialing/re-credentialing information is kept confidential; and

- State that practitioners have a right to be informed of the status of their application upon request, and must describe the process for responding to such request, including information that the organization may share with practitioners with the exception that this does not require the organization to allow a practitioner to review references, recommendations or other peer- review protected information.

5.12 Notification Requirement

The Health Plan is required have procedures for reporting to appropriate authorities, including the Arizona Health Care Cost Containment System (AHCCCS), the provider's regulatory board or agency, Adult Protective Services (APS), Department of Child Safety (DCS), Office of the Attorney General (OAG), any known serious issues and/or serious quality deficiencies that could result in a provider's suspension or termination from The Health Plan's network. If the issue is determined to have criminal implications, a law enforcement agency must also be notified. The Health Plan is required to:

- Maintain documentation of implementation of the procedure, as appropriate;
- Have a reconsideration process for instances in which The Health Plan The Health Plan chooses to alter the provider's contract based on issues of quality of care and/or service; and
- Inform the provider of the reconsideration process.

5.13 Additional Standards

Other standards related to the credentialing process include the following:

- The credentialing process must be in compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid:
 - Documentation must show that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated without the right to appeal:
 - [Health and Human Services-Office of Inspector General \(HHS-OIG\) List of Excluded Individuals/Entities \(LEIE\)](#); and
 - [General Services Administration \(GSA\) Excluded Parties List System \(EPLS\)](#). Use Chrome when accessing this website.
- Mechanisms must be put in place to verify that licensed providers renew licenses or certifications required by the appropriate licensing/certifying entity and continuously practice under a current and valid license/certification; and
- Health care providers who are part of The Health Plan network are subject to an initial site visit as part of the initial credentialing process or in the case of adverse findings on the States Site Survey or on the CMS Site Survey Report.

5.14 Provider's Right for Reconsideration

The Health Plan's Medical Director or Credentialing Committee may decide not to extend participation status to an applicant. The Credentialing Committee Chair or designee will notify the practitioner of the Credentialing Committee denial decision within 14 calendar days of the Credentialing Committee's decision.

The letter of denial shall include information on the practitioner's right to review information obtained by The Health Plan to evaluate the practitioner's credentialing and/or re-credentialing application, and right to request reconsideration and/or correct any erroneous information submitted by another party in the event the practitioner believes any of the information is erroneous or if any documents gathered during the primary source verification process differ from those submitted by the practitioner. A copy of the letter will be retained in the practitioner's closed file and maintained in the monthly Credentialing Committee folders for future reference.

Information obtained from any outside primary source will be released to a practitioner only if the practitioner has submitted a written and signed request to The Health Plan's Credentialing Department.

New applicants who are declined participation for reasons such as quality of care, their credentials have exceeded threshold limits or liability claims issues have the right to request a reconsideration of the decision in writing within thirty 30 calendar days of the formal notice of denial. All written requests will need to include additional supporting documentation in favor of the applicant's reconsideration for network participation. Reconsiderations will be reviewed by the Chief Medical Officer, Medical Director Designee or at the next regularly scheduled Committee meeting, but in no case later than 60 calendar days from the receipt of the additional documentation. Applicants will be notified within 14 calendar days of the committee decision. The provider does not have the any further recourse if the decision is to uphold the initial decision.

Should any information gathered as part of the primary source verification process differ from that submitted by the practitioner on the application, the practitioner must provide a written explanation detailing the error or the difference in information within 30 calendar days of receipt of the committee decision.

Providers who are denied initial participation may reapply for admission into The Health Plan's network no earlier than one year from the Credentialing Committee final decision date.

Recredentialing Applicants: Current Practitioners whose participation is suspended, reduced, or terminated, shall have the right to request reconsideration of the decision in writing within 30 calendar days of receipt of the formal termination notice. All written requests for reconsideration will need to include additional supporting documentation in favor of the applicant's request for continued network participation. The reconsideration review will be scheduled no later than 60 days after the receipt of the request. The final recommendation will be based upon the practitioner's submitted credentials, the credentialing committee's recommendations and supporting documentation submitted by the provider. The reconsideration determination will be by an affirmative vote of the majority of the members of

the panel. The provider does not have the any further recourse if the decision is to uphold the recredentialing denial.

Terminations that cannot be reconsidered: Per [AHCCCS AMPM Chapter 900-950](#), any provider that is found to be on the Health and Human Services Office of Inspector General (HHS-OIG) list of Excluded Individual/Entities (LEIE) or the General Services Administration Excluded Parties List Systems (EPLS) will be terminated without the right to appeal, in accordance with the [AHCCCS ACOM Policy 103](#).

5.15 Ongoing Monitoring Process Between Re-Credentialing Cycles

The Health Plan's Credentialing Department monitors on a monthly basis:

- Practitioner Medicare/Medicaid sanctions;
- Limitations or sanctions on State licensure;
- The Compliance Department submitted report of Office of Inspector General (OIG) and Excluded Parties List System (EPLS) checks;
- Items eligible for expiration.

Reports are provided to the Credentialing Committee. The Chief Medical Officer (CMO) or designee working with the Credentialing Committee will initiate appropriate corrective action for providers when occurrences of poor quality are identified. The CMO, designee or Credentialing Committee reviews sanctions during regularly scheduled meetings or via an Ad Hoc emergency meeting. For records that have been submitted to the Credentialing Committee, the Committee's members will be asked for their professional feedback and be given an opportunity to vote on whether or not the provider should be allowed continuation in The Health Plan's Network or be placed on administrative review or corrective action.

Providers will be immediately terminated if they are found to be excluded from the Medicaid/Medicare programs via the OIG or EPLS checks conducted. For reconsideration, a release from the reporting agency must be submitted. Corrective Action Plans (CAPs) in progress are not considered a release from the reporting agency.

5.16 Notice of Requirements (Limited to Providers)

The Health Plan has procedures for reporting (in writing) to appropriate authorities (AHCCCS, the provider's regulatory board or agency, Office of the Attorney General, etc.) any known serious issues and/or quality deficiencies. If the issue/quality deficiency results in a provider's suspension or termination from The Health Plan's Network, it must be reported. If the issue is determined to have criminal implications, a law enforcement agency must also be notified.

- The Health Plan is required maintain documentation of implementation of the procedure, as appropriate;
- The Health Plan is required have an appeal process for instances in which The Health Plan chooses to alter the provider's contract based on issues of quality of care and/or service; and
- The Health Plan is required to inform the provider of the reconsideration process.

5.17 Provider Locations that Accommodate Members with Accessibility Needs

In accordance with [AHCCCS ACOM Policy 406](#) and [AHCCCS ACOM Policy 416](#), Arizona Complete Health-Complete Care Plan shall maintain a web-based provider directory that includes the following provider location accessibility information:

- Non-English language, if any, spoken or signed by a health care provider or other medical professional as well as non-English language spoken or signed by a qualified medical interpreter, if any, on the provider's staff.
- Physical and Equipment Accessibility Information that shows if a participating provider/entity has basic or limited access in, at a minimum, the following areas:
 - American Sign Language - Signage with Braille and raised tactile text characters at office, elevator, stairwells and restroom doors. Rooms that are not likely to change function (like a restroom, kitchen, elevators, etc) should be identified by name. Other rooms that may change function can be identified by a numbers or letters.
 - Exam Room, the entrance to the exam room is accessible with a clear path. The doors open wide enough to accommodate a wheelchair/scooter to turn around.
 - There is an accessible ramp to the building. Curb ramps and other ramps to the building are wide enough for a wheelchair/scooter. Handrails are provided on both sides of the ramp. Doors are wide enough to allow entrance for a wheelchair/scooter and the doors have handles that are easily opened
 - Doors are wide enough for a wheelchair/scooter and have handles that are easily opened. There are interior ramps available and the ramps have handrails. If an elevator is present, it must be available for use by the public and patients. The elevator has easy-to-hear sounds and Braille buttons within reach. The elevator is large enough for a wheelchair/scooter to turn around. If a chair lift is present, it can be utilized without help
 - CMS Medical Equipment Access. An accessible examination room has features that make it possible for patients with mobility disabilities, including those who use wheelchairs, to receive appropriate medical care. These features allow the patient to enter the examination room, move around in the room, and utilize the accessible equipment provided. The features that make this possible are:
 - an accessible route to and through the room;
 - an entry door with adequate clear width, maneuvering clearance, and accessible hardware;

- appropriate models and placement of accessible examination equipment (including an adjustable height accessible exam table that lowers for transfers) and
 - adequate clear floor space inside the room for side transfers and use of lift equipment.
- Parking spaces, including van-accessible space(s), are accessible. Pathways have curb ramps between the parking lot, office and at drop-off locations.
- Patient Areas Members can get to and use all common areas and equipment with or without help.
- Patient Diagnostic And Treatment Use Patients are able to access and use testing and treatment areas, and equipment.
- The restroom is accessible, has doors wide enough to accommodate a wheelchair/scooter and are easy to open. The restroom is large enough for a wheelchair/scooter to turn around and close the door. The restroom has grab rails which allows a transfer from the wheelchair to the toilet. Toilet paper is easy to reach. The sink is accessible and the faucets and soap are easy to reach and use
- Exam Table/Scale. There is a height-adjustable exam table. There is enough room next to the exam table for a wheelchair/scooter user to approach, park and transfer or be assisted onto the exam table. There is a weight scale with a platform that can accommodate a wheelchair/scooter and the patient.
- A statement informing enrollees that they are entitled to language interpreter services at no cost, including information on how to obtain interpretation services.
- A statement informing enrollees that they are entitled to full and equal access to covered services, including enrollees with disabilities as required under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.
- Access to Web-based directory must be available to the public without restrictions or limitations and be 508 compliant.

Members with disability access needs may contact the Arizona Complete-Complete Care Plan Health toll-free Member/Provider Services number at 1-888-788-4408 (TTY/TDD Hearing Impaired: 711) to request:

- An accommodation from Arizona Complete Health-Complete Care Plan; or assistance requesting an accommodation from an Arizona Complete Health provider, vendor, affiliate, and/or delegate.
- Arizona Complete Health-Complete Care Plan staff assists members with scheduling appointments or other health plan activities shall ask the member if they “need any assistance with walking, seeing, reading, hearing, communicating, speaking, filling out forms, getting on and off a table, or any other assistance.”
- Arizona Complete Health-Complete Care Plan staff will record in all data systems, in a consistent and prominent place, any member disability access needs, accommodation requests, and actions taken in response to requests. This information shall be routinely updated during each contact.
- The entire interactive process to respond and implement the member’s request shall be completed within (30) calendar days, or sooner if necessary to provide an urgent accommodation (e.g. for an acute situation).

Section 6 - DATA SYSTEMS/REPORTING REQUIREMENTS

6.1 Enrollment, Disenrollment and Other Data Submission

With respect to decisions on enrollment providers shall defer to AHCCCS, which has exclusive authority to enroll and dis-enroll Medicaid eligible members in accordance with the rules set forth in A.A.C., R9-22, Article 17 and R9-31, Articles 3 and 17. Providers shall also defer to AHCCCS, which has exclusive authority to designate who will be enrolled and dis-enrolled as Non-Medicaid eligible members.

The collection and reporting of accurate, complete and timely enrollment, and disenrollment data is of vital importance to the successful operation of the AHCCCS health service delivery system. It is necessary for providers to submit specific data on each person who is actively receiving services from the health system. As such, it is important for provider staff (e.g., intake workers, clinicians, data entry staff) to have a thorough understanding of why it is necessary to collect the data, how it can be used and how to accurately label the data. This policy has particular relevance for those providers that conduct assessments, ongoing service planning, and annual updates. This data in turn is used by the AHCCCS to:

- Monitor and report on outcomes of individuals in active care (e.g., changes in diagnosis, employment/educational status, behavioral health category, substance use,);
- Comply with federal and state funding and/or grant requirements;
- Assist with financial-related activities such as budget development and rate setting;
- Support quality management and utilization management activities; and
- Inform stakeholders and community members.

The intent of this section is to describe requirements for providers to submit the following data in a timely, complete, and accurate manner:

- Non-Title XIX/XXI 834 batch enrollment and dis-enrollments.

The Health Plan's Management Information System has the capability to automatically receive and load data from a provider's EHR to collect enrollment data for submission to AHCCCS. The Health Plan providers required to transmit 834 records to The Health Plan, must have a certified EHR and use their system to electronically send data in the required format.

Additionally, The Health Plan and AHCCCS shall have access privileges and user-rights to any and all Member information within Contractor's MIS system, and that of any Management Information System (MIS)/Electronic Health Record (EHR) system operated by a subcontracted provider. At a minimum, The Health Plan and AHCCCS shall be permitted real-time access to client level data, claims and billing, service planning, assessment, and grievance and appeal data.

6.1.1 Enrollment And Disenrollment Transactions

6.1.1.1 **General Requirements:**

- Arizona Health Care Cost Containment System (AHCCCS) enrolled individuals are considered enrolled with The Health Plan at the onset of their eligibility. They are provided an AHCCCS identification card listing their assigned Health Plan. This assignment is sent daily from AHCCCS to The Health Plan.
- For a Non-Title XIX/XXI eligible person to be enrolled, providers must submit an 834 enrollment transaction to The Health Plan. All AHCCCS enrolled individuals with a mental health benefit are considered enrolled with The Health Plan at the time of their AHCCCS eligibility.
- For a Non-Title XIX/XXI eligible person who receives a covered service, they must be enrolled effective the date of first contact by a provider.

6.1.1.2 **When to Collect Enrollment Information**

For Non-Title XIX/XXI eligible individuals, information necessary to complete an 834 transaction is usually collected during the intake and assessment process (see **Section 12.5 - Assessment and Service Planning**). **Provider Manual Attachment 13.1.1, 834 Transaction Data Requirements** that can be obtained by calling the Provider Services Call Center at 866-796-0542 which contains a list of the data elements necessary to create an 834 enrollment transaction.

For AHCCCS enrolled individuals, the 834 information will be provided to The Health Plan by AHCCCS.

6.1.1.3 **Data Included in an 834**

The data fields that are included in the 834 transmittals are dictated by HIPAA and consist, in part, of:

- Key client identifiers used for file matching (e.g., person's name, address, date of birth);
- Basic member information (e.g., gender, marital status); and
- Information on third party insurance coverage.

Reference The Health Plan 834 file specification document for full details on what to collection and how to submit Non-Title 834 files. You can obtain a current version of the 834 file specifications by contacting EDI Help Desk at 1-888-460-4310.

6.1.1.4 **Lack of Information to Complete an Enrollment**

Providers must actively secure any needed information to complete the enrollment (834 transaction) for a Non-Title XIX/XXI eligible individual. An 834 transaction will not be accepted by the Health Plan if required data elements are missing. For Title XIX/XXI eligible individuals, the 834 information will be provided to The Health Plan by AHCCCS.

6.1.1.5 *Timeframes for Submitting Enrollment and Disenrollment Data for A Non-Title XIX/XXI Eligible Individual*

- The following data submittal timeframes apply to the enrollment/disenrollment transactions: The 834-enrollment transaction must be submitted to Health Plan within 7 calendar days of the first contact with a member.
- The 834 disenrollment transaction must be submitted to The Health Plan within 7 calendar days of the person being dis-enrolled from the system; and any changes to the enrollment/disenrollment transaction data fields (e.g., change in address, insurance coverage) must be submitted 7 calendar days from the date of identifying the need for the change.

6.1.1.6 *Other Events Requiring a Submittal of an 834 Transaction For A Non-Title XIX/XXI Eligible Individual*

In addition to submitting an 834 transaction at enrollment and disenrollment, an 834 transaction must also be submitted when any of the following elements of the 834 transaction have changed:

- Name;
- Address;
- Date of birth;
- Gender;
- Marital status; or
- Third party insurance information.

6.1.1.7 *Other Considerations for Both Non-Title XIX/XXI Eligible and AHCCCS Enrolled Individuals*

For an AHCCCS enrolled individual, AHCCCS will notify The Health Plan of changes to the above information.

When a person in an active care permanently relocates from one RBHA/MCO/Health Plan's geographic area to another RBHA/MCO/Health Plan's geographic area, an Inter-RBHA/MCO transfer must occur (see **Section 13.2 – Inter-RBHA/MCO Coordination of Care**). The steps that are necessary to facilitate an Inter-RBHA/MCO transfer include the following data submission requirements:

- The home T/RBHA/Health Plan must submit an 834 disenrollment transaction effective on the date of transfer;
- The receiving T/RBHA/Health Plan must submit an 834 enrollment transaction on the date of accepting the person for services and start of treatment; and
- AHCCCS will notify The Health Plan when The Health Plan enrolled person is determined eligible for the Arizona Long Term Care System (ALTCs) Elderly and Physically Disabled (EPD) Program. This information will be passed to The Health Plan in a daily file.

6.1.1.8 ***Technical Assistance Available to Help with Problems Associated with Electronic Data Submission***

At times, technical problems or other issues may occur in the electronic transmission of the data from the provider to The Health Plan. If a provider requires assistance for technical related problems or issues, please email The Health Plan EDI Help Desk at 1-888-460-4310.

6.1.2 **Member and Clinical Data**

6.1.2.1 ***When Member and Clinical Data Is Collected***

Member and clinical data shall be collected starting at the first date of service. For Non-Title XIX/XXI eligible individuals, an 834 must be completed. The AHCCCS Demographic & Outcomes Data Set User Guide

<https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html>

describes minimum required data elements that comprise the demographic data set, in part. Providers are required to comply with AHCCCS demographic requirements, submitting demographic data to AHCCCS through the AHCCCS demographic portal.

Section 7 - FINANCE/BILLING

7.1 General Information

This section contains general information related to The Health Plan's billing rules and requirements for Claims or Encounters.

Payment responsibilities for AHCCCS covered physical and behavioral health services provided to AHCCCS members are pursuant to and clarified in [AHCCCS ACOM Policy 432](#). This policy includes general requirements regarding the payment responsibility of:

- Physical and behavioral health services;
- Physical health services that are provided to members that are also receiving behavioral health services;
- Specific circumstances regarding payment for behavioral health services; and
- Specific circumstances regarding payment for physical health services at the Arizona State Hospital.

7.2 Claims versus Encounters

A **Claim** is a detailed invoice that providers must submit to The Health Plan to illustrate what services were rendered to our members. Claims have a dollar amounts tied to them as cash value typically under Fee For Service (FFS payment methodologies).

Encounters have zero cash value as they are used as proof of monies earned through different contracting means such as block purchase, per member per month (PMPM) agreements, grant funds, or otherwise alternate payment methodologies as required.

7.3 Claim or Encounter Submission Requirements

Claims or Encounters that are not legible or not submitted on the correct form type or not submitted in conformance with the Health Insurance Portability and Accountability Act (HIPAA) transactions requirements, National Uniform Claim Committee Edits (NUCC) and 5010 Standards, will be returned to providers without being processed. This is known as a claim or encounter rejection.

Rejected Claims or Encounters do not count as a clean initial submission. Timely filing guidelines are not considered for rejected claims.

Applicable form types for claim or encounter submissions are as follows:

- HIPAA Format 837P or HCFA 1500 is used to bill or encounter non-facility services, including professional services, transportation, housing and independent laboratories.
- HIPAA Format 837I or UB04 Forms is used to bill or encounter hospital inpatient, outpatient, emergency room, hospital-based clinics and Behavioral Health Inpatient Facility services.
- HIPAA Format NCPDP is used by pharmacies to bill or encounter pharmacy services using NDC codes.
- HIPAA Format 837D or the ADA Dental Claim Form is used by dental providers to bill or claims or encounters for dental service.

Paper Claims are to be mailed, Arizona Complete Health-Complete Care Plan PO Box 9010, Farmington, MO 63640. Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges or are handwritten are not considered legible submissions claim submission. Liquid paper correction fluid ("White Out") may not be used. If the claim or encounter is submitted in this manner, the claim will be rejected and returned to the provider.

When submitting claims please ensure that the printed information is aligned correctly with the appropriate section/box on the form. If a claim is not aligned correctly, it may cause the (Optical Character Recognition (OCR) system to read the data incorrectly and the claim will reject.

Payor ID for Submission of 837I or 837P is 68069

Providers also have the option to enroll for access to our Provider Portal to direct key entry claims and supporting supplemental documents. Providers can request access to the Provider Portal by going to The Health Plan website at www.azcompletehealth.com

Select the option "For Providers" then select "Provider Portal" then Create An Account.

7.4 Claim Submission Time Frames

In accordance with AHCCCS Requirements, claim and encounter services provided to The Health Plan members must be received in a timely manner. The Health Plan timely filing guidelines are as follows:

- Claims or Encounters must be accepted as a clean claim within 6 months from the end date service or from the date of eligibility posting whichever is later, unless there is a contractual exception. For hospital inpatient claims, date of service means the date of discharge of the patient.
- A retro-eligibility claim is a claim where no eligibility was entered in the AHCCCS system for the date(s) of service, but at a later date eligibility was posted retroactively to cover the date(s) of service. Timely filing time frames are as follows:
 - The initial claim must be received no later than six months from the AHCCCS date of eligibility posting.
 - Retro-eligibility claims must obtain clean claim status no later than 12 months from the AHCCCS date of eligibility posting.
 - This time limit does not apply to adjustments.
- Claim or Encounter Resubmissions: Claims or Encounters must be accepted as a clean claim within 365 days from the date of provision of the covered service or eligibility posting deadline, whichever is later.
- If the member has primary insurance (i.e. insurance in addition to The Health Plan), claims or encounters must be submitted to The Health Plan within 6 months from the date of service or 90 days from the date of the primary payer's EOP, whichever one is later. Secondary claims that are not received within 6 months days from the date of service or 90 days from the date of the primary payer's EOP will be denied for timely filing.

7.5 Claim Reimbursement

Claims reimbursement is based on contractual agreements that utilize AHCCCS pricing methodologies. These are inclusive of, but are not limited to:

- All patient refined diagnosis related group (APR-DRG)
- Tiered per diem payment structure.
- Outpatient Hospital Fee Schedule (OPFS) for outpatient facilities.
- AHCCCS fee schedules and negotiated rates.
- Arizona Department of Health Services (ADHS) rates.

7.5.1 CMS-1500 Claim Form

AHCCCS identification (ID) number (paper claims only):

- Member's name, gender and date of birth;
- Diagnosis code number (ICD-10) - enter at least one ICD-10 diagnosis code to describe the member's condition. Up to 12 ICD-10 codes may be entered. The codes must be entered in the A, B, C format order indicated on the claim form. Behavioral health

- providers must not use DSM-4 or DSM-5 diagnosis codes;
- Medicaid resubmission code (box 22 on the CMS- 1500), if applicable - enter the appropriate code (7 to indicate a replaced or corrected claim or 8 to indicate a void of a previous claim), along with the applicable claim identification number;
- date(s) of service - enter the beginning and ending service dates;
- place of service emergency indicator, if applicable - enter a check mark, X or Y if the service was an emergency service;
- procedures, services and supplies - enter the CPT or HCPCS procedure code that identifies the service provided;
- diagnosis code pointer;
- billed amount for each service line;
- service units;
- rendering provider NPI (box 24J);
- billing provider tax ID number;
- patient account number, if applicable;
- total charges for the claim;
- amount previously paid, if applicable - enter the total payment amount the provider received for this claim from all sources other than The Health Plan;
- signature and date - the provider or their representative must sign and date the claim;
- service facility location information, NPI and AHCCCS ID number, if applicable; and
- billing provider's name, address, telephone number, and NPI.

7.5.2 **UB-04 Claim Form**

- name, address and telephone number of the provider rendering service;
- patient control number, if applicable;
- bill type;
- facility's federal tax ID number;
- statement covers period - enter the beginning and ending dates of the billing period;
- patient name, address, date of birth and gender;
- admission/start of care date;
- admission hour, if applicable;
- type of admission;
- point of origin for admission or visit;
- discharge hour;
- patient discharge status;
- condition codes, if applicable;
- occurrence codes, if applicable;
- responsible party name and address, if applicable;
- value codes and amounts, if applicable;
- revenue code(s);
- revenue code description/NDC code, if applicable;
- HCPCS/rates - enter the inpatient accommodation rate and the appropriate CPT or HCPCS code;
- service date and service units;

- total charges for each revenue code;
- non-covered charges, if applicable;
- payer - enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred;
- billing provider's NPI;
- diagnosis and procedure code qualifier;
- principle diagnosis code, admitting diagnosis code;
- other diagnosis codes, if applicable;
- principle procedure code and dates, if applicable;
- attending provider name and identifiers, if applicable;
- operating physician and identifiers, if applicable; and
- other procedure codes, if applicable.

Detailed instructions on how to fill out the claim forms can be found on the AHCCCS website.

7.5.3 Clean Submission Guidelines

As defined by Arizona Revised Statutes (ARS) §36-2904 (G)(1) a "clean claim" is a claim that may be processed without obtaining additional information from the provider of service or from a third party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

A claim is considered "clean" when the following conditions are met:

- All required information has been received by The Health Plan;
- The claim meets all Arizona Health Care Cost Containment System (AHCCCS) submission requirements;
- The only acceptable claim forms are those printed in Flint OCR Red, J6983 or exact match ink;
- Any errors in the data provided have been corrected; and
- All medical documentation required for medical review has been provided.

Reasons for claim denial include, but are not limited to, the following:

- Duplicate submission;
- Member is not eligible for date of service;
- Incomplete data;
- Non-covered services;
- Provider of service is not registered with AHCCCS on the date of service; and
- Information from the primary carrier is required.

7.5.4 Corrected Claim Submission

Providers must correct and resubmit claims to The Health Plan within the 12-month resubmission time frame. When resubmitting a claim, the resubmission indicator (7 for replacement or 8 to void a prior claim) must be indicated in Box 22 along with the original claim number from the remittance advice (RA). The Health Plan utilizes this information to identify the claim as a resubmission. . If the original claim number is missing, the claim may be entered as a

new claim and denied for past timely filling or as a duplicate.

Corrected claims must be appropriately marked as such and submitted to the appropriate claims mailing address.

7.6 Remittance Advice and Electronic Funds Transfer (EFT)

The Health Plan will prepare remittance advice or the appropriate responses that describes its payments, denials or reject reason which will include:

- A description of the rejection, denial or adjustments;
- The reasons for the rejection, denial and adjustments;
- The amount billed;
- The amount paid if applicable;
- Application of coordination of benefits and copays if applicable; and
- Provider rights to assert a claim dispute only in the case the claim was processed.

The Health Plan will submit the related remittance advice with the payment, unless the payment is made by Electronic Funds Transfer (EFT), in which case the remittance will be mailed, or otherwise sent to the provider, no later than the date of the EFT.

Upon request by a provider, an electronic Health Care Claim Payment/Advice 835 transaction will be provided to a provider in accordance with HIPAA requirements if the provider submits an 837I or 837P.

7.7 Electronic Claim Submission

The Health Plan contracts with Capario, Change Health Care (formerly Emdeon (WebMD)) and Ability Network (formerly MD On-Line) to provide claims clearinghouse services for The Health Plan electronic claim submission.

The benefits of electronic claim submission includes:

- Reduction and elimination of costs associated with printing and mailing paper claims;
- Improvement of data integrity through the use of clearinghouse edits;
- Faster receipt of claims by The Health Plan resulting in reduced processing time and faster payment;
- Confirmation of receipt of claims by the clearinghouse; and
- Availability of reports when electronic claims are rejected and ability to track electronic claims, resulting in greater accountability.

7.8 Reports

For successful electronic data interchange (EDI) claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Acceptance/rejection reports from EDI vendor
- Acceptance/rejection reports from EDI clearinghouse
- Acceptance/rejection reports from The Health Plan

Providers are encouraged to contact their vendor/ clearinghouse to see how these reports can be accessed/ viewed. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

Providers may also check the status of paper and electronic claims online at 866-796-0542

For questions regarding electronic claims submission, contact your Provider Engagement Specialist at 866-796-0542.

7.9 Filing a Claim

The Health Plan encourages the electronic filing of claims whenever possible. When submitting claims, it is important to accurately provide all required information as described in Claim Submission Requirements.

Claims submitted with missing data may result in a delay in processing or a denial of the claim. The Health Plan requires that all facility claims be submitted on a UB-04 claim form. Professional fees must be submitted on an original (red) CMS-1500 claim form. Copies of claim forms are not accepted. Participating providers receive a Remittance Advice (RA) each time a claim is processed. When The Health Plan is the primary payer, claims must be submitted no later than six months from the date of service or the date of eligibility posting (whichever is later). For inpatient hospital claims, the date of service is considered to be the date of discharge. Initial claims submitted more than six months after the date of service are denied.

When The Health Plan is the secondary payer, claims must be submitted within six months from the date of service even if payment from Medicare or other insurance has not been received. A copy of the primary carrier's Explanation of Benefits (EOB) must be attached to the claim form. Following the initial claim submission, The Health Plan allows submission of the secondary claim for up to one year from the primary EOB date. The submission must include the primary carrier's EOB.

If payment is denied based on a provider's failure to comply with timely filing requirements, the claim is treated as non-reimbursable and cannot be billed to the member.

Acceptable proof of timely filing includes:

- EOB from another insurance carrier dated within The Health Plan's timely filing limits.
- Denial letter from another insurance carrier, printed on its letterhead and dated within The Health Plan's timely filing limits;
- Electronic data interchange (EDI) rejection report from clearinghouse which indicates claim was forwarded and accepted by The Health Plan (showing date received versus date of service) that reflects the claim was submitted within The Health Plan's timely filing limits. Claims that were rejected must be corrected and resubmitted in a timely manner.

Unacceptable proof of timely filing includes:

- Screen-print of claim invoice;
- Billing ledger;
- Copy of original claim;
- Denial letter from another insurance carrier without a date and not on letterhead;
- Record of billing stored in an Excel spreadsheet.

7.9.1 Interest Calculation

The following information applies to interest rate calculations and turnaround times for Medicaid claims.

7.9.1.1 ***Non-Hospital Claim Turnaround Times***

Non-hospital claims for both participating and non- participating providers must be processed within 45 calendar days unless otherwise indicated by contract.

7.9.1.2 ***Claim Payment Standards***

The Health Plan Access insures that 95 percent of all clean claims are adjudicated within 30 calendar days of receipt of the clean claim, and 99 percent are adjudicated within 60 calendar days of receipt of the clean claim.

7.9.1.3 ***Interest***

For hospital clean claims, The Health Plan is required to pay interest on payments made after 60 day of receipt of the clean claim, unless otherwise specified in the contract. Interest shall be paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment (A.R.S. §36-2903.01)

For non-hospital clean claims The Health Plan is required to pay interest on payments made after 45 days of receipt of the clean claim, unless otherwise specified in the contract. Interest shall be paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.

For authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS provider, or a home and community based ALTCS provider, The Health Plan is required to pay interest on payments made after 30 days of receipt of the clean claim. Interest shall be paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment (A.R.S. §36-2943.D).

7.9.1.4 ***Obstetrical Services***

The global obstetrical (OB) package includes all antepartum visits, delivery, postpartum visits, and all services associated with admission to and discharge from a hospital.

- Only services not included in the global OB care CPT code (59400 or 59510) may be billed separately.

- A minimum of 5 antepartum visits during an eligible period are required for OB package reimbursement
- While there is not a separate reimbursement for the evaluation and management services that are provided during the prenatal and postpartum care periods, AHCCCS requires that the codes and individual dates of services be included in the global OB service billing.
- Claims for ineligible services are denied when billed in addition to the global OB code.

Services not included in the global OB package and may be billed separately include:

- Amniocentesis;
- Ultrasound;
- special screening tests for genetic conditions;
- visits for unrelated conditions.

Refer to the *Maternity Care and Delivery* section of the CPT code book for details regarding the appropriate coding to use for obstetrical services.

7.10 Overpayment Recovery Procedures

The Health Plan makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's remittance advice (RA). An automatic system offset, where applicable, might occur in accordance with the reprocessing of the claim for the overpayment, or on subsequent check runs.

In the event that a provider independently identifies an overpayment from The Health Plan (such as a credit balance), the provider must take the following steps:

- Send a check made payable to Arizona Complete Health-Complete Care Plan

Include a copy of the RA that accompanied the overpayment to expedite The Health Plans' adjustment of the provider's account. If the RA is not available, the following information must be provided: The Health Plan member name, date of service, payment amount, The Health Plan member identification (ID) number, vendor name, provider tax ID number, provider number, vendor number, and reason for the overpayment refund. If the RA is not available, it takes longer for The Health Plan to process the overpayment refund.

- Send the overpayment refund and applicable details to The Health Plan Overpayment Recovery Department at:

Arizona Complete Health-Complete Care Plan
333 E. Wetmore Road
Tucson, AZ 85705
Attn: Overpayment Recovery Department

If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of The Health Plan, the provider must follow the overpayment refund instructions provided by the vendor.

If a provider believes they have received a The Health Plan check in error and the provider has not cashed the check, they should return the check to The Health Plan Overpayment Recovery Department with the applicable RA and a cover letter indicating why the check is being returned.

7.11 Prior Period Coverage

Prior period coverage refers to the time frame from the effective date of eligibility to the day the member is enrolled with The Health Plan. The Health Plan is responsible for payment of all claims for medically necessary covered services, including behavioral health services provided on or after October 1, 2015 to dual- eligible members with General Mental Health/Substance Abuse (GMH/SA) needs, during prior period coverage.

7.12 Professional Claim Editing

The Health Plan claim processing includes programs that support editing related to National Correct Coding Initiatives (NCCI), bundling/unbundling, multiple procedure/surgical reductions and global E&M bundling standards. The source logic is obtained through various resources such as the Centers for Medicare & Medicaid.

Services (CMS), the American Medical Association (AMA) and other specialty academies. The Health Plan has the ability to apply advanced contextual processing for application of The Health Plan edit logic.

7.13 Remittance Advice

The Health Plan remittance advice (RA) contains important information about claims submissions and cash receipts for overpayments. The RA should be reviewed upon receipt and reconciled against billing records. The RA includes The Health Plan member names and dollar amounts paid for all claims processed during the course of a week.

Processing claims and adjustments results in one of the following remittance situations:

- **Positive remittance** - A remittance that totals to a positive amount and results in a payment to the provider. The total at the bottom of the RA agrees with the check or electronic payment the provider receives.
- **Negative remittance** - A remittance produced when the adjusted dollars exceed the total amount of payment on the remittance. The total at the bottom of the RA is negative, and does not result in a check or electronic payment to the provider

The Health Plan makes every attempt to identify a claim overpayment and indicate the correct processing of the claim on the provider's RA. An automatic system offset, where applicable,

might occur in accordance with the reprocessing of the claim for the overpayment, or on immediate subsequent check runs.

Providers are encouraged to register to receive The Health Plan Electronic RA (ERA) and Electronic Funds Transfer (EFT) through PaySpan. Providers can sign up for PaySpan via their website at www.PaySpanHealth.com or providers can contact PaySpan provider support at 1-877-331-7154.

To register for ERA or EFT, contact the Provider Engagement Specialist at 866-796-0542.

7.14 Specific Billing Requirements

The following are billing requirements for specific services and procedures.

Anesthesia - Anesthesia services (except epidurals) require the continuous physical presence of the anesthesiologist or certified nurse anesthetist (CRNA). Anesthesiologists and CRNAs must enter the approved American Society of Anesthesiologists (ASA) code in field 24D and the total number of minutes in field 24G of the CMS 1500 claim form.

Assistant Surgeon - Include the name of the surgeon in box 17 of the CMS-1500 form. Use the appropriate modifiers to reflect the assistant surgeon provider type (80/AS) as well as any services subject to multiple surgery guidelines.

Billing by Report - Include the operative report or chart notes for “by report” procedures, including high level examinations or consultations.

Multiple Surgeons - Include the appropriate modifiers to ensure proper payment of claims. Use modifier 80/AS for assistant surgeon, modifier 62 for co-surgeons and modifier 66 for surgical team.

Newborn Billing - The Health Plan’s Newborn Data Collection Unit must be notified of all newborn admissions. Identification of the admitting pediatrician must be provided when calling in the notification. Notification must be given no later than three days after the birth in order to ensure proper enrollment of the newborn with the Arizona Health Care Cost Containment System (AHCCCS) and The Health Plan.

Newborns whose childbearing members are The Health Plan members are eligible for The Health Plan from the time of delivery. Newborns receive separate The Health Plan identification (ID) numbers, and services for a newborn must be billed separately using the newborn’s ID number.

7.15 Vaccines for Children Billing Procedures

Arizona Health Care Cost Containment System (AHCCCS) providers who have registered for the Vaccines for Children (VFC) program must submit claims to The Health Plan for the VFC program supplied immunizations in order to receive reimbursement for the administration. The vaccines must be on the VFC listing and must be billed as follows:

For each immunization administered, the claim must include:

- Vaccine CPT code with the modifier SL(indicating a state-supplied vaccine).
 - No charge
- Applicable administration CPT code with the modifier SL (indicating a state supplied vaccine) and unit value equal to the code description and number of vaccines provided.
 - Usual and customary charge.

Providers must submit administration and vaccine codes on one claim form. Multiple claims should not be submitted.

Providers submitting multiple CMS-1500 for successor forms must staple the completed forms together and number the pages appropriately.

Use of modifier SL sufficiently identifies the claim as a state-supplied vaccine for which the billed vaccine charge is not reimbursed. Using modifier SL ensures that the claim is processed, the provider is reimbursed for the administration fee and the vaccination is included in performance measurements.

These billing procedures are designed to standardize billing practices and eliminate erroneous payments for state-supplied vaccines, which necessitate collection of overpayments from providers. The Health Plan may seek reimbursement of amounts that were paid inappropriately.

Failure to bill VFC claims in accordance with the billing procedures noted above results in denials for both the vaccine and the associated administration.

7.16 Claim Coding Policies

7.16.1 Basic Coding Guidelines

Current ICD-10-CM codes, CPT codes, HCPCS codes, and modifiers reflective of the date of service are required on all The Health Plan claims.

These codes should be used in basic accordance with the publishers' stated guidelines. Three major publications, the American Medical Association's (AMA) CPT-4 codebook, the Centers for Medicare & Medicaid Services (CMS) HCPCS code book and the ICD-10-CM, represent the basic standard of service code documentation and reference required by The Health Plan .

Valid ICD-10-CM diagnosis codes are required on all claims. The first diagnosis on the claim form is reserved for the primary diagnosis. Up to four diagnoses may be reported. Code each diagnosis to the highest level of specificity (fourth or seventh digit when available).

Valid AMA CPT-4 and Level II HCPCS procedure codes are required on all claims. A three-month grace period for submitting deleted codes is allowed. After three months, deleted codes are denied.

Procedure codes should be chosen based on the publishers' definitions and be appropriate for the age and gender of the patient.

Procedure code modifiers are to be used only when the service meets the definition of the modifier and are to be linked only to procedure codes intended for their use.

If a deleted code and its current replacement code are submitted on the same date of service, the last code submitted is denied as a duplicate.

The Health Plan does not require documentation at the time of claim submission; however, in the event the claim is audited, documentation may be required.

Supporting Sources

- AMA CPT code book
- CMS national policy
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

7.16.2 Global Surgery

The global surgical package includes all necessary services normally provided by the surgeon before, during and after the surgical procedure. The global surgical package applies to minor procedures that have a zero or 10-day post-operative period and major procedures that have a 90-day post-operative period as defined by the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule.

The global surgical package policy applies to all places of service.

7.16.2.1 Services Included in the Global Package

The following services are included in the global surgical package and, therefore, are not eligible for separate payment:

- Preoperative evaluation and management (E&M) services that are performed one day prior to major surgery or on the same day as a minor or major procedure;
 - o Exception: New patient visits (CPT codes 99201- 99205) on the same day as a minor surgery are not included in the global package.
- Intraoperative services that are a usual and necessary part of the surgical procedure;
- Anesthesia provided by the surgeon;
- Supplies;
- All additional medical or surgical services required of the surgeon during the post-operative period because of complications, which do not require additional trips to the operating room;
- Post-operative E&M services that are related to the surgery;
- Post-operative pain management by the surgeon; and
- Dressing changes, local incision care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, and splints, insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and change and removal of tracheostomy tubes.

7.16.2.2 ***Services Not Included in the Global Surgery Package***

The following services are not included in the global surgical package and are eligible for separate payment:

- E&M service that was significant and separately identifiable from the minor surgical procedure performed on the same day. Modifier -25 should be added to the E&M code;
- E&M service performed the day prior to or on the same day of surgery that resulted in the decision for a major surgical procedure. Modifier -57 should be added to the E&M code;
- E&M services that occur during the post-operative period that are unrelated to the surgery. Modifier -24 should be added to the E&M code;
- Critical care when billed for serious injuries or burns;
- Services of other physicians not in the same provider group of the physician that performed the surgery, except where a formal transfer of care occurs;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the post-operative period that are not re-operations or treatment for complications. Modifiers -58 (staged procedure) or -79 (unrelated procedure or service performed by a physician during the post-operative period) should be added to the surgical procedure code;
- Treatment of post-operative complications that require a trip to the operating room. Modifier -78 should be added to the surgical procedure code; and
- Immunosuppressive therapy for organ transplants. Modifier -24 should be added to the E&M code.

Note: An E&M service that was significant and separately identifiable from the minor surgical procedure performed on the same day that falls within a global period of a previous service but is not related to the previous service requires both a modifier -25 and a modifier -24.

The Health Plan does not require documentation at the time of claim submission unless the service is listed as by report; however, in the event the claim is audited, documentation may be required.

Supporting Sources

CMS national policy

7.16.3 **Multiple Procedure Reduction**

When multiple procedures are performed by the same provider at the same session, they are typically subject to the multiple procedure reduction. The primary procedure code is reported as listed and is reimbursed at the full allowed amount. The additional procedure code(s) is reported with a modifier -51 and is reimbursed at a reduced amount. Add-on codes and American Medical Association (AMA) CPT modifier -51 exempt codes should not be reported with modifier -51 as they are excluded from multiple procedure reduction.

The Health Plan applies the multiple procedure reduction to the list of codes on the Centers for Medicare & Medicaid Services (CMS) National Physician Fee Schedule that are subject to multiple surgery guidelines with the exception of the AMA CPT modifier -51 exempt codes on the list. These codes are not subject to multiple procedure reduction. Final adjudication is based

on information presented in the Arizona Health Care Cost Containment System (AHCCCS) reference files. If there is a conflict, the AHCCCS reference files will be the guideline utilized, but a request for review can be initiated with supporting documentation.

The Health Plan reimburses multiple procedures using a 100 percent, 50 percent, 50 percent methodology. The procedure with the highest reimbursement value is paid at 100 percent of the allowed amount. Subsequent procedures are paid at 50 percent of the allowed amount.

All procedures should be billed together on one claim to avoid subsequent retractions and adjustments that may occur when procedures are billed separately.

The Health Plan does not require documentation at the time of claim submission other than for by report procedures; however, if the claim is audited, documentation may be required.

Supporting Sources

- CMS national policy
- AMA CPT code book
- AHCCCS reference files

7.16.4 Provider Preventable Conditions

Section 2702 of the Patient Protection and Affordable Care Act reduces or prohibits payments to health care providers for Medicaid services rendered as a result of certain preventable health care acquired illnesses or injuries.

The Health Plan processes medical claims utilizing the list of Provider Preventable Conditions (PPCs) and surgical errors and reduces or prohibits payments for PPCs.

The Centers for Medicare & Medicaid Services (CMS) issued a final rule implementing section 2702, which reduces or prohibits payments related to PPCs. This rule was built on Medicare's strategies that already reduces or prohibits hospital payments for preventable conditions, and also improved alignment between Medicare and Medicaid payment policies. Although the new rule gives states the flexibility to expand the list of other provider preventable conditions (OPPCs), Arizona currently employs only the Medicare National Coverage Determinations (NCDs) list as described in the Other Provider-Preventable Conditions definition below.

7.16.4.1 Definitions

PPCs are defined as either of the following:

- Health Care-Acquired Condition (HCAC) - Applies only to Medicaid inpatient hospital settings and are included in the following Medicare list of hospital-acquired conditions (HACs):
 - Retained foreign object following surgical procedures;
 - Air embolism;
 - Blood incompatibility;
 - Stage III and IV pressure ulcers;
 - Injuries resulting from falls and trauma;
 - Catheter-associated urinary tract infections;

- Vascular catheter-associated infections;
 - Manifestations for poor glycemic control;
 - Mediastinitis following coronary artery bypass graft (CABG) procedures;
 - Surgical site infections following orthopedic surgery procedures involving spinal column fusion or re-fusion, arthrodesis of the shoulder or elbow, or other procedures on the shoulder or elbow;
 - Surgical site infections following bariatric surgery procedures; and
 - Deep vein thrombosis or pulmonary embolism following total hip or knee procedures, except in pediatric or obstetrical patients.
- Other Provider-Preventable Condition (OPPC) - Applies to Medicaid inpatient or outpatient health care settings and includes any of the three Medicare NCDs:
 - Surgery on the wrong patient;
 - Wrong surgery on a patient;
 - Surgery on the wrong site.

7.16.4.2 Reporting Requirements

The Health Plan requires providers to both report to the proper Arizona authorities and to The Health Plan incidents of abuse, neglect, as well as any injury (such as falls and fractures), exploitation, HCAC, and/ or unexpected death as soon as the providers are aware of the incident. In turn, The Health Plan reports all incidents of abuse, neglect, injury, exploitation, HCAC, and unexpected deaths to the Arizona Health Care Cost Containment System (AHCCCS) Clinical Quality Management Unit.

7.17 Billing AHCCCS Recipients

Arizona Revised Statue 36-2903.01(K) prohibits providers from billing AHCCCS recipients including Qualified Medicare Beneficiary (QMB) recipients for covered services or be reported to a collection agency for any covered service provided. Providers may not charge members for services that are denied or reduced due to the provider's failure to comply with billing requirements, such as timely filing, lack of authorization or lack of clean claim status. Upon oral or written notice from the member that the patient feels the claim or encounter can be covered by The Health Plan, a contracted or non-contracted provider shall not do either of the following unless the provider has verified through The Health Plan that the member has been determined ineligible, has not yet been determined eligible or was not eligible at the time services were rendered:

- Charge, submit a claim to or demand to collect payment from the member; and
- Refer or report a member who has been determined as eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for services covered.

7.18 Resubmissions, Replacements and Voids

The Health Plan Claim and Encounter Adjudication will deny claims with errors that are identified during the editing process. These errors will be reported to Providers on their Remittance Advice. Provider should correct claims error and resubmit the correction to The Health Plan within 365 days from the date of provision.

When resubmitting a denied claim or encounter, providers must submit a new claim form containing all previously submitted lines. The original claim reference number must be included on the claim or encounter to enable The Health Plan system to identify the claim being resubmitted. Otherwise the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame.

7.19 Submissions for Non-Title XIX/XXI Enrolled Persons

Submitted encounters or claims for services delivered to Non-Title XIX/XXI enrolled persons must be submitted in the same manner and timeframes as described in the sections above.

7.20 Pseudo Identification Numbers for Non-Title XIX/XXI Eligible Persons

Pseudo identification numbers are only applicable to providers under contract with The Health Plan.

On very rare occasions, usually following a crisis episode, basic information about a Member may not be available. When the identity of a Member is unknown, a provider may use a pseudo identification number to register an unidentified person. This allows an encounter to be submitted to AHCCCS, allowing The Health Plan and the provider to be reimbursed for delivering certain covered services. Covered services that can be encountered/billed using pseudo identification numbers are limited to:

- Crisis Intervention Services (Mobile);
- Case Management; and
- Transportation.

Pseudo identification numbers must only be used as a **last option** when other means to obtain the needed information have been exhausted. Inappropriate use of a pseudo identification number may be considered a fraudulent act. The Health Plan's pseudo identification number for the South GSA in Greater Arizona is **[AHCCCS ID FOR SOUTH ARIZONA GSA – NR010126M0 for service dates after 10/1/2015]**

7.21 Provider Preventable Conditions and Fraud Waste and Abuse Edits

42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable Conditions. A Provider-Preventable Condition is a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC) as defined in Section 7.17.4.1 above.

A Member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication". If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed. If it is determined that the HCAC or OPPC was a result of mistake or error by a hospital or medical professional, The Health Plan will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

7.21.1 Fraud, Waste and Abuse (FWA) Claim or Encounter Edits

As part of our Contract Requirement, claims and encounters are cycled through our editing software which is based on National Correct Coding Initiatives (NCCI). NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The "National Correct Coding Initiative Policy Manual for Medicare Services" is updated annually. The PTP code pair edits, MUE tables, and NCCI manual are accessed through the National Correct Coding Initiative Edits webpage at cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html on the CMS website. Providers can request formal reconsideration of these denials by sending a written reconsideration letter with medical records to:

Arizona Complete Health Complete Care Plan
PO Box 9010
Farmington MO 63640.

Providers should reference the Control Reference Number in their cover letter. Actual copies of the claim or encounter is not needed.

7.22 Copayments

7.22.1 Introduction

A copayment is a monetary amount that a Member pays directly to a provider at the time covered services are rendered. This section covers AHCCCS copayments for the Title XIX/XXI (Medicaid)/XXI (KidsCare) population and also covers the AHCCCS copayments for the Non-Title XIX /XXI population. Although persons may be exempt from AHCCCS copayments, these individuals may still be subject to Medicare copayments. Most Medicaid eligible Members remain exempt from copayments, such as SMI Members and Members under the age of nineteen (19), while others are subject to an optional and mandatory copayment.

Prior to billing and before attempting to collect copayments from a Member, providers are required to verify the Member is not exempt or eligible to be exempt from being charged for copayments. Furthermore, providers must apply copayments for Members in conformance with the AHCCCS Policy on copayments and [AAC R9-22-711](#).

7.22.2 AHCCCS Copayments for Non-Title XIX/XXI Eligible Persons with a Serious Mental Illness (SMI)

- For individuals who are Non-Title XIX/XXI eligible persons with SMI, AHCCCS has established a copayment to be charged to these Members for covered services (A.R.S. 36-3409).
- Copayment requirements are not applicable to services funded by the Substance Abuse Block Grant (SABG), 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.
- Persons with 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 person in their comprehensive clinical record.
- Copayments assessed for Non-Title XIX/XXI persons with SMI are intended to be payments by the Member for all covered 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 person's health treatment;
 - Clearly document in the person's comprehensive clinical record all efforts to resolve non-payment issues, as they occur; and
 - Not refuse to provide or terminate services when an individual states they are unable to pay copayments described in this section. The Health Plan encourages a collaborative approach to resolve non-payment issues, which may include the following:
 - Engage in informal discussions and avoid confrontational situations;
 - Re-screen the person for AHCCCS eligibility; and
 - Present other payment options, such as payment plans or payment deferrals, and discuss additional payment options as requested by the person.

7.22.3 AHCCCS Copayments for Title XIX/XXI Members

Persons who are Title XIX/XXI eligible will be assessed a copayment in accordance with AAC R9-22-711. Certain populations and certain services are exempt from copayments. AHCCCS copayments are not charged to the following persons for any service:

1. Persons under age 19;
2. Persons that are Seriously Mentally Ill (SMI);
3. Individuals up through age 20 eligible for the Children's Rehabilitative Services Program (CRS);
4. Acute care members who are placed in nursing facilities or residential facilities such as an Assisted Living Home when such placement is made as an alternative to hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year.
5. Persons who are enrolled in the Arizona Long Term Care System (ALTCS);
6. People who are eligible for Qualified Medicare Beneficiary (QMB) A.A.C. Title 9, Chapter 29
7. Persons receiving hospice care;
8. American Indian Members who are active or previous users of the Indian Health Service, tribal health programs operated under a tribal 638 facility, or urban Indian health programs;
9. Individuals in the Breast and Cervical Cancer Treatment Program;
10. Adults eligible under [AAC R9-22-1427\(E\)](#). These individuals are known as the Adult Group. Persons 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 R9-22-1427(E) with income above 100% FPL, but not greater than 133% FPL;
11. Individuals receiving child welfare services under Part B Title IV of the Social Security Act, on the basis of being a child in foster care without regard to age;
12. Individuals receiving adoption or foster care assistance under Part E of Title IV of the Social Security Act without regard to age; and
13. Individuals who are pregnant through the postpartum period.

Copayments are not charged for the following services:

1. Hospitalizations,
2. Emergency Services
3. Family Planning services and supplies
4. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
5. Services paid on a Fee-For-Services basis
6. Preventive services, such as well visits, immunizations, pap smear, colonoscopies and mammograms and
7. Provider preventable services

7.22.4 Non-Mandatory (Nominal/Optional) Copayments

Individuals eligible for AHCCCS through any of the populations listed below may have nominal (optional) copayments for certain services. Nominal copayments are also referred to as optional copayments (see Table 1 below). Providers are prohibited from refusing services to Members who have nominal (optional) copayments if the Member states they are unable to pay the copayment.

Persons with nominal (optional) copayments are:

1. Caretaker relatives eligible under [AAC R9-22-1427\(A\)](#) (also known as AHCCCS for Families with Children under section 1931 of the Social Security Act);
2. Individuals eligible under the Young Adult Transitional Insurance (YATI) for young adults who were in foster care;
3. Individuals eligible for the State Adoption Assistance for Special Needs Children who are being adopted;
4. Individuals receiving Supplemental Security Income (SSI) through Social Security Administration for people who are age 65 or older, blind or disabled;
5. Individuals receiving SSI Medical Assistance Only (SSI MAO) who are age 65 or older, blind or disabled; and
6. Individuals in the Freedom to Work (FTW) program.

Table 1: Nominal (Optional) Copayments	
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. This excludes emergency room/emergency department visits	\$3.40

7.22.5 Mandatory Copayments for Certain AHCCCS Members

Persons with higher income who are determined eligible for AHCCCS through the Transitional Medical Assistance (TMA) program will have mandatory copayments for some medical services (see Table 2 below). TMA Members are described in [AAC 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 section.

Table 2: Mandatory Copayments	
Service	Copayment
Prescriptions	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care. This excludes emergency room/emergency department visits.	\$4.00
Physical, Occupational and Speech Therapies	\$3.00

Outpatient Non-emergency or voluntary surgical procedures. This excludes emergency room/emergency department visits.	\$3.00
--	--------

7.22.6 Copayment Limits

Members subject to copays will not be required to pay additional copayments once the total amount of copayments made is more than 5% of the gross family income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December).

The Health Plan will track each member's specific copayment levels by service type to identify those members who have reached the 5% copayment limit. With the exception of prescription drugs (where a copay is charged for each drug received), only **one** copay may be assessed for services received during a visit. If the coding for the visit falls within more than one copayment category, the member is responsible for the highest copayment amount.

7.23 Third Party Liability and Coordination of Benefits

Third party liability refers to situations in which persons enrolled in the public health care system also have health care service coverage through another health insurance plan, or "third party". The third party can be liable or responsible for covering some or all the services a person receives, including medications. Providers are responsible for determining and verifying if a person has third party health insurance before using other sources of payment such as Medicaid (Title XIX), KidsCare (Title XXI) or State appropriated health care funds. Pursuant to federal and State law, Medicaid is the payer of last resort except under limited situations, meaning that Medicaid funds shall be used as a source of payment for covered services only after all other Sources of payment have been exhausted.

The intent of this section is to describe the requirements for providers to:

- Determine if a person has third party health insurance coverage before using federal or State funds;
- Coordinate services and assign benefit coverage to third party payers when information regarding the existence of third party coverage is available; and
- Submit billing information that includes documentation that third party payers were assigned coverage for any covered services that were rendered to the enrolled person.
- Coordinate benefits for persons enrolled with Medicare Part A, Part B, and/or Part D.
- Coordinate benefits for persons enrolled in a qualified health plan through the federal health insurance exchange.

7.23.1 Additional Information

- If third party information becomes available to the provider at any time for Title XIX/XXI eligible persons, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery.

- An online Medical Insurance Referral should be completed and submitted to AHCCCS through the Health Management Systems (HMS) website whenever an AHCCCS Member is discovered to have other medical insurance, or whenever other medical insurance has terminated or changed. HMS has launched a new Third Party Liability (“TPL”) Referral Web Portal. The site to gain this access is <https://www.azahcccs.gov/PlansProviders/HealthPlans/tpl.html>
- AHCCCS has also established a process for The Health Plan to report third party information for Title XIX/XXI eligible persons daily to the AHCCCS on a Third Party Leads submission file. After submitting the file to AHCCCS for verification of the information, The Health Plan will receive notification of updated information on the TPL files. The Health Plan makes third party payer information available to all providers involved with the person receiving services.
- Third parties include, but are not limited to, private health insurance, Medicare, employment related health insurance, medical support from non-custodial parents, court judgments or settlements from a liability insurer, state worker’s compensation, first party probate-estate recoveries, long term care insurance and other federal programs.
- For those Medicare Part A and Part B services that are also covered under Title XIX, there is no cost sharing obligation if The Health Plan has a contract with the Medicare provider and the provider’s subcontracted rate includes Medicare cost sharing as specified in the contract.
- As of January 1, 2006, Medicare Part D Prescription Drug coverage became available to all Medicare eligible persons. Medicare is considered third party liability and must be billed prior to use of Title XIX/XXI or state funds.
- Children who qualify for Adoption Subsidy will be eligible for Title XIX/XXI benefits. In addition, their families may also have private insurance. Simultaneous use of the private insurance and Title XIX/XXI coverage may occur through the coordination of benefits. Following an intake and assessment, providers must determine the services and supports needed. Any necessary services that are not covered through the private insurance, including copayments and deductibles, may be covered under Title XIX.

7.23.2 Identifying Other Health Insurance

Providers are responsible for determining and verifying if a person has third party health insurance before using other sources of payment such as Medicaid (Title XIX), Title XXI or State appropriated health funds.

- Providers must identify the existence of potentially liable parties through the use of trauma code edits, utilizing diagnostic codes 800 to 999.9 (excluding code 994.6), external causes of injury codes E000 through E999, and other procedures.
- If third party information becomes available to the provider at any time for Title XIX/XXI eligible persons, that information must be reported to the AHCCCS Administration within 10 days from the date of discovery.
- Providers must report third party information via the following website: <https://www.azahcccs.gov/PlansProviders/HealthPlans/tpl.html> . From this link, you

can navigate to Health Management Systems (HMS), where you can enter a Member's TPL information.

The Health Plan will receive notification of updated information on the TPL files. The Health Plan makes third party payer information available to all providers involved with the person receiving services.

Providers must inquire about a person's other health insurance coverage during the initial appointment or intake process. When providers attempt to verify a person's Title XIX/XXI eligibility, information regarding the existence of any third party coverage is provided through AHCCCS's automated eligibility verification systems. If a person is not eligible for Title XIX/XXI benefits, they will not have any information to verify through the automated systems. Therefore, the existence of third party payers must be explored with the person during the screening and application process for AHCCCS health insurance.

7.23.3 Services Covered by Other Health Insurance Party

Third party health insurance coverage may cover all or a portion of the health services rendered to a person. Providers must contact the third party directly to determine what coverage is available to the person. At times, The Health Plan may incur the cost of copayments or deductibles for a Title XIX/XXI eligible person or person with SMI, while the cost of the covered service is reimbursed through the third party payer. However, payments by another State agency are not considered third party and in this circumstance, AHCCCS and The Health Plan are not the payer of last resort.

- In an emergency situation, the provider must first provide any medically necessary covered services, and then coordinate payment with any potential third party payers.
- When coverage from a third party payer has been verified, there are two methods used in the coordination of benefits:
 - **Cost avoidance** - Providers must cost avoid all claims or services that are subject to third-party payment. The Health Plan may deny payment to a provider if a provider is aware or unaware of third party liability and submits a claim or encounter to The Health Plan. In emergencies, providers must provide the necessary services and then coordinate payment with the third party payer; or
 - Post-payment recovery is necessary in cases where a health provider has not established the probable existence of third party coverage at the time services were rendered or paid for, or was unable to cost avoid.

If a third-party insurer requires a person to pay a copayment, coinsurance or deductible, The Health Plan is responsible for covering those costs for Title XIX/XXI eligible persons if the third party payer is not another State agency. AHCCCS and The Health Plan are required to be the payers of last resort for Title XIX/XXI and Non-Title XIX/XXI covered services. Payment by another State agency is not considered third party and, in this circumstance, AHCCCS and The Health Plan are not the payer of last resort.

7.23.4 Requirements

Upon determination that a person has third party coverage, a provider must submit proper documentation to demonstrate that the third party has been assigned responsibility for the covered services provided to the person. An Explanation of Payments (EOP) and an Explanation of Benefits (EOB) are the only suitable documents that can be submitted for coordination of benefits.

Initial third party claims received after 6 months from date of service or 90 days from the primary payer's EOP will be denied for Past Filing Deadline (PFD) regardless of primary insurance coverage.

The following guidelines must be adhered to by health providers regarding third party payers:

- Providers must bill claims for any covered services to any third party payer when information on that third party payer is available. Documentation that such billing has occurred must accompany the claim when submitted for payment. Such documentation includes a copy of the Explanation of Payment or Explanation of Benefits (EOB) from the third party payer. The only exceptions to this billing requirement are:
 - When it is determined that the person had relevant third party coverage after services were rendered or reimbursed;
 - When a Member eligible for both Medicaid and Medicare (dual eligible) receives services in a Behavioral Health Inpatient facility that is not Medicare certified. Non-Medicare certified facilities may be utilized for dual eligible members when a Medicare certified facility is not available; or
 - When a Member is receiving covered services from a preferred provider (i.e., the provider is close to person's home) and the provider is unable to bill the person's third party payer.
- The Health Plan may deny payment to a provider if a provider is aware of third party liability and submits a claim to The Health Plan. However, if the provider knows that the third party payer will not pay for or provide a medically necessary covered service, the provider must not decline to render the service to the member.
- If the provider does not know whether a particular medically necessary covered service is covered by the third party payer, the provider must contact the third party payer rather than requiring the person receiving services to do so.
- Providers may not employ cost avoidance strategies that limit or deny a person eligible for services from receiving timely, clinically appropriate, accessible, medically necessary covered services.

7.23.5 Discovery of Third Party Liability After Services Were Rendered or Reimbursed

If it is determined that a person has third party liability after services were rendered or reimbursed, providers must identify all potentially liable third party payers and pursue reimbursement from them. In instances of post-payment recovery, the provider must submit an adjustment to the original claim, including a copy of the Explanation of Payment (EOP) or the Explanation of Benefits (EOB). Providers shall not pursue recovery in the following

circumstances, unless the case has been referred to The Health Plan and the provider by AHCCCS or AHCCCS's authorized representative:

- Uninsured/underinsured motorist insurance;
- Restitution Recovery;
- First- and third-party liability insurance;
- Worker's Compensation;
- Tortfeasors, including casualty;
- Estate Recovery; or
- Special Treatment Trust Recovery.

The provider must report any cases involving the above circumstances to The Health Plan, which will then report such cases to AHCCCS's authorize representative for determination of a "total plan" case. Providers may be asked to cooperate with AHCCCS and/or AHCCCS in third party collection efforts.

7.23.6 Copayments, Premiums, Coinsurance and Deductibles for Non-Title XIX/XXI Persons with SMI for Which There Is Third Party Liability

The copayment assessed for Non-Title XIX/XXI persons with SMI is intended to be paid by the Member for services covered in the medication only benefit (e.g., psychiatric assessments, medication management, medications), but copayments are only collected at the time of the psychiatric assessment and psychiatric follow up appointments.

Non-Title XIX/XXI persons with SMI may be assessed the AHCCCS copayment in accordance with **Section 8.11 - Copayments**, or may be assessed copayments, premiums, coinsurance and/or deductibles for services covered by the third party insurer. When a Non-Title XIX/XXI person with SMI is assessed for the AHCCCS copayment, they will pay the AHCCCS copayment or the copayment required by the third party insurer, whichever is less (see AHCCCS Report Third Party Liability (TPL) at <https://www.azahcccs.gov/PlansProviders/HealthPlans/tpl.html>)

Additionally, when a Non-Title XIX/XXI person with SMI is assessed a copayment for a generic medication that is also on the AHCCCS Non-Title XIX/XXI Formulary, they will pay the AHCCCS copayment or the copayment required by the third party insurer, whichever is less. The Health Plan is responsible for covering the difference between the AHCCCS copayment and the third party copayment when the third party copayment is greater than the AHCCCS copayment.

Members are responsible for third party copayments for services that are not services that the AHCCCS covers (see AHCCCS Guidelines to the RBHA/MCO/Health Plans and Providers for Services to Non-Title XIX/XXI Members with a Serious Mental Illness) and third party premiums, coinsurance and deductibles, if applicable.

When Non-Title XIX/XXI persons with SMI have difficulty paying copayments, the provider must re-screen the individual for Title XIX/XXI eligibility.

7.23.7 Medicaid Eligible Persons with Medicare Part A and Part B

Providers are responsible for identifying whether Members are enrolled in Medicare Part A or Medicare Part B and covering services accordingly. For Medicaid eligible persons with Medicare Part A, Part B, and/or Part D:

- Title XIX/XXI eligible person may receive coverage under both Medicaid (AHCCCS) and Medicare. These persons are sometimes referred to as “dual eligibles” or “Duals”. In most cases, providers are responsible for payment of Medicare Part A and Part B coinsurance and/or deductibles for covered services provided to dual eligible persons. However, there are different cost sharing responsibilities that apply to dual eligible persons for a variety of situations. Unless prior approval is obtained from AHCCCS or The Health Plan, providers must limit their cost sharing responsibility according to ACOM Policy 201 and Policy 202. Providers shall have no cost sharing obligation if the Medicare payment exceeds what the provider would have paid for the same service of a non-Medicare Member.
- Some dual eligible AHCCCS Members may have Medicare Part B only. As these Members do not have Medicare Part A, Medicaid is the primary payer for services which generally would be covered under Part A including hospitalizations, skilled nursing facilities, and hospice. A claim should not be denied for a lack of Medicare Explanation of Payment (EOP) when the Member is not enrolled in Medicare Part A;
- In the same way, if Members have Medicare Part A only, Medicaid is the primary payer for services which are generally covered under Part B including physician visits and durable medical equipment; and
- In the event that a Title XIX/XXI eligible person also has coverage through Medicare, providers must ensure adherence with the requirements described in this subsection.

Qualified Medicare Beneficiary (QMB) Duals are entitled to all AHCCCS and Medicare Part A and B covered services. The Health Plan is responsible for payment of Medicare cost sharing for all Medicare covered services regardless of whether the services are covered by AHCCCS. The Health Plan only has responsibility to make payments to providers registered with AHCCCS to provide services to AHCCCS eligible Members. The payment of Medicare cost sharing must be provided regardless of whether the provider is in The Health Plan network or prior authorization has been obtained.

QMB Dual Cost Sharing Matrix

Covered Services	The Health Plan Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	Cost sharing responsibility only	YES	YES
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	YES

Emergency Services	Cost sharing responsibility only	YES	YES
--------------------	----------------------------------	-----	-----

**Subject to The Health Plan Policy*

The Health Plan is responsible for the payment of the Medicare cost sharing for AHCCCS covered services for Non-QMB Duals that are rendered by a Medicare provider within The Health Plan network.

Non-QMB Dual Cost Sharing Matrix

Covered Services	The Health Plan Responsibility	In Network	Out of Network
Medicare Only—not covered by AHCCCS	No cost sharing responsibility	NO	NO
AHCCCS Only—not covered by Medicare, including pharmacy and other prescribed services	Reimbursement for all medically necessary services	YES*	NO*
AHCCCS and Medicare covered Service (except for emergent)	Cost sharing responsibility only	YES	NO*
Emergency Services	Cost sharing responsibility only	YES	YES

7.23.7.1 *Limits on Cost Sharing:*

The Health Plan shall have no cost sharing obligation if the Medicare payment exceeds The Health Plan contracted rate for the services. The Health Plan liability for cost sharing plus the amount of Medicare's payment shall not exceed The Health Plan contracted rate for the service. There is no cost sharing obligation if The Health Plan has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing.

The exception to these limits on payments as noted above is that The Health Plan The Health Plan shall pay 100% of the Member copayment amount for any Medicare Part a Skilled Nursing Facility (SNF) days (21 through 100) even if The Health Plan has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part a SNF day.

The Health Plan can require prior authorization, but if the Medicare provider determines that a service is medically necessary, The Health Plan is responsible for Medicare cost sharing, even if The Health Plan determines otherwise. If Medicare denies a service for lack of medical necessity, The Health Plan will apply its own criteria to determine medical necessity. If criteria support medical necessity, then The Health Plan shall cover the cost of the service.

For QMB Dual Members, The Health Plan has cost sharing responsibility regardless of whether the services were provided by an in or out of network provider. For AHCCCS covered services rendered by an out of network provider to a non-QMB Dual, The Health Plan The Health Plan is not liable for any Medicare cost sharing unless The Health Plan The Health Plan has authorized the Member to obtain services out of network. If a Member has been advised of The Health Plan network, and the Member's responsibility is delineated in the Member handbook, and the Member elects to go out of network, The Health Plan is not responsible for paying the Medicare cost sharing amount.

7.23.8 Medicare Part D Prescription Drug Coverage

7.23.8.1 *Cost sharing and coordination of benefits for persons enrolled in Medicare Part D:*

Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D.

The Health Plan will utilize available Non-Title XIX/XXI funds to cover Medicare Part D copayments for Title XIX and Non-Title XIX persons with SMI, with the following limitations:

- Copayments are to be covered for medications on the AHCCCS Behavioral Health Drug List. Copayments are to be covered for medications prescribed by in-network providers. The Health Plan may utilize Non-Title XIX/XXI funds for coverage of medications during the Medicare Part D coverage gap; and
- If a request for an exception has been submitted and denied by the Medicare Part D plan, The Health Plan may utilize Non-Title XIX/XXI funds to cover the cost of the non-covered Part D medication for persons with SMI, regardless of Title XIX/XXI eligibility.

The Health Plan may utilize at its discretion Non-Title XIX/XXI funds for coverage of medications during the Medicare Part D coverage gap. If a request for an exception has been submitted and denied by the Medicare Part D plan, The Health Plan may utilize at its discretion Non-Title XIX/XXI funds to cover the cost of the non-covered Part D medication for persons with SMI, regardless of Title XIX/XXI eligibility.

7.23.9 The Health Plan Providers' Enrollment Responsibilities

The Health Plan providers must educate and encourage Non-Title XIX/XXI Members with SMI to enroll in a qualified health plan through the federal health insurance exchange and offer assistance for those choosing to enroll during open enrollment periods and qualified life events. The following applies for Members who enroll in a qualified health plan through the federal health insurance exchange:

- Members enrolled in a qualified health plan through the Federal Health Insurance Marketplace continue to be eligible for Non-Title XIX/XXI covered services that are not covered under the exchange plan.
- Non-Title XIX/XXI funds may not be used to cover premiums or copays associated with qualified health plans through the Federal Health Insurance Marketplace or other third party liability premiums or copays other than Medicare Part D for Members with SMI.
- The Health Plan is required issue approval prior to any utilization of Non-Title XIX/XXI funding for services otherwise covered under a qualified plan through the Federal Health Insurance Marketplace.

7.24 Transportation

Providers shall maintain all records in compliance with the noted specifications for record keeping related to transportation services. It is the responsibility of the provider 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.

The Health Plan will cover medically necessary non-emergency ground and air transportation to and from a required medical service for most recipients. Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form or 837P. Loaded mileage is defined as the distance traveled, measured in statute miles, with a recipient on board the vehicle and being transported to receive medically necessary covered services.

Transportation billing guidelines related to Third Party Liability and Coordination of Benefits are the same. Providers must identify all potentially liable third party payers and pursue reimbursement from them.

Providers must provide and retain fiscal responsibility for transportation for Title XIX/XXI persons in order for the person to receive a covered health service reimbursed by a third party, including Medicare.

7.25 Refunds or Overpayments on Services Rendered

Claims will be reviewed and if applicable adjustments will be made to the claim. If a provider chooses to submit a refund as opposed to having Claims Technical Assistance do the review for adjustment, payments should be made to:

Arizona Complete Health-Complete Care Plan
333 E. Wetmore Road
Tucson, AZ 85705
Attn: Overpayment Recovery Department

7.26 Financial Sanctions and Notice to Cure

7.26.1 Health Plan Sanction Authority

Arizona Complete Health-Complete Care Plan may impose financial sanctions for failure to comply with the terms of the Contract (including requirements set forth in documents incorporated by reference and the Health Plan Provider Manual). Health Plan shall determine, at its sole discretion, the amount of any sanction. Sanctions shall be assessed according to the severity of the violation. Sanction amounts may be doubled each month for continued failure to adequately address contract performance challenges.

7.26.2 Administration of Sanction Payments

Any financial sanctions due and owing to Health Plan may be offset by Health Plan against any payments due Provider under the Health Plan Contract until the full amount is paid. Provider and Health Plan each acknowledge that the financial sanctions constitute liquidated damages for the loss of a bargain, are not

penalties, and are a reasonable approximation of Health Plan's damages under the circumstances, as can best be determined as of the date hereof. Health Plan shall have the right to impose such an offset even if Provider contests the financial sanction; provided, however, that if the financial sanction is reduced or eliminated following a provider Claim Dispute, Health Plan shall pay any such sums within thirty (30) days of the final resolution of the dispute process.

7.26.3 Sanctions Imposed by State or Federal Authorities

If any State or federal authority imposes a sanction against Health Plan, for any act or omission that Provider was prohibited or required (respectively) to perform pursuant to the Health Plan Contract, Health Plan may, in addition to any other remedies available under the Health Plan Contract, impose a sanction against Provider in an amount equal to the amount of any such sanction imposed on Health Plan. Provider shall reimburse Health Plan for these sanctions upon demand, or, at Health Plan's election, the sanctions may be offset against any payments due to Provider under the Health Plan Contract. Health Plan will not levy these sanctions upon Provider until such time as the sanctioning authority actually imposes sanctions upon Health Plan. If any such sanction applies to more than one provider and the sanctioning authority does not delineate individual provider responsibility, Health Plan may apportion sanctions to Provider based on an equitable method that accounts for Provider's share of responsibility.

7.26.4 Sanction for Failure to Provide Deliverables

Provider has agreed to the time frames for the Deliverables set forth in the Health Plan Provider Manual. In the event Provider fails to provide the Deliverables in accordance with the Health Plan Provider Manual, Provider shall pay a fine for such delay in the amount of five hundred dollars (\$500.00) per incident.

7.26.5 Performance Sanctions

Unless explicitly stated otherwise in this Health Plan Provider Manual or documents incorporated by reference, at Health Plan's discretion, Providers are subject to the following additional sanctions:

- 7.26.5.1 One Thousand dollar (\$1,000.00) fine for failure to submit a Corrective Action Plan by the due date specified in a Corrective Action Letter issued by Health Plan.
- 7.26.5.2 One thousand dollar (\$1000.00) fine for failure to respond to a concern raised by AHCCCS within the time frame specified by AHCCCS.
- 7.26.5.3 Sanction for failure to provide appropriate coordination of care for a Member, resulting in an untoward event that affects the local community or the Member; amount of sanction determined at the sole discretion of the Health Plan commensurate with the seriousness of the untoward event.
- 7.26.5.4 Three thousand dollar (\$3000.00) fine per incident or failure to adhere to contract requirements or Health Plan Provider Manual requirements.

7.26.6 Notice to Cure

Arizona Complete Health-Complete Care Plan may issue a Notice to Cure for substantial non-compliance with a contract requirement or Health Plan Provider Manual expectation. A Notice to Cure may be issued on a particular program or on the contract as a whole. The Notice to Cure will specify the action required to cure the Notice to Cure, the timeline required, and the consequences for failure to cure the deficiency.

Section 8 - GRIEVANCE AND APPEAL SYSTEM

The Health Plan members and providers have access to a grievance system that fairly and efficiently reviews and resolves identified issues. The Health Plan grievance system staff address member, provider, and stakeholder concerns in a courteous, responsive, effective, and timely manner. This section provides an overview of the following grievance system processes:

- Member Grievances and Provider Complaints;
- Grievances and Investigations Concerning Persons with Serious Mental Illness (SMI);
- Notice Requirements and Appeal Process (TXIX/XXI);
- Notice Requirements and Appeal Process (Non-Title XIX/XXI (SMI and GMH/SA)); and
- Provider Claim Disputes

Providers must understand The Health Plan grievance system in order to assist The Health Plan members who wish to utilize a grievance system process. Grievance system processes also afford Providers a formal process for expressing dissatisfaction, including but not limited to dissatisfaction regarding nonpayment of a claim, imposition of sanctions, and service denials.

Providers are required to fully cooperate with The Health Plan grievance and appeal system staff with respect to grievance system processes. This includes, but is not limited to:

- Ensuring The Health Plan members are provided all Enrollee rights as provided for in 42 C.F.R. § 438.100. See also **Provider Manual Section 9.1, Member Rights**.
- Providing education to The Health Plan members about their rights and making that information readily available to members upon request. This includes, but is not limited to, providing and posting [AHCCCS ACOM Policy 444, Attachment D Notice of Discrimination Prohibited](#) and [AHCCCS ACOM Policy 444-Attachment B-Notice of Legal Rights for Persons with Serious Mental Illness](#));
- Assisting The Health Plan members who wish to utilize a grievance system process. This includes, but is not limited to, assisting a member with reducing a grievance or appeal to writing and/or assisting a member with calling The Health Plan Customer Service;
- Responding to inquiries from The Health Plan staff within the specified timeframe and if no timeframe is specified, within a reasonable amount of time;
- Producing clinical records to grievance system staff upon request when review of such records, in The Health Plan's discretion, is necessary to resolve a member or provider concern;
- Making staff available to respond to The Health Plan inquiries upon request;
- Adhering to all corrective actions or directives imposed by The Health Plan within the specified timeframes; and
- Adopting policies and procedures to ensure compliance with The Health Plan and AHCCCS policy, including policies that prohibit retaliation against members or other persons who file grievances.

Providers who fail to cooperate with grievance system staff may be subject to corrective actions, sanctions, or other remedies as described in this manual and in the Participating Provider Agreement.

The Health Plan does not retaliate against any member or provider who exercises their rights. The Health Plan does not take punitive action against a provider who supports a member's appeal or who supports an expedited resolution of an appeal. Similarly, The Health Plan providers shall not take punitive action against any person who exercises their rights in any manner, including through an established grievance system process.

8.1 Member Grievance and Provider Complaint Process

Any person may file a grievance to express dissatisfaction with any aspect of a member or prospective member's care. Similarly, providers may file grievances for any reason including dissatisfaction with The Health Plan with respect to its customer service or operations as it relates to the provider's care or treatment of The Health Plan member.

A grievance may be initiated by contacting The Health Plan Customer Service at 866-796-0542. The Customer Service Representative (CSR) will transfer the caller to the appropriate department if the CSR is unable to resolve the caller's concern.

A grievance may also be filed by writing to The Health Plan at the following address:

Arizona Complete Health-Complete Care Plan
Attn: Grievance and Appeal Department
1870 W. Rio Salado Parkway Suite 2A

Please note the following exclusions:

- Member or provider dissatisfaction with an authorization decision made by The Health Plan are not treated as grievances but may be appealed as described in Section 8.
- Providers that are dissatisfied with respect to The Health Plan's adjudication of its claim(s) may challenge the processing of the claim(s) as described in Section 8.
- For The Health Plan members in the Serious Mental Illness (SMI) Program, additional or alternative grievance procedures may apply as outlined in Section 8.5.
- For Quality of Care Concerns, The Health Plan follows the Quality of Care Concern process described in Section 10.7.

8.2 The Health Plan Grievance Resolution Process

The Health Plan follows all AHCCCS requirements with respect to the processing of member and provider grievances. Specifically, The Health Plan adheres to the following grievance resolution process:

- **Acknowledgement.** All grievances are acknowledged within 5 business days. Grievances are acknowledged verbally or in writing based on the member's (or other person's) preference. Grievances received orally (in-person or by telephone) are verbally acknowledged when possible.
- **Communication and Information.** The Health Plan assures effective communication.
 - The Health Plan follows requirements outlined in **Section 12.14 - Cultural Competence** regarding oral interpretation services, translation of written materials, and services for the deaf and hard of hearing.
 - All information is provided in a manner and format that may be easily understood and readily accessible to members as required by AHCCCS ACOM 405 and 42 C.F.R. § 438.10.
- **Resolution.** The Health Plan addresses all identified issues as quickly as the circumstances dictate.
 - Grievances that identify an immediate clinical need or health or safety concern are addressed immediately upon receipt through an established grievance and appeal process or through another internal or external process or authority.
 - The Health Plan resolves most grievances within 10 days and all grievances are resolved within 90 days. Resolutions are communicated verbally or in-writing based on the preference of the grievant.
 - In delivering notification of resolution to the grievant, The Health Plan staff provide the member or other individual with information describing other internal or external agencies or departments that may be available to the grievant if they are dissatisfied with The Health Plan's resolution.
- **Decision making.** Grievance system staff consult appropriate subject-matter experts and individuals with appropriate clinical expertise when necessary to resolve a grievance and take into account all available information in reaching a resolution.

- Individuals making decisions about grievances that involve the denial of an expedited resolution of an appeal or that involve clinical issues are health care professionals with the appropriate clinical expertise in treating the recipient's condition.
- Individuals who make decisions regarding grievances and appeals are individuals not involved in any previous level of review or decision making, or a subordinate of such individual(s) (See PM Sections 8.3 and 8.4).
- Individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination (See PM Sections 8.3 and 8.4).

In the event a grievant is dissatisfied with The Health Plan's resolution of their grievance, the issue(s) in dispute may still be referred to applicable appeal and grievance processes.

The Health Plan does not route or otherwise encourage the direct filing of grievances with Arizona Health Care Cost Containment System (AHCCCS) except in limited circumstances.

8.3 Grievances and Investigations Concerning Persons with Serious Mental Illness (SMI)

The Health Plan providers are required to understand the legal rights of persons with SMI provided for in Arizona Administrative Code Title 9, Chapter 21 ([9 A.A.C. 21](#)), Article 2. The Health Plan and its providers are required to initiate an SMI Grievance Investigation upon receipt of a non-frivolous allegation that (1) a mental health provider has violated a member's legal rights; or (2) a condition requiring investigation exists (an incident or condition that appears to be dangerous, illegal, or inhumane, including a client death).

Filing Requirements:

A request for an SMI Grievance Investigation involving an alleged rights violation or condition requiring investigation that does not involve a client death or an allegation of physical or sexual abuse shall be filed with and investigated by The Health Plan. Requests for an SMI Grievance Investigation must be submitted to The Health Plan, orally or in writing, no later than 12 months from the date the alleged violation or condition requiring investigation. This timeframe may be extended for good cause.

Any person may request an SMI Grievance Investigation by completing **Provider Manual Form 15.4.1 – Appeal or SMI Grievance** (Providers are directed to call the Provider Service Center to obtain a copy of this form, if needed, at 1-866-796-0542) and delivering it to The Health Plan at the following address:

Arizona Complete Health-Complete Care Plan
Attn: Grievance and Appeal Department
1870 W. Rio Salado Parkway Suite 2A

Tempe, AZ 85281
Fax: (866) 714-7998

A request for an SMI Grievance Investigation involving client death, physical abuse, or sexual abuse are filed with and investigated by the AHCCCS Administration pursuant to AHCCCS ACOM 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness.

The Health Plan and its providers are required to report Quality of Care Concerns and Incidents, Accidents, and Deaths to The Health Plan Quality Management. **(See Section 10 – Quality Management Requirements)**. The provider’s obligation to request an SMI Grievance Investigation as described above is separate from the provider’s reporting requirements described in **Section 10 – Quality Management Requirements**.

Please note the following exclusions:

- This process does not apply to allegations asserting a violation relating to the right to receive services, supports and/or treatment that are State-funded and are no longer funded by the State due to limitations on legislative appropriation;
- This process does not apply to service planning disagreements more appropriately managed as appeals as described in Sections 15.3 and 15.4 and [A.A.C. R9-21-405](#);
- This process is only available for allegations involving behavioral health services. Grievances involving physical health services or services for persons who are not in the SMI Program are managed according to Section 15.1.

Notice of Decision and Right to Appeal:

The Health Plan follows the investigation process described in Arizona Administrative Code Title 9, Chapter 21 (9 A.A.C. 21), Article 4, and in [AHCCCS ACOM 446](#) (Grievance and Investigations Concerning Persons with Serious Mental Illness). When the investigation is concluded, The Health Plan issues a decision letter to the grievant (and the member and other authorization representatives) outlining the investigation, findings of fact, conclusions of law, and in the case of substantiated allegations, the corrective measure(s) being imposed to correct the identified deficiency or deficiencies.

If the member or authorized representative is not satisfied with the outcome of The Health Plan’s Investigation, the grievant has access to an administrative review and/or an administrative hearing as described in [AHCCCS ACOM 446](#) (Grievance and Investigations Concerning Persons with Serious Mental Illness). To request an administrative review or administrative hearing, the appellant must send their written request to The Health Plan at the following address:

Arizona Complete Health-Complete Care Plan
Attn: Grievance and Appeal Department
1870 W. Rio Salado Parkway Suite 2A
Tempe, AZ 85281
Fax: (866) 714-7998

Upon receipt of a request for an administrative review or administrative hearing, The Health Plan transmits the request and the file, if any, to AHCCCS Office of Administrative Legal Services pursuant to [AHCCCS ACOM 445](#) (Submission of Request for Hearing).

8.4 Notice Requirements and Appeal Process (Title XIX/XXI)

The Health Plan issues a Notice of Adverse Benefit Determination (NOABD) to The Health Plan members whenever The Health Plan makes a decision to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services (collectively referred to as “adverse benefit determinations.”). The NOABD details The Health Plan’s decision and the member’s right to appeal the adverse decision in easily understood language. The Health Plan issues NOABD and processes Title XIX/XXI Appeals consistent with [AHCCCS ACOM 414](#) (Notice of Adverse Benefit Determination and Notices of Extension for Service Authorizations)

The Health Plan members or providers may complain about the adequacy of an NOABD. If a Title XIX/XXI Member complains about the adequacy of a NOABD or its ability to be understood, The Health Plan reviews the NOABD to ensure it meets all contractual requirements as described in [AHCCCS ACOM 414](#). If The Health Plan determines the original NOABD is inadequate or deficient, The Health Plan issues an amended NOABD. If an amended NOABD is required, the timeframe for the Member to appeal and request continuation of services (if applicable), starts to run from the date the amended NOABD was received by the member or guardian.

If a member complains to The Health Plan about the adequacy of the amended NOABD, The Health Plan is required to promptly inform AHCCCS Division of Health Care Management/Medical Management Unit (DHCM/MM) of the complaint. Additionally, The Health Plan is required to inform the member of their right to contact the AHCCCS DHCM/MM unit if the issue is not resolved to the member’s satisfaction.

8.4.1 Notice of Adverse Benefit Determination Requirements

The Health Plan issues an NOABD following:

- The denial or limited authorization of a requested service;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) for the standard resolution of grievances and appeals;
- For a resident of a rural area with only one health plan, the denial of an enrollee’s request to exercise their right, under § 438.52(b)(2)(ii), to obtain services outside the network; and
- The denial of an enrollee’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

8.4.2 Timing of NOABD

The Health Plan issues NOABD within the following timeframe as required by [AHCCCS ACOM 414](#):

- For termination, suspension, or reduction of a previously authorized service, the notice must be mailed at least 10 days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 210 providing exceptions to advance notice. [42 CFR 431.213; 42 CFR 431.214; 42 CFR 438.404 (c)(1)].
- For standard service authorization decisions that deny or limit services, within 14 days from the receipt of the request unless there is a Notice of Extension (refer to Notice of Extension in this manual and in 42 CFR 438.404 (c)(3)).
- For expedited service authorization decisions, within 72 hours from the receipt of the request unless there is a Notice of Extension.
- After a Notice of Extension has been issued, within 14 days of issuance of the NOE and in no event later than the 28th day after receipt of the request.

8.4.3 Title XIX/XXI Appeal and State Fair Hearing Process

A Title XIX/XXI eligible person may appeal the following adverse benefit determinations 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 Title XIX/XXI covered;
- The failure to provide Title XIX/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 Title XIX/XXI enrollee's request to obtain services outside The Health Plan's provider network.

A Title XIX/XXI eligible person adversely affected by PASRR determination in the context of either a preadmission screening or a resident review may file an appeal.

8.4.4 Responsibility for Processing Appeals

The Health Plan is responsible for processing all appeals; The Health Plan does not delegate this function. However, appeals that relate to PASRR determinations must be filed with and processed by AHCCCS. Information gathered during the appeal process is considered confidential and the person's rights to privacy are protected throughout the process. The information below is provided to familiarize providers with the Title XIX/XXI appeal process.

8.4.5 Filing an Appeal

The following persons or representatives may file an appeal regarding an action:

- A Title XIX/XXI eligible person;

- A legal or authorized representative, (e.g., Department of Economic Security/Division of Children, Youth and Families/Department of Child Safety Specialist and/or advocate for persons with a SMI requiring special assistance), including a provider, acting on behalf of the person, with the person's or legal representative's written consent.

8.4.6 Timeframe for Filing an Appeal

A Title XIX/XXI eligible person has up to 60 days after the date of the Notice of Action to file a standard appeal. The appeal may be filed orally or in writing.

Arizona Complete Health-Complete Care Plan
Attn: Grievances and Appeals
1870 W. Rio Salado Parkway Suite 2A
Tempe, AZ 85281
Fax Number: (866) 796-0542
Phone: (866) 714-7998
Email: AzCHgrievanceandappeals@azcompletehealth.com

8.4.7 Standard and Burden of Proof

The burden 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 appellant (individual or agency).

8.4.8 Denial of Request for Appeal

In the event The Health Plan refuses to accept a late appeal or determines that the decision being appealed does not constitute an adverse benefit determination subject to these appeal requirements, The Health Plan will inform the appellant in writing by sending a Notice of Appeal Resolution.

8.4.9 Timeframe for resolution of a standard appeal

The Health Plan will acknowledge receipt of a standard appeal in writing within 5 working days of receipt.

The Health Plan will resolve standard appeals no later than 30 days from the date of receipt of the appeal, unless an extension is approved. A Notice of Appeal Resolution will be delivered within 30 days after the day the appeal is received.

8.4.10 Extension of standard appeal resolution timeframe

If a Title XIX/XXI eligible person requests an extension of the 30-day timeframe, The Health Plan will extend the timeframe up to an additional 14 days. If The Health Plan needs additional information and the extension is in the best interest of the member, The Health Plan may extend the 30-day timeframe up to an additional 14 days. If The Health Plan extends the timeframe it will provide a written notice to the Title XIX/XXI eligible person of the reason for the delay and issue and carry out its decision as expeditiously as the persons' health condition requires, but no later than the date the extension expires.

8.4.11 Failure to send Notice of Appeal Resolution

If the Notice of Appeal Resolution is not sent within the timeframes set forth above, the appeal shall be considered denied on the date that the timeframe expires.

8.4.12 Circumstances for expediting an appeal

The Health Plan conducts an expedited appeal if:

- The Health Plan determines or the requesting provider indicates that taking the time for a standard appeal resolution could seriously jeopardize the person's life, physical or mental health, or ability to attain, maintain, or regain maximum function;

8.4.13 Denial of request for an expedited appeal

If The Health Plan denies a request for expedited resolution of an appeal from a Title XIX/XXI eligible person, The Health Plan will resolve the appeal within the resolution timeframes set forth above and make reasonable efforts to give the person prompt oral notice of the denial. Within two calendar days, The Health Plan will follow up with written notice of the denial.

Objections to the denial of a request for expedited resolution of an appeal shall be processed as grievances, as set forth in **Section 8.0 Grievance and Appeal System**.

8.4.14 Timeframe for resolution of an expedited appeal

The Health Plan will provide a written acknowledgment of the receipt of an expedited appeal within one working day after it receives the appeal.

The Health Plan will resolve expedited appeals and deliver written Notices of Appeal Resolution to the Member within 72 hours after The Health Plan receives the appeal. The Health Plan will also make reasonable efforts to provide prompt oral notice.

8.4.15 Extension of expedited appeal resolution timeframe

If a Title XIX/XXI eligible person requests an extension of the 72 hour timeframe, The Health Plan will extend the timeframe up to an additional 14 days. If The Health Plan needs additional information and the extension is in the best interest of the person, The Health Plan is required extend the three working day timeframe up to an additional 14 days. If The Health Plan extends the timeframe it will provide a written notice to the Title XIX/XXI eligible person of the reason for the delay and issue and carry out its decision as expeditious as the person's health condition requires, but no later than the date the extension expires.

8.4.16 Notice of Appeal Resolution

A Notice of Appeal Resolution must contain:

- The results of the resolution process and the date it was completed; and
- For those appeals not resolved wholly in favor of the Title XIX/XXI eligible person:
 - The Title XIX/XXI eligible person's right to request a State Fair Hearing by submitting a written request to The Health Plan no later than 30 days from the date of receipt of The Health Plan's Notice of Appeal Resolution;

- The right to request to receive services while the State Fair Hearing is pending, if applicable, and how to do so;
- The factual and legal basis for the decision; and
- An explanation that the Title XIX/XXI eligible person may be held liable for the cost of benefits being appealed if the State Fair Hearing decision results in The Health Plan decision being upheld.

8.4.17 Requesting a State Fair Hearing

A Title XIX/XXI eligible person, legal or authorized representative may request a State Fair Hearing following The Health Plan's resolution of an appeal. The request must be in writing and submitted to:

Arizona Complete Health-Complete Care Plan
 Attn: Grievances and Appeals
 1870 W. Rio Salado Parkway Suite 2A
 Tempe, AZ 85281
 Fax Number: (866) 714-7998
 Phone: (866) 796-0542
 Email: AzCHgrievanceandappeals@azcompletehealth.com

The request must be received by The Health Plan no later than 120 days after the date that the person received the Notice of the Appeal Resolution. The Health Plan will forward the request for hearing to AHCCCS Office of Administrative Legal Services.

8.4.18 What assistance must be provided to Title XIX/XXI eligible persons in filing an appeal and/or requesting a State Fair Hearing?

Reasonable assistance must be provided to Title XIX/XXI eligible persons in completing forms and other procedural steps during the appeal process. 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 The Health Plan Grievance and Appeals utilizing one of the methods indicated above.

8.4.19 Continuation of Services During the Appeal or State Fair Hearing Process

The Health Plan will ensure that benefits under appeal or in the State Fair Hearing process continue unless continuation of services would jeopardize the health or safety of the person or another person if the following conditions are met:

- The person files the appeal before the later of 10 days after the delivery of the Notice of Action or the effective date of the action, as indicated in the Notice of Action;
- 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 person requests continuation of services.

If a person wishes services to continue during appeal, they must request the continuation of services when the appeal is initially filed, and again at the time of any request for a State Fair Hearing.

8.4.20 At What Point Will a Person's Services No Longer Be Continued during the Appeal or State Fair Hearing Process?

The Health Plan will continue services until any of the following occurs:

- The Title XIX/XXI eligible person withdraws the appeal;
- The Title XIX/XXI eligible person makes no request for continued benefits within 10 days of the delivery of the Notice of Appeal Resolution; or
- The AHCCCS Administration issues a State Fair Hearing decision adverse to the Title XIX/XXI eligible person.

If The Health Plan's or the AHCCCS Director's decision upholds a decision to deny authorization of services, and if the services were furnished solely because of the continuation requirements of **Section 8.4.** above. The Health Plan may recover the cost of the continued services furnished to a Title XIX/XXI eligible person.

8.4.21 Reversal of Decision to Deny Authorization of Services by the State

If The Health Plan or the State Fair Hearing decision reverses a decision to deny, limit or delay services not furnished while the appeal was pending, The Health Plan will authorize or provide the services promptly and as expeditiously as the Title XIX/XXI eligible person's health condition requires.

If The Health Plan 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 was pending, The Health Plan shall process a claim for payment from the provider in a manner consistent with The Health Plan or Director's Decision and applicable statutes, rules, policies, and contract terms (See ARS § [36-2904](#)).

The provider shall have 90 days from the date of the reversed final agency decision to submit a clean claim to The Health Plan for payment. For all claims submitted as a result of a reversed final agency decision, The Health Plan is prohibited from denying claims as untimely if they are submitted within the 90-day timeframe.

The Health Plan is also prohibited from denying claims submitted by providers as a result of a reversed decision because the Member chooses not to request continuation of services during the appeals/hearing process: a Member's failure to request continuation of services during the appeals/hearing process is not a valid basis to deny the claim.

8.4.22 Cooperation with AHCCCS

The Health Plan and its providers must fully cooperate with AHCCCS in the event AHCCCS decides to intervene in, participate in or review any Notice, Grievance, Appeal, SMI Grievance, or Claim Dispute or any other grievance system process or proceeding. The Health Plan will comply with or implement any AHCCCS directive within the time specified pending formal resolution of the issue.

8.5 Notice Requirements and Appeal Process (SMI and GMH/SA Non-Title XIX/XXI)

8.5.1 General Requirements for Notice and Appeals

Providers must be aware of general requirements guiding notice and appeal rights for the populations covered in this section. Providers may have direct responsibility for designated functions (i.e., sending notice) as determined by The Health Plan and/or may be asked to provide assistance to persons who are exercising their right to appeal.

8.5.1.1 *Time Computed*

In computing any time prescribed or allowed in this section the period begins the day after the act, event or decision occurs. If the period is 11 days or more, the time period must be calculated using calendar days, which means that weekends and legal holidays are counted. If, however, the period of time is less than 11 days, the time 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 that is not a weekend or a legal holiday.

8.5.1.2 *Language, Format and Comprehensive Clinical Record Requirements*

Notice and related forms must be available in each prevalent, non-English language spoken in The Health Plan's geographic service area (GSA). As designated by The Health Plan, providers must provide free oral interpretation services to all persons who speak non-English languages for purposes of explaining the appeal process and/or information contained in the notice. The Health Plan is responsible for providing oral interpretation services at no cost to the person 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 person applying for or receiving services. The Health Plan 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 person's comprehensive clinical record.

8.5.1.3 *Delivery of Notices and Appeal Decisions*

All notices and appeal decisions must be personally delivered or mailed by certified mail to the required party, at their last known residence or place of business. In the event that it may be unsafe to contact the person at their home, or the person has indicated that they do not want to receive mail at home, the alternate methods identified by the person for communicating

notices must be used. Providers are directed to call the Provider Service Center to obtain a copy of any forms and/or attachments listed in this section, if needed, at 1-866-796-0542.

Notices pursuant to this section shall be delivered to:

- The eligible person; or
- The eligible person's legal or authorized representative and for persons identified as in need of Special Assistance, this includes the person designated to meet the Special Assistance needs.

Provision of notice shall be evidenced by retaining a copy of the notice in the comprehensive clinical record of the person receiving or requesting services. See **Provider Manual Form 15.3.1 Notice of Decision and Right to Appeal** (can be obtained by calling the Provider Services Call Center at 866-796-0542).

8.5.2 **Notice Requirements for Persons Being Evaluated For or with Serious Mental Illness**

The following provisions apply to notice requirements for persons with SMI and for persons for which an SMI eligibility determination is being considered.

A Notice of Decision and Right to Appeal (for Individuals with a Serious Mental Illness) (**Provider Manual Attachment 15.3.1 Notice of SMI Grievance and Appeal Procedure** which can be obtained by calling the Provider Services Call Center at 866-796-0542, if needed) must be provided to persons with SMI or to persons 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/XXI funds. In this case, notice must be provided at least 30 days prior to the effective date unless the person 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 person receiving services or others;
- A decision is made that the person 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 person.

8.5.2.1 **Additional Notices**

The following additional notices must be provided to persons with SMI or persons applying for SMI services:

- [AHCCCS ACOM Policy 444, Attachment B Notice of Legal Rights for Persons with Serious Mental Illness](#) at the time of admission to a behavioral health provider agency for evaluation or treatment. The person receiving this notice must

acknowledge in writing the receipt of the notice and the behavioral health provider must retain the acknowledgement in the person's comprehensive clinical record. All providers must post the Notice of Legal Rights for Persons with Serious Mental Illness in both English and Spanish, so that it is readily visible to behavioral health recipients and visitors;

- [AHCCCS ACOM Policy 444, Attachment D Notice of Discrimination Prohibited](#) so that it is readily visible to persons visiting the agency, and a copy provided at the time of discharge from the behavioral health provider agency.

8.5.3 Notice Requirements for Non-Title XIX/XXI/Non-SMI Population

Notice is not required to persons who are not eligible for Title XIX/XXI or SMI services under this policy.

8.5.4 Appeal Requirements

Appeals must be filed with The Health Plan. The Health Plan adheres to the requirements and procedures outlined in [AHCCCS ACOM Section 444](#) when managing appeals pursuant to this section.

Title XIX/XXI eligible persons 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 8.4 – Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons**) or the appeal process for persons with SMI described in this **Section 8.3, Notice and Appeal Requirements** (SMI and Non-SMI/Non-Title XIX/XXI).

8.5.4.1 Filing Persons and Entities

The following persons 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, the person meeting Special Assistance needs;
- A legal guardian or parent who is the legal custodian of a person under the age of 18 years;
- A court appointed guardian ad litem or an attorney of a person 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 which does not have legal custody or control of the person, to the extent specified in the ISA/IGA between the agency and the AHCCCS; and
- A provider, acting on the behavioral health recipient's behalf and with the written authorization of the person.

8.5.4.2 Timeframes for Appeals

Appeals must be filed orally or in writing with The Health Plan within 60 days from the date of the decision being appealed. Late appeals must be accepted upon showing good cause.

An extension of the appeal timeframes required in this policy may be secured either at the request of the appellant or with the permission of The Health Plan Director or AHCCCS Director or designee. An extension of time may only be approved upon a showing of necessity and upon a showing that the delay will not pose a threat to the safety or security of the behavioral health recipient. Documentation of the reason for and approval of the extension of time must be maintained in the appeal case record.

8.5.5 Appeal Process for Persons with Serious Mental Illness

An appeal may be filed concerning one or more of the following:

- Decisions regarding the person's SMI eligibility determination (this type of appeal is managed by the Crisis Response Network);
- 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, ISP 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 with regard to the person'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 ISP, 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 case management services to a person who is refusing such services, or a decision not to provide such services to the person;
- Decisions regarding a person's fee assessment or the denial of a request for a waiver of fees;
- Denial of payment of a claim;
- Failure of The Health Plan or AHCCCS to act within the timeframes regarding an appeal; or
- 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 person.

8.5.6 Continuation of Services during Appeal Process

For persons with SMI, the person's behavioral health services will continue while an appeal of a modification to or termination of a covered 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 person or another individual; or

- The person or, if applicable, the person's guardian, agrees in writing to the modification or termination.

8.5.7 Standard Appeal Process

Within 5 working days of receipt of an appeal, The Health Plan 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 The Health Plan refuses to accept a late appeal or determines that the issue may not be appealed, The Health Plan must inform the appellant in writing that they may, within 10 days of their receipt of The Health Plan's decision, request AHCCCS conduct an Administrative Review of the decision.

If a timely request for Administrative Review is filed with AHCCCS of The Health Plan's decision, AHCCCS shall issue a final decision of within 15 days of the request (for persons requiring Special Assistance, see **Section 12.11 - Special Assistance for Persons Determined to Have a Serious Mental Illness**).

8.5.8 Informal Conference with The Health Plan

Within 7 days of receipt of an appeal, The Health Plan shall hold an informal conference with the person, guardian, any designated representative, Health Care Coordinator or other representative of the service provider, if appropriate.

The Health Plan 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 The Health Plan with authority to resolve the issues under appeal, who shall seek to mediate and resolve the issues in dispute. The Health Plan 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 person or guardian, if applicable, The Health Plan shall issue a dated written Notice of Appeal Resolution 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 person or guardian and the issues in dispute do not relate to the person's eligibility for behavioral health services, the person 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 person or guardian and the issues in dispute relate to the person's eligibility for SMI services or the person or guardian has requested a waiver of the AHCCCS informal conference in writing, The Health Plan shall:

- Provide written notice to the person or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the person or guardian is requesting The Health Plan to request an administrative hearing on behalf of the person or guardian and, if so, file the request with AHCCCS within 3 days of the informal conference.
- For a person who is in need of 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 person appealing fails to attend the informal conference and fails to notify The Health Plan of their inability to attend prior to the scheduled conference, The Health Plan shall reschedule the conference. If the person appealing fails to attend the rescheduled conference and fails to notify The Health Plan of their inability to attend prior to the rescheduled conference, The Health Plan will close the appeal docket and send written notice of the closure to the person 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, The Health Plan can re-open the appeal and proceed with the informal conference.
- For all appeals unresolved after an informal conference with The Health Plan, The Health Plan must forward the appeal case record to the AHCCCS Office of Grievance and Appeals (OGA) within three days from the conclusion of the informal conference.

8.5.9 AHCCCS Informal Conference

Unless the person or guardian waives an informal conference AHCCCS 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 The Health Plan 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 person 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 person 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 person or guardian, AHCCCS shall:

- Provide written notice to the person or guardian of the process to request an administrative hearing.
- Determine at the informal conference whether the person or guardian is requesting AHCCCS to request an administrative hearing on behalf of the person or guardian and, if so, file the request within 3 days of the informal conference.
- For a person who is in need of Special Assistance, send a copy of the notice to the Office of Human Rights.
- In the event the person 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 an Administrative 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, the AHCCCS can re-open the appeal and proceed with the informal conference.

8.5.10 Requests for Administrative Hearing

A written request for administrative hearing shall be filed with The Health Plan for forwarding to AHCCCS. The hearing request must contain the following information:

- Case name (name of the applicant or person receiving services, name of the appellant and the AHCCCS docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

The Health Plan shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS Office of Administrative Legal Services within 3 days from such date.

Administrative hearings shall be conducted and decided pursuant to A.R.S. § 41-1092 et seq.

8.5.11 Expedited appeals

A person, or a provider on the person'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, The Health Plan 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 section.

8.5.12 Arizona Complete Health-Complete Care Plan Expedited Informal Conference

Within 2 days of receipt of a written request for an expedited appeal, The Health Plan shall hold an informal conference to mediate and resolve the issues in dispute.

8.5.13 AHCCCS Expedited Informal Conference

Within two days of notification from The Health Plan, 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 an administrative 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 an administrative hearing.

8.5.14 Requests for Administrative Hearing

A written request for an administrative hearing shall be filed with The Health Plan and must contain the following information:

- Case name (name of the applicant or person receiving services, name of the appellant and the AHCCCS docket number);
- The decision being appealed;
- The date of the decision being appealed; and
- The reason for the appeal.

The Health Plan shall ensure that the written request for hearing, appeal case record and all supporting documentation is received by the AHCCCS Office of Grievance and Appeals within 3 days.

Administrative hearings shall be conducted and decided pursuant to A.R.S. §41-1092 et seq.

8.5.15 Non-SMI/Non-Title XIX/XXI Member Appeals

This process applies to actions or decisions related to determination of need for Non- SMI, Non-Title XIX/XXI funded, covered behavioral health services.

The Health Plan 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 person 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, The Health Plan will advise the appellant in writing of their right to request an administrative hearing with the AHCCCS Administration no later than 30 days from the date of The Health Plan's decision, and how to do so.

8.6 Provider Claim Disputes

The provider claim dispute process affords providers the opportunity to challenge a decision by The Health Plan that impacts the provider for issues involving:

- Payment or nonpayment of a claim;
- The recoupment of payment on a claim; and
- The imposition of sanctions.

Providers may submit a claim dispute to The Health Plan, which does not delegate its claim-dispute responsibilities, when:

- Challenging a decision of The Health Plan; or
- Disputing a claim payment issue for services provided to persons enrolled with The Health Plan.

This section does not apply to disputes between The Health Plan and a prospective provider made in connection with The Health Plan's contracting process.

Once The Health Plan or AHCCCS makes a decision regarding a provider claim dispute, the provider may request another review of the decision, referred to as an administrative hearing.

Many times, disagreements between a provider and The Health Plan or AHCCCS can be resolved through an informal process. Providers are encouraged to try and resolve 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 section is to describe the options available to providers to resolve issues and other events related to a decision of The Health Plan or AHCCCS. The section is organized to delineate the process for filing a claim dispute:

- For providers disputing a decision of The Health Plan; and
- The process for requesting an administrative hearing in the event a provider does not agree with the claim dispute decision of The Health Plan or AHCCCS.

The Health Plan provides non-contracted providers with its claim dispute policy with a remittance advice within 45-days of receipt of a claim.

8.6.1 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:

Arizona Complete Health-Complete Care Plan
Attn: Claims Department
1870 W. Rio Salado Parkway Suite 2A
Tempe, AZ 85281
Email: AzCHClaims@azcompletehealth.com

Providers are also encouraged to discuss concerns about claim processing with a Provider Engagement Specialist.

8.6.2 General Requirements

8.6.2.1 *Computation of Time*

A written claim dispute is considered filed when it is received by The Health Plan, as established by a date stamp or other record of receipt. Providers must use the following methodology in computing any period of time 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 The Health Plan, the provider must file the claim dispute with The Health Plan at:

Arizona Complete Health-Complete Care Plan
Attn: Grievances and Appeals
1870 W. Rio Salado Parkway Suite 2A
Tempe, AZ 85281
Fax Number: (866) 714-7998
Phone: (866) 796-0542

The Health Plan utilizes a unique Docket Number for each claim dispute filed. All documentation received during the claim dispute resolution process is date stamped upon receipt.

All claim dispute case records are filed in secured locations and retained for five years after the most recent decision has been rendered.

8.6.2.2 *Notification of Right to File Claim Dispute*

The Health Plan provides an affected provider a remittance advice that includes providers' right to file a claim dispute and how to do so, upon the payment, denial or recoupment of payment of a claim. The Health Plan notifies 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.

8.6.2.3 *Initiating 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.

A 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.

8.6.2.4 *Timeframes for Initiating Claim Dispute*

The claim dispute must be filed within the following established timeframes:

- Within 60 days of the date of notice advising that a sanction will be imposed, or
- For challenges relating 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.

8.6.3 *Claim Disputes of Arizona Complete Health-Complete Care Plan re Decisions*

Within 5 days of receipt of a claim dispute, The Health Plan's issues a 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 The Health Plan determines that it was not responsible for the claim dispute, it will immediately forward the claim dispute to the responsible RBHA/MCO/Health Plan or to AHCCCS with an explanation of why the claim dispute is being forwarded. A copy of the transmittal is sent by The Health Plan to the party filing the claim dispute. The receiving RBHA/MCO/Health Plan or AHCCCS must ensure that a decision is rendered within 30 days of The Health Plan's receipt of the notice of claim dispute, unless an extension has been granted.

8.6.3.1 *The Health Plan Decision*

The Health Plan shall issue a written, dated decision that is mailed to all parties no later than 30 days after the provider files a claim dispute with The Health Plan, unless the provider and The

Health Plan have agreed to an extension. The Decision must include and describe in detail, the following:

- The nature of the claim dispute;
- The issues involved;
- The Health Plan's decision and the reasons supporting The Health Plan's decision, including references to applicable statutes, rules, contractual provisions, and policies and procedures;
- The provider's right to request a hearing by filing a written request for hearing to AHCCCS no later than 30 days after the date the provider receives The Health Plan'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 The Health Plan 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.

8.6.4 Extension of Time

The time to issue a decision may be extended upon agreement between the parties. Documentation of the agreement to the extension of time must be maintained in the claim dispute case record.

8.6.5 Requests for Administrative Hearing

If the party filing a claim dispute is dissatisfied with an AHCCCS or The Health Plan decision, or if a decision is not received within 30 days after the claim dispute is filed, absent an extension of time, a request for an administrative hearing may be filed, in writing, with The Health Plan. The Health Plan will forward the request for hearing to AHCCCS OALS.

8.6.5.1 *Timeframes for Requesting an Administrative Hearing*

The provider's request for a hearing must be filed in writing and received by AHCCCS no later than 30 calendar days of the date of receipt of the AHCCCS or The Health Plan decision, absent an extension of time, or in the event no decision is rendered, within 30 days of the date of filing the claim dispute, absent an extension.

8.6.5.2 *Scheduling of an Administrative Hearing*

Pursuant to A.R.S. § 41-1092.03, upon receipt of a request for an administrative hearing, an administrative hearing will be scheduled pursuant to A.R.S. § 41-1092.05.

AHCCCS Office of Administrative Legal Services shall accept a written request for withdrawal from the filing party if the request is received prior to AHCCCS scheduling and mailing of a Notice of Hearing. Otherwise, a filing party who wishes to withdraw must send a written request (motion) for withdrawal to the Office of Administrative Hearings consistent with AAC R2-19-106(A)(3).

If The Health Plan's decision regarding a claim dispute is reversed through the claim dispute or hearing process, The Health Plan will 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.

8.6.6 Administrative Process

The Administrative Hearing Process is conducted according to A.R.S. Title 41, Chapter 6, Article 10.

8.6.7 Detecting Fraud And Program Abuse

The Health Plan tracks, trends and analyzes claim disputes for purposes of detecting fraud and program abuse. The Health Plan reports all suspected fraud, waste and/or program abuse involving any Title XIX funds to the AHCCCS Office of the Inspector General (OIG) consistent with the requirements in **Section 9.8 – Corporate Compliance**.

Section 9 - COMPLIANCE

9.1 Member Rights

The following are member rights in accordance with 42 CFR Section 438.100:

- Be treated with respect and with recognition of the member's dignity and need for privacy. (42 CFR 438.100.(b)(2)(ii));
- The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.
- The Health Plan and its providers must ensure the confidentiality of health, service and medical records and of other member information. (Refer to the Medical Records Requirements included in Policy 940 of the [AHCCCS AMPM Chapter 900](#)).
- Receive required information in a manner and format that may be easily understood and is readily accessible. (42 CFR 438.10.c.1);
- Notified that oral interpretation is available for any language and written information is available in prevalent languages, that auxiliary aids and services are available upon request at no cost to the member and how to access those services. (42 CFR 438.10.d.5);
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand (42 CFR 438.100(b)(2)(iii));
- Participate in decisions regarding their health care, including the right to refuse treatment (42 CFR 438.100(b)(2)(iv));
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 CFR .438100(b)(2)(v));
- Request and receive a copy of their medical records, and to request that the record be amended or corrected, as specified in 45 CFR part 164.524 and 164.526 and applicable state law (42 CFR 438.100(b)(2)(vi)); and
- Free to exercise their rights and that the exercise of those rights shall not adversely affect service delivery to the Member (42 CFR 438.100(c)).

The Health Plan recognizes the member rights and responsibilities as set forth in the [AHCCCS AMPM Chapter 900 - Policy 930](#). The expectation is that all providers are informed and have implemented processes to ensure that all elements described in Policy 930 are integral part of their operation.

9.2 Cultural Competence System of Care Requirements

The Health Plan and its providers must respond to the unique cultural, ethnic, and linguistic characteristics of the population they serve to ensure that services are culturally competent for all members.

The Health Plan has adopted the Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards; 42 CFR 438; Affordable Care Act Section 1557) as its cultural competency framework to support a more consistent and comprehensive approach to cultural and linguistic competence in health care. By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations. Providers are required to adhere to and implement the CLAS standards in order to comply with Cultural Competency Health Care Requirements. The National CLAS Standards can be obtained and reviewed at <https://minorityhealth.hhs.gov>.

In order to ensure competence and proficiency of those providing language assistance, the Health Plan requires that persons who provide oral interpretation and written translation are certified through language testing by ALTA Services or another approved language testing vendor with a score of eight (8) or higher, with a higher level of proficiency needed for the provision of more complex communication, such as psychiatric services and psychological testing, and medical care. Providers can register for testing at <http://www.altalang.com>. The charge for the testing is the provider agency's responsibility. Certificates of proficiency indicating level/testing scores shall be maintained in personnel records and/or subcontractor's files and made available to The Health Plan. The Health Plan will audit providers to verify they are using certified bilingual staff at the appropriate level of proficiency to provide the language assistance or that they are using a language vendor.

The Health Plan makes available tools for individual and organizational self-assessments related to cultural and linguistic competence. Providers who are interested in assessing their organization may email AzCHCulturalAffairs@azcompletehealth.com for more information.

What is Culture?

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. Culture defines the preferred ways for meeting needs, and may be influenced by factors such as geographic location, lifestyle and age. Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

AHCCCS defines Cultural Competency as "A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, which enables that system, agency or those professionals to work effectively in cross-cultural situations. Competence

implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.”

Culturally Competent Care

The Health Plan and its providers must ensure that cultural considerations are being integrated in approaches to member care. Culturally competent health care incorporates cultural considerations that include, but are not limited to the following: ethnicity, race, age, gender identity, sexual orientation, economic status, military experience, physical abilities and limitations, literacy, primary/preferred languages, spiritual beliefs and practices, communities, family roles, and English proficiency. To comply with the Culturally Competent Care requirements, The Health Plan and its providers must provide culturally relevant and appropriate services for all members. They must be treated fairly without regard to age, ethnicity, race, sex, religion, national origin, creed, tribal affiliation, ancestry, gender identity, sexual orientation, marital status, genetic information, socio-economic status, physical or intellectual disability, ability to pay, mental illness, and/or cultural and linguistic need. Cultural Competency Program representatives develop, establish and monitor programs for members that meet the cultural contractual requirements established by the Arizona Health Care Cost Containment System (AHCCCS). For more information on cultural and linguistic services provided by The Health Plan or cultural community resources, contact The Health Plan Cultural Competency Program at AzCulturalAffairs@AzCompleteHealth.com

Organizational Supports for Cultural and Linguistic Need

Under State guidance, and to comply with the Organizational Supports for Cultural Competence, The Health Plan and providers must:

- Conduct ongoing assessments of the organization’s CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities;
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints;
- 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.

Workforce Development and Training

Providers are required to:

- Recruit, retain, promote, and support culturally and linguistically diverse representation within all levels of the organization that is responsive to the population in the service area(s) and reflects the cultural background of Members served;
- Provide new hire, ongoing, and annual training to the workforce. This includes addressing the requirements in the Cultural Competency section of the Provider Manual, the CLAS Standards, use of language assistance and alternative formats for Members with Limited English Proficiency (LEP), diversity awareness, and culturally relevant topics customized to meet the needs of their service area(s). Providers must maintain full compliance with all mandatory Cultural Competency trainings (see Section 15 — Training Requirements), and verify that staff at all levels and across all disciplines

receive the ongoing education and training in culturally and linguistically appropriate service delivery;

- Ensure all staff have access to resources for Members with diverse cultural needs.

Documenting Clinical Cultural and Linguistic Need

To advance health literacy, reduce health disparities, and identify the individual's unique needs, providers are required to do the following:

- Providers must document in a Member's medical record if the person has a preferred language other than English. Maintain documentation within the medical record of oral interpretation provided in a language other than English- by certified bilingual staff or an interpretation vendor. Documentation must include the date of service, interpreter name, type of language provided, interpretation duration, and type of interpretation assistance provided;
- Providers must document the language not only of the Member but also of the guardian or legal appointed representative if the Member care requires the presence of a legal parent or guardian who does not speak English (e.g., when the patient/Member is a minor or severely disabled).
- Collect and maintain accurate and reliable cultural (for example: age, ethnicity, race, national origin, sex, gender identity, sexual orientation, tribal affiliation, refugee status, veteran status, disability) and linguistic (for example, primary language, preferred language, language spoken at home,) needs within the medical records to inform service delivery;

Communication and Language Assistance

In accordance with Title VI of the Civil Rights Act, Prohibition against national Origin Discriminations, the President's Executive Order 131166, section 1557 of the Patient Protection and Affordable care Act, The Health Plan and its providers must make language assistance available to persons with Limited English Proficiency (LEP) at all points of contact during all hours of operation. Oral interpretation, American Sign Language, and written translation are provided at no charge to AHCCCS eligible persons. Members must be provided with information instructing them how to access these services. Providers must post nondiscrimination notices and language assistance taglines in lobbies and on websites. Language assistance taglines notify individuals of the availability of language assistance in at least the top 15 languages utilized in Arizona as identified by the ACA 1557, and include at least one tagline in 18 point font. Nondiscrimination notices and taglines must also be included in significant correspondence sent to the member. For more information on what specific information needs to be included in the nondiscrimination notice and taglines - <https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html>.

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. 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. (Arizona Commission for the Deaf and the Hard of Hearing www.acdhh.org or 602-542-3323 (V/TTY)). The Health Plan can be contacted via TDD/TTY line, 24 hours a day, 7 days a week at 711.

Information regarding interpreter assistance is available by contacting The Health Plan Provider Services Call Center number at 866-795-0542 (TTY 711). When calling, the following information is required:

- Member name;
- Member ID number;
- Appointment date and time (advance note preferred, if possible);
- Type of interpretation needed;
- Language requested.

The Health Plan has customer service representatives who are available to speak to members/family members in their preferred language, or will conference in an interpreter. The Provider Services Call Center, at 866-796-0542 also has the ability to conference in an interpreter, as needed.

Providers must ensure any document that requires the signature of the Member, and that contains vital information such as the treatment, medications or notices, or service plans must be translated into their preferred/primary language upon request.

Providers must ensure their websites meet compliance with Section 508 Accessibility Standards. Section 508 is a federal law that requires agencies to provide people with disabilities equal access to electronic information and data comparable to those who do not have disabilities.

Restrictions Related to Interpretation or Facilitation of Communication

A Provider shall NOT require an individual with limited English proficiency to provide their own interpreter or rely on an adult or child accompanying an individual with limited English proficiency to interpret or facilitate communication. In addition, a Provider shall NOT rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. Exceptions to these expectations include:

- In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
- Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances for minimal needs;

Laws and Policies Addressing Discrimination and Diversity

Provider agencies must abide by the following referenced federal and state applicable rules, regulations and guidance documents:

- AHCCCS Contractor Operations Manual ([ACOM](#)) [Section 405-Cultural Competency](#): This Policy applies to Acute Care, ALTCS/EPD, CRS, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. Title VI of the Civil Rights Act prohibits discrimination on the basis of

race, color, and national origin in programs and activities receiving federal financial assistance;

- Section 1557 of the Patient Protection and Affordable Care Act is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex (including gender identity and sexual stereotypes), age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in any health program or activity any part of which receive federal funding.
- Department of Health and Human Services - Guidance to Federal Financial Assistance Members Regarding Title VI Prohibition Against National Origin Discrimination affecting Limited English Proficient Persons;
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability in delivering contract services;
- Section 508 of the Rehabilitation Act requires that institutions receiving federal funds solicit, procure, maintain and use all Information and Communication Technology (ICT) so that equal or alternate/comparable access is given to federal employees and members of the public with and without disabilities. It is a federal law that requires agencies to provide people with disabilities equal access to electronic information and data comparable to those who do not have disabilities; and,
- The Americans with Disabilities Act prohibits discrimination against persons who have a disability. Providers must deliver services so that they are readily accessible to persons with a disability.

9.3 Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits

In the State of Arizona, verification of United States (U.S.) Citizenship or Lawful Presence of non-citizens is mandatory prior to a person being able to receive public health benefits ([A.R.S. § 1-502](#)). In addition to citizenship/lawful presence, the Arizona Health Care Cost Containment System, (AHCCCS) requires verification of a person's identification in order to determine eligibility. A person who has verified both citizenship/lawful presence and identification and has been found eligible for AHCCCS may:

- Be eligible for Title XIX/XXI (Medicaid) or Title XXI (KidsCare) covered services; or
- Not qualify for Title XIX/XXI entitlements, but be eligible for services.

The Health Plan and its providers must verify U.S. citizenship or lawful presence in the U.S. of all persons applying for publicly funded services.

9.3.1 Eligibility to Receive Public Services with Verification Of U.S. Citizenship/Lawful Presence

The following individuals are eligible for public services:

- Persons determined to be eligible for AHCCCS; and

Persons not eligible for AHCCCS but with a Serious Mental Illness (SMI) AND who can provide documentation of citizenship/lawful presence (see **AHCCCS Medical Assistance Chapter 500, Section 507 Proof of Citizenship at**

<https://www.azahcccs.gov/Resources/GuidesManualsPolicies/EligibilityPolicy/EligibilityPolicyManual>)

9.3.2 Eligibility to Receive Public Services Without Verification

Persons not eligible for AHCCCS and NOT with SMI, but who qualify to receive behavioral health services funded through the Substance Abuse Block Grant (SABG) or the Projects for Assistance in Transition from Homelessness (PATH) Program are eligible to receive services in accordance with **Section 12.10 - Special Populations**. However, persons receiving services funded by SABG or PATH must still be screened for AHCCCS eligibility in accordance with **Section 12.1 - Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program**.

Persons presenting for and receiving crisis services are not required to provide documentation of eligibility with AHCCCS nor are they required to verify U.S. citizenship/lawful presence prior to or in order to receive crisis services.

9.3.3 Completing an AHCCCS Eligibility Determination Screening as Part of the Verification Process

If a person is currently enrolled with AHCCCS and has been assigned to a T/RBHA/Health Plan, verification of citizenship/lawful presence has already been completed.

For an illustration on how the verification process works, see **Provider Manual Attachment 12.2.2, Citizenship/Lawful Presence Verification Process Through Health-e-Arizona PLUS** which can be obtained by calling the Provider Services Call Center at 866-796-0542.

For a list of those persons who are exempt from citizenship verification, see **Provider Manual Attachment 12.2.3, Persons Who Are Exempt from Verification of Citizenship during the Prescreening and Application Process** which can be obtained by calling the Provider Services Call Center at 866-796-0542.

Providers must complete an eligibility determination screening for all persons who are not identified as being currently enrolled with AHCCCS using the subscriber version of the [Health-e-Arizona PLUS online application](#). An eligibility screening will be conducted:

- Upon initial request for services;
- At least annually thereafter, if still receiving services; and
- When significant changes occur in the person's financial status.

9.3.3.1 ***What Is the Process for Completing the Eligibility Screening Using Health-E-Arizona PLUS?***

The Health Plan or its provider meet with the person and complete the [Health-e- Arizona PLUS online application](#). Once the online application screening has been completed, the Health-e-Arizona PLUS online application tool will indicate:

- If the person is potentially AHCCCS eligible, The Health Plan or its provider must obtain from the applicant:
 - Documentation of identification and U.S. Citizenship needed if the person claims to be a U.S. citizen (see **Provider Manual Attachment 12.2.1, Documents Accepted by AHCCCS To Verify Citizenship and Identity** which can be obtained by calling the Provider Services Call Center at 866-796-0542); or
 - Documentation needed of identification and lawful presence in the U.S. if the applicant states that they are not a U.S. citizen (see **Provider Manual Attachment 12.2.4, Non-Citizen/Lawful Presence Verification Documents** which can be obtained by calling the Provider Services Call Center at 866-796-0542).
- The required U.S. citizenship/lawful presence documents are considered “permanent documents”. Permanent documents include proof of age, Social Security Number, U.S. citizenship or immigration status. These are eligibility factors that typically do not change and only need to be verified once, and
- When providers use the online Member verification system and enter a Member’s social security number, the Member’s photo, if available from the Arizona Motor Vehicles Department, will be displayed on the AHCCCS eligibility verification screen along with other AHCCCS coverage information. The added photo image assists providers to quickly validate the identity of a Member.

If the Health-e-Arizona PLUS online screening tool indicates that the person may not be eligible for AHCCCS, the person may:

- Choose to continue with the AHCCCS eligibility application, in which case the provider must assist the person in completing the application process and obtain the required identification and citizenship/lawful presence documents as indicated above or those required for Non-Title XIX/XXI Eligible individuals as outlined in **AHCCCS Medical Assistance Chapter 500, Section 507 Proof of Citizenship at <https://www.azahcccs.gov/Resources/GuidesManualsPolicies/EligibilityPolicy/EligibilityPolicyManual>**); or
- Decide to not continue with the online application process. The provider will need to determine if the person is eligible for services as described in AHCCCS AMPM Policy 110 Special Populations. The provider must continue to work with the person to obtain the required citizenship/lawful presence documents whenever possible for future eligibility status need.

9.3.3.2 *Inability to Provide the Required Identification or Citizenship/Lawful Presence Documents at the Time of Application*

To the extent that it is practicable, The Health Plan or its providers are expected to assist applicants in obtaining required documentation of identification and citizenship/lawful presence within the timeframes indicated by Health-e-Arizona PLUS (30 days from date of application submission unless otherwise stated).

Persons who are unable to provide required documentation of citizenship or lawful presence are not eligible for publicly funded services unless they meet the criteria outline in this section. If the person obtains the required documentation at a later date they may reapply for AHCCCS eligibility using Health-e-Arizona PLUS (and submit all required documentation with the reapplication, with no waiting period).

Pending the outcome of the AHCCCS eligibility determination, a person may be provided services in accordance with **Section 12.10 - Special Populations**.

9.3.4 Documentation Requirements

Documentation of screening a Member through Health-e-Arizona PLUS must be included in medical record, including the Application Summary and final Determination of eligibility status notification printed from the Health-e-Arizona PLUS website.

If a person has refused to participate in the screening process, the documented refusal to participate in the screening and/or application process must be maintained in accordance with **Section 12.1 - Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage and the Limited Income Subsidy Program**.

The State and/or The Health Plan may conduct unscheduled, periodic process and documentation audits to ensure that The Health Plan and/or its providers are in compliance with this section. The Health Plan may enforce all available contract remedies against a provider, up to and including termination for failure to comply with this section.

9.4 Reporting Discovered Violations of Immigration Status

Employees of The Health Plan and its providers are considered agents of the State, and therefore, must report discovered violations of immigration status to AHCCCS, which is responsible for submitting the reports to the U.S. Immigration and Customs Enforcement (ICE) agency. Failure to report a discovered violation is a Class 2 Misdemeanor.

9.4.1 Identification of Violations

The Health Plan and its providers must refrain from conduct or actions that could be considered discriminatory behavior. It is unlawful and discriminatory to deny persons services, exclude persons from participation in those services, or otherwise discriminate against any person based on grounds of race, color or national origin.

The Health Plan and its providers must not use any information obtained about a person's citizenship or lawful presence for any purpose other than to provide a person with services. Factors that must NOT be considered when identifying a potential violation:

- The person's primary language is a language other than English;
- The person was not born in the United States;
- The person does not have a Social Security number;
- The person has a "foreign sounding" name;
- The person cannot provide documentation of citizenship or lawful presence;
- The person is identified by others as a non-citizen; and
- The person has been denied AHCCCS eligibility for lack of proof of citizenship or lawful presence.

If a person applying for services, in the course of completing the application process or while conducting business with The Health Plan or a The Health Plan provider, voluntarily reveals that they are not lawfully present in the United States then and only then may The Health Plan or its providers consider it to be a reportable violation.

The Health Plan and its providers must not require documentation of citizenship or lawful presence from persons who are not personally applying for services, but who are acting on behalf of or assisting the applicant (for example, a parent applying on behalf of a child).

It is not the responsibility of The Health Plan or its providers to ensure the validity of the submitted documents. Documents must be copied for files and submitted, as requested, to the appropriate agency, as instructed through Health-e-Arizona PLUS (see **Section 9.2 - Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits**).

The criteria for screening and applying for AHCCCS eligibility are not changed by these reporting requirements. Further, the documentation requirements for verifying or establishing citizenship or lawful presence are not changed by this process (see **Section 9.2 - Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits**).

The Health Plan and its providers must follow the expectations outlined in this policy when identifying and reporting violations. Questions regarding reporting requirements may be submitted via email to the AHCCCS Corporate Compliance Officer at AHCCCSFraud@azahcccs.gov

9.4.2 Reporting Process

The Health Plan or a provider that identifies a violation must submit a report to AHCCCS via secure email to AHCCCS Corporate Compliance at AHCCCSFraud@azahcccs.gov that contains the following information:

- First and last name of identified individual;
- Residential address/street, address of identified individual, including city, state, and zip code; and
- Reason for referral.

Additionally, the link “How to Report Fraud, Waste or Abuse of the Program is:
<https://www.azahcccs.gov/Fraud/ReportFraud/>

9.4.3 Documentation Expectations

The Health Plan or its providers must document in the person’s medical record (if a provider) or in the Corporate Compliance Office (The Health Plan) the following:

- Reason for making a report, including how the information was obtained and whether it was an oral or written declaration;
- The date the report was submitted to AHCCCS;
- Any actions taken as a result of the report; and
- A copy of the email to AHCCCS that contains the report.

9.5 Duty to Report Abuse, Neglect or Exploitation

Any employee of The Health Plan basis to believe that abuse, neglect, exploitation, injuries, and unexpected death of an incapacitated or vulnerable adult or minor child has occurred shall immediately report the incident to a peace officer, the Department of Economic Security/ Adult Protective Services (DES/APS) or the Department of Economic Security/Department of Child Safety (DES/DCS) worker as appropriate, as well as to The Health Plan. The Health Plan will then report it to AHCCCS Quality Management.

9.5.1 Duty to Report Abuse, Neglect or Exploitation of a Vulnerable Adult

Providers responsible for the care of adults, including incapacitated or vulnerable adults, 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 person 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 persons who have control or custody of the adult, if known;
- The adult's age and the nature and extent of their 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 person 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 person 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 (see **Section 9.6.1, Disclosure of Health Information**). Records disclosed are confidential and may be used only in a judicial or administrative proceeding or investigation

resulting from the report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information from the records before they are made available:

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

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

Additionally, providers must report to The Health Plan healthcare acquired conditions, abuse, neglect, exploitation, injuries, high profile cases and unexpected death of adults as required under **Section 10.10 - Reporting of Incidents, Accidents, and Deaths**.

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

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

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

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

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

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

statement if the physician, psychologist, or behavioral health professional determines it is reasonable and necessary to accomplish the purposes of the treatment.

Upon written request by the investigating peace officer or DCS worker, the person who has custody or control of medical records of a minor for whom a report is required shall make the records, or a copy of the records, available (see **Section 9.6.1 - Disclosure of Health Information**). Records are confidential and may be used only in a judicial or administrative proceeding or investigation resulting from the required report. If psychiatric records are requested, the custodian of the records shall notify the attending psychiatrist, who may remove the following information before the records are made available:

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

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

Additionally, providers must report to The Health Plan healthcare acquired conditions, abuse, neglect, exploitation, injuries, high profile cases, denial or deprivation of medical or surgical care or nourishment, and unexpected death of minors as required under **Section 10.10 - Reporting of Incidents, Accidents, and Deaths**.

9.6 Duty to Warn

Any health provider employed or subcontracted by The Health Plan or a provider of a mental health provider that has determined a patient poses a serious danger of violence to others shall take reasonable actions to protect the potential victim(s) of that danger ([AHCCCS AMPM 960](#)).

9.6.1 Duty to Protect Potential Victims of Physical Harm

All health providers employed or subcontracted by The Health Plan under certain circumstances. When a health provider employed or subcontracted by The Health Plan or a provider of a mental health provider determines, or under applicable professional standards, reasonably should have determined that a patient poses a serious danger to others, they bear 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, health providers employed or subcontracted by The Health Plan or a provider of a mental health 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 health provider employed or subcontracted by The Health Plan or a provider of a mental health 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, and in accordance with **Section 12.9 - Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment**; or
- Taking any other precautions that a reasonable and prudent health provider would take under the circumstances.

The Health Plan contracted providers are required to immediately notify by telephone The Health Plan crisis line provider (The Crisis Call Center) when a patient is identified as a potential danger to self or others, and update The Crisis Call Center as appropriate based on the level of risk to the Member and the community. Providers are required to report to The Crisis Call Center all relevant information; including, information about the person's access to weapons, names and addresses of potential victims, attempts to protect victims, police involvement, relevant clinical information and support system information.

9.7 Confidentiality

9.7.1 Disclosure of Health Information

This section is intended to provide guidance to protect the privacy of persons who receive services, guidance as to whom information can be disclosed and when authorization¹ is required prior to that disclosure, and guidance on the notification of those persons in the event their unsecured Protected Health Information (PHI) is breached. It is not all-inclusive of the HIPAA and State Laws; the references throughout are available for providers to access and examine the applicable laws for more detail.

Information and records obtained in the course of providing or paying for services to a person are confidential and are only disclosed according to the provisions of applicable federal and State law. In the event of an unauthorized use/disclosure of unsecured PHI, The Health Plan's providers must notify all affected persons.

9.7.2 Overview of Confidentiality Information

The Health Plan and its providers must keep medical records, payment records, behavioral health records and all information contained in those records, and any other personal health and enrollment information that may identify a particular Member or subset of Members confidential and cannot disclose such information unless permitted or required by federal or State law. Providers must verify that all emails being sent by the provider with Protected Health Information (PHI) are sent using a secure email program and must use an individualized secure

¹ For purposes of uniformity and clarity, the term "authorization" is used throughout this section to reference a person's permission to disclose medical records and protected health information and has the same meaning as "consent" which is used in 42 C.F.R. Part 2.

business domain email, and not use public email entities (such as Google or Yahoo) to conduct business and transmit PHI.

The law regulates two major categories of confidential information:

- Information obtained when providing services not related to alcohol or drug abuse referral, diagnosis and treatment; and
- Information obtained in the referral, diagnosis and treatment of alcohol or drug abuse.

The Health Plan also requires its providers to have policies and procedures in place to protect the privacy of individuals verified to be in the Address Confidentiality Program. See 41 A.R.S. § 161 et seq.

9.7.2.1 *Health Information Not Related to Alcohol and Drug Treatment*

Information obtained when providing services not related to alcohol and drug abuse treatment is governed by State law and the HIPAA Privacy Rule, 45 C.F.R., Part 164, Subparts A and E, Part 160 Subparts A and B (“the HIPAA Rule”). The HIPAA Rule permits a covered entity (health plan, health care provider, or health care clearinghouse) to use or disclose protected health information with or without patient authorization in a variety of circumstances, some of which are required and others that are permissive. Many of the categories of disclosures contain specific words and phrases that are defined in the HIPAA Rule. Careful attention must be paid to the definitions of words and phrases in order to determine whether disclosure is allowed. In addition, the HIPAA Rule may contain exceptions or special rules that apply to a particular disclosure. State law may affect a disclosure. For example, the HIPAA Rule may preempt State law or State law may preempt the HIPAA Rule. HIPAA, when read together with State law, may impose additional requirements for disclosure. In addition, a covered entity must, with certain exceptions, make reasonable efforts to limit protected health information to the minimum necessary to accomplish the intended purpose of the disclosure.

Before disclosing protected health information, it is good practice to consult the specific citation to the HIPAA Rule, State law, and consult with legal counsel. See **Section 9.6.4** below for more detail regarding the disclosure of health information not related to alcohol or drug referral, diagnosis or treatment.

9.7.2.2 *Drug and Alcohol Abuse Information*

Information regarding treatment for alcohol or drug abuse is afforded special confidentiality by federal statute and regulation (42 U.S.C. § 290 dd-3, 290 ee-3, 42 C.F.R. Part 2). This includes any information concerning a person’s diagnosis or treatment from a federally assisted alcohol or drug abuse program or referral to a federally assisted alcohol or drug abuse program. See **Section 9.6.5** below for more detail regarding the disclosure of drug and alcohol abuse information.

9.7.3 *General Procedures for All Disclosures*

Unless otherwise accepted by State or federal law, all information obtained about a person related to the provision of services to the person is confidential whether the information is in oral, written, or electronic format.

All records generated as a part of the State or The Health Plan grievance and appeal processes are legal records, not medical or payment records, although they may contain copies of portions of a person's medical record. To the extent these legal records contain personal medical information, the State or The Health Plan will redact or de-identify the information to the extent allowed or required by law.

9.7.3.1 *List of Persons Accessing Records*

The Health Plan's providers must verify that a list is kept of every person or organization that inspects a currently or previously enrolled person's records other than the person's clinical team, the uses to be made of that information and the staff person authorizing access. The access list must be placed in the enrolled person's record and must be made available to the enrolled person, their guardian or other designated representative.

9.7.3.2 *Disclosure to Clinical Teams*

Disclosure of information to Members of a clinical team may or may not require an authorization depending upon the type of information to be disclosed and the status of the receiving party. Information concerning diagnosis, treatment or referral for drug or alcohol treatment may only be disclosed to Members of a clinical team with authorization from the enrolled person as prescribed in **Section 9.6.5** below. Information not related to drug and alcohol treatment may be disclosed without patient authorization to Members of a clinical team who are providers of health, mental health or social services, provided the information is for treatment purposes as defined in the HIPAA Rule. Disclosure to Members of a clinical team who are not providers of health, mental health or social services requires the authorization of the person or the person's legal guardian or parent as prescribed in **Section 9.6.4** below.

9.7.3.3 *Disclosure to Persons Involved in Court Proceedings*

Disclosure of information to persons involved in court proceedings including attorneys, probation or parole officers, guardian ad litem and court appointed special advocates may or may not require an authorization depending upon the type of information to be disclosed and whether the court has entered orders permitting the disclosure.

9.7.4 *Disclosure of Information Not Related to Alcohol and Drug Treatment*

The HIPAA Rule and State law allow a covered entity to disclose protected health information under a variety of conditions. This is a general overview and does not include an entire description of legal requirements for each disclosure. Below is a general description of all required or permissible disclosures:

- To the individual and the individual's health care decision maker;
- To health, mental health and social service providers for treatment, payment or health care operations;
- Incidental to a use or disclosure otherwise permitted or required by 45 C.F.R. Part 160 and Part 164, Subpart E;
- To a person or entity with a valid authorization;
- Provided the individual is informed in advance and has the opportunity to agree or prohibit the disclosure:
 - For use in facility directories;

- To persons involved in the individual's care and for notification purposes.
- When required by State or federal law;
- For public health activities;
- About victims of child abuse, neglect or domestic violence;
- For health oversight activities;
- For judicial and administrative proceedings;
- For law enforcement purposes;
- About deceased persons;
- For cadaveric organ, eye or tissue donation purposes;
- For research purposes, if the activity is conducted pursuant to applicable federal or State laws and regulations governing research;
- To avert a serious threat to health or safety or to prevent harm threatened by patients;
- To a human rights committee;
- For purposes related to the Sexually Violent Persons program;
- With communicable disease information;
- To personal representatives including agents under a health care directive;
- For evaluation or treatment;
- To business associates;
- To the Secretary of Health and Human Services or designee to investigate or determine compliance with the HIPAA Rule;
- For specialized government functions;
- For worker's compensation;
- Under a data use agreement for limited data;
- For fundraising;
- For underwriting and related purposes;
- To the Arizona Center For Disability Law in its capacity as the State Protection and Advocacy Agency;
- To a third party payer the payer's contractor to obtain reimbursement;
- To a private entity that accredits a health care provider;
- To the legal representative of a health care entity in possession of the record for the purpose of securing legal advice;
- To a person or entity as otherwise required by state or federal law;
- To a person or entity permitted by the federal regulations on alcohol and drug abuse treatment (42 CFR Part 2);
- To a person or entity to conduct utilization review, peer review and quality assurance pursuant to A.R.S. §§ 36-441, 36-445, 36-2402 or 36-2917;
- To a person maintaining health statistics for public health purposes as authorized by law; and
- To a grand jury as directed by subpoena.

9.7.4.1 ***Disclosure to an Individual***

A covered entity is required to disclose information in a designated record set to an individual when requested unless contraindicated. Contraindicated means that access is reasonably likely to endanger the life or physical safety of the patient or another person (See A.R.S. § 36-507(3); 45 CFR § 164.524; A covered entity should read and carefully apply the provisions in 45 CFR § 164.524 before disclosing protected health information in a designated record set to an individual.

An individual has a right of access to their designated record set, except for psychotherapy notes and information compiled for pending litigation. See 45 CFR § 164.524(a)(1) and Section 13405(e) of the Health Information Technology for Economic and Clinical Health (HITECH) Act. Under certain conditions a covered entity may deny an individual access to the medical record without providing the individual an opportunity for review. See 45 CFR § 164.524(a)(2); ARS § 12-2293. Under other conditions, a covered entity may deny an individual access to the medical record and must provide the individual with an opportunity for review. See 45 CFR § 164.524(a)(3). A covered entity must follow certain requirements for a review when access to the medical record is denied. See 45 CFR § 164.524(a)(4).

An individual must be permitted to request access or inspect or obtain a copy of their medical record. See 45 CFR § 164.524(b)(1). A covered entity is required to act upon an individual's request in a timely manner. See 45 CFR § 164.524(b)(2). An individual may inspect and be provided with one free copy per year of their own medical record, unless access has been denied.

A covered entity must follow certain requirements for providing access, the form of access and the time and manner of access. See 45 CFR § 164.524(c).

A covered entity is required to make other information available in the record when access is denied, must follow other requirements when making a denial of access, must inform an individual of where medical records are maintained and must follow certain procedures when an individual requests a review when access is denied. See 45 CFR § 164.524(d).

A covered entity is required to maintain documentation related to an individual's access to the medical record. See 45 CFR § 164.524(e).

9.7.4.2 ***Disclosure with an Individual or the Individual's Health Care Decision Maker's Authorization***

The HIPAA Rule allows information to be disclosed with an individual's written authorization.

For all uses and disclosures that are not permitted by the HIPAA Rule, patient authorization is required. See 45 CFR §§ 164.502(a)(1)(iv); and 164.508. An authorization must contain all of the elements in 45 CFR § 164.508.

A copy of the authorization must be provided to the individual. The authorization must be written in plain language and must contain the following elements:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
- The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure;
- A description of each purpose of the requested use or disclosure. The statement “at the request of the individual” is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement “end of the research study,” “none,” or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository; and
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of the representative’s authority to act for the individual must also be provided.

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

- The individual’s right to revoke the authorization in writing, and either:
 - The exceptions to the right to revoke and a description of how the individual may revoke the authorization; or
 - A reference to the covered entity’s notice of privacy practices if the notice of privacy practices tells the individual how to revoke the authorization.
- The ability or inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, by stating either:
 - The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations in 45 CFR § 164.508 (b)(4) applies; or
 - The consequences to the individual of a refusal to sign the authorization when, in accordance with 45 CFR § 164.508 (b) (4), the covered entity can condition treatment, enrollment in the health plan or eligibility for benefits on failure to obtain such authorization.
- The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the Member.

9.7.4.3 ***Disclosure to Health, Mental Health and Social Service Providers for Treatment, Payment or Health Care Operations; Reports of Abuse and Neglect***

Disclosure is permitted without patient authorization to health, mental health and social service providers involved in caring for or providing services to the person for treatment, payment or health care operations as defined in the HIPAA Rule. These disclosures are typically made to

primary care Providers, psychiatrists, psychologists, social workers (including DES and DDD) or other behavioral health professionals. Particular attention must be paid to 45 CFR §164.506(c) and the definitions of treatment, payment and health care operations to determine the scope of disclosure. For example, a covered entity is allowed to disclose protected health information for its own treatment, payment or health care operations. See 45 CFR §164.506(c)(1). A covered entity may disclose for treatment activities of a health care provider including providers not covered under the HIPAA Rule. See 45 CFR § 164.506(c)(2). A covered entity may disclose to both covered and non-covered health care providers for payment activities. See 45 CFR § 164.506(c)(3). A covered entity may disclose to another covered entity for the health care operations activities of the receiving entity if each entity has or had a direct treatment relationship with the individual and the disclosure is for certain specified purposes in the definition of health care operations 42 CFR. See 45 CFR § 164.506(c)(4).

If the disclosure is not for treatment, payment, or health care operations or required by law, patient authorization is required unless otherwise allowed by law.

The HIPAA Rule does not modify a covered entity's obligation under A.R.S. § 13-3620 to report child abuse and neglect to Department of Child Safety or disclose a child's medical records to the Department of Child Safety for investigation of child abuse cases.

Similarly, a covered entity may have an obligation to report adult abuse and neglect to Adult Protective Services. See A.R.S. § 46-454. The HIPAA Rule imposes other requirements in addition to those contained in A.R.S. § 46-454, primarily that the individual be notified of the making of the report or a determination by the reporting person that it is not in the individual's best interest to be notified. See 45 CFR § 164.512(c).

9.7.4.4 *Disclosure to Other Persons Including Family Members Who Are Actively Participating in The Patient's Care, Treatment, or Supervision*

A covered entity may disclose protected health information without authorization to other persons including family members actively participating in the patient's care, treatment or supervision. Prior to releasing information, an agency or non-agency treating professional or that person's designee must have a verbal discussion with the person to determine whether the person objects to the disclosure. If the person objects, the information cannot be disclosed. If the person does not object, or the person lacks capacity to object, or in an emergency circumstance, the treating professional must perform an evaluation to determine whether disclosure is in that person's best interests. A decision to disclose or withhold information is subject to review pursuant to A.R.S. § 36-517.01.

An agency or non-agency treating professional may only release information relating to the person's diagnosis, prognosis, need for hospitalization, anticipated length of stay, discharge plan, medication, medication side effects, and short-term and long-term treatment goals. See A.R.S. § 36-509(7).

The HIPAA Rule imposes additional requirements when disclosing protected health information to other persons including family members. A covered entity may disclose to a family member or other relative the protected health information directly relevant to the person's involvement with the individual's care or payment related to the individual's health care. If the individual is present for a use or disclosure and has the capacity to make health care decisions, the covered

entity may use or disclose the protected health information if it obtains the individual's agreement, provides the individual with the opportunity to object to the disclosure and the individual does not express an objection. If the individual is not present, or the opportunity to agree or object to the use or disclosure cannot practicably be provided because of the individual's incapacity or an emergency circumstance, the covered entity may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the individual and, if so, disclose only the protected health information that is directly relevant to the person's involvement with the individual's health care. See 45 CFR § 164.510(b).

9.7.4.5 *Disclosure to an Agent Under a Health Care Directive*

A covered entity may treat an agent appointed under a health care directive as a personal representative of the individual. See 45 CFR § 164.502(g). Examples of agents appointed to act on an individual's behalf include an agent under a health care power of attorney, see A.R.S. § 36-3221 et seq.; surrogate decision makers, see A.R.S. § 36-3231; and an agent under a mental health care power of attorney, see A.R.S. § 36-3281.

9.7.4.6 *Disclosure to a Personal Representative*

A covered entity may disclose protected health information to a personal representative, including the personal representative of an un-emancipated minor, unless one or more of the exceptions described in 45 CFR §§ 164.502(g)(3)(i) or 164.502(g)(5) applies. See 45 CFR § 164.502(g)(1).

The general rule is that if State law, including case law, requires or permits a parent, guardian or other person acting *in loco parentis* to obtain protected health information, then a covered entity may disclose the protected health information. See 45 CFR § 164.502(g)(3)(ii)(A).

Similarly, if State law, including case law, prohibits a parent, guardian or other person acting *in loco parentis* from obtaining protected health information, then a covered entity may not disclose the protected health information. See 45 CFR § 164.502(g)(3)(ii)(B).

When State law, including case law, is silent on whether protected health information can be disclosed to a parent, guardian or other person acting *in loco parentis*, a covered entity may provide or deny access under 45 CFR § 164.524 to a parent, guardian or other person acting *in loco parentis* if the action is consistent with State or other applicable law, provided that such decision must be made by a licensed health care professional, in the exercise of professional judgment. See 45 CFR § 164.502(g)(3)(ii)(C).

9.7.4.7 *Disclosure to a Personal Representative, Adults and Emancipated Minors*

If under applicable law, a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, a covered entity must treat such persons as a personal representative with respect to protected health information relevant to such personal representation. See 45 CFR § 164.502(g)(2). Simply stated, if there is a State law that permits the personal representative to obtain the adult or emancipated minor's protected health information, the covered entity may disclose it. A covered entity may withhold protected health information if one or more of the exceptions in 45 CFR § 164.502(g)(5) applies.

9.7.4.8 ***Deceased Persons***

If under applicable law, an executor, administrator or other person has authority to act on behalf of a deceased individual or of the individual's estate, a covered entity must treat such persons as a personal representative with respect to protected health information relevant to the personal representation. See 45 CFR § 164.502(g)(4). A covered entity may withhold protected health information if one or more of the exceptions in 45 CFR § 164.502(g)(5) applies. A.R.S. § 12-2294 (D) provides certain persons with authority to act on behalf of a deceased person.

9.7.4.9 ***Disclosure for Court-Ordered Evaluation or Treatment***

An agency in which a person is receiving court ordered evaluation or treatment is required to immediately notify the person's guardian or agent or, if none, a member of the person's family that the person is being treated in the agency. See A.R.S. § 36-504(B). The agency shall disclose any further information only after the treating professional or that person's designee interviews the person undergoing treatment or evaluation to determine whether the person objects to the disclosure and whether the disclosure is in the person's best interests. A decision to disclose or withhold information is subject to review pursuant to section A.R.S. § 36-517.01.

If the individual or the individual's guardian makes the request for review, the reviewing official must apply the standard in 45 CFR § 164.524(a)(3). If a family member makes the request for review, the reviewing official must apply the "best interest" standard in A.R.S. § 36-517.01.

The reviewer's decision may be appealed to the superior court. See A.R.S. § 36-517.01(B). The agency or non-agency treating professional must not disclose any treatment information during the period an appeal may be filed or is pending.

9.7.4.10 ***Disclosure for Health Oversight Activities***

A covered entity may disclose protected health information without patient authorization to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions or other activities necessary for appropriate oversight of entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards. See 45 CFR § 164.512(d).

9.7.4.11 ***Disclosure for Judicial And Administrative Proceedings Including Court Ordered Disclosures***

A covered entity may disclose protected health information without patient authorization in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by the order. See 45 CFR § 164.512(e). In addition, a covered entity may disclose information in response to a subpoena, discovery request or other lawful process without a court order if the covered entity receives satisfactory assurances that the requesting party has made reasonable efforts to provide notice to the individual or has made reasonable efforts to secure a qualified protective order. See 45 CFR §§ 164.512(e)(1)(iii),(iv) and (v) for what constitutes satisfactory assurances.

9.7.4.12 *Disclosure to Persons Doing Research*

A covered entity may disclose protected health information to persons doing research without patient authorization provided it meets the de-identification standards of 45 CFR § 164.514(b). If the covered entity wants to disclose protected health information that is not de-identified, patient authorization is required or an Institutional Review Board or a privacy board in accordance with the provisions of 45 CFR § 164.512(i)(1)(i) can waive it.

9.7.4.13 *Disclosure to Prevent Harm Threatened by Patients*

Mental health providers have a duty to protect others against the harmful conduct of a patient under certain circumstances. See A.R.S. § 36-517.02. When a patient poses a serious danger of violence to another person, the provider has a duty to exercise reasonable care to protect the foreseeable victim of the danger. *Little v. All Phoenix South Community Mental Health Center, Inc.*, 186 Ariz. 97, 919 P.2d 1368 (1996). A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information without patient authorization if the covered entity, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat, or is necessary for law enforcement authorities to identify or apprehend an individual. See 45 CFR § 164.512(j)(1)(ii); 164.512(f)(2) and (3) for rules that apply for disclosures made to law enforcement. See 45 CFR § 164.512(j)(4) for what constitutes a good faith belief.

9.7.4.14 *Disclosures to Human Rights Committees*

Protected health information may be disclosed to a human rights committee without patient authorization provided personally identifiable information is redacted or de-identified from the record. See A.R.S. §§ 36-509(10) and 41-3804. In redacting personally identifiable information, a covered entity must comply with the HIPAA Rule de-identification standards in 45 CFR § 164.514(b) and not State law. If a human rights committee wants non-redacted identifiable health information for official purposes, it must first demonstrate to AHCCCS that the information is necessary to perform a function that is related to the oversight of the health system, and in that case, a covered entity may disclose protected health information to the human rights committee in its capacity as a health oversight agency. See 45 CFR § 164.512(d)(1).

9.7.4.15 *Disclosure to the Arizona Department of Corrections*

Protected health information may be disclosed without patient authorization to the state department of corrections in cases where prisoners confined to the State prison are patients in the State hospital on authorized transfers either by voluntary admission or by order of the court. See A.R.S. § 36-509(5). The HIPAA Rule limits disclosure to correctional institutions to certain categories of information that are contained in 45 CFR § 164.512(k)(5).

9.7.4.16 *Disclosure to a Governmental Agency or Law Enforcement To Secure Return of a Patient*

Protected health information may be disclosed to governmental or law enforcement agencies if necessary to secure the return of a patient who is on unauthorized absence from any agency where the patient was undergoing court ordered evaluation or treatment. See A.R.S. § 36-509(6). A covered entity may disclose limited information without patient authorization to law enforcement to secure the return of a missing person. See 45 CFR § 164.512(f)(2)(i). In addition,

a covered entity is permitted limited disclosure to governmental agencies to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. See 45 CFR § 164.512(j).

9.7.4.17 *Disclosure to a Sexually Violent Persons (SVP) Program*

Protected health information may be disclosed to a governmental agency or a competent professional, as defined in A.R.S. § 36-3701, in order to comply with the SVP Program (Arizona Revised Statutes, Title 36, Chapter 37). See A.R.S. § 36-509(9)).

A "competent professional" is a person who may be a psychologist or psychiatrist, is approved by the Superior Court and is familiar with the State's sexually violent person's statutes and sexual offender treatment programs. A competent professional is either statutorily required or may be ordered by the court to perform an examination of a person involved in the sexually violent persons program and must be given reasonable access to the person in order to conduct the examination and must share access to all relevant medical and psychological records, test data, test results and reports. See A.R.S. § 36-3701(2).

In most cases, the disclosure of protected health information to a competent professional or made in connection with the sexually violent persons program is required by law or ordered by the court. In either case, disclosure under the HIPAA Rule without patient authorization is permitted. See 45 CFR § 164.512(a) (disclosure permitted when required by law) and 45 CFR § 164.512(e) (disclosure permitted when ordered by the court). If the disclosure is not required by law or ordered by the court or is to a governmental agency other than the sexually violent persons program, the covered entity may have the authority to disclose if the protected health information is for treatment, payment or health care operations. See 45 CFR § 164.506(c) to determine rules for disclosure for treatment, payment or health care operations.

9.7.4.18 *Disclosure to Third Party Payors*

Disclosure is permitted to a third party payor to obtain reimbursement for health care, mental health care or behavioral health care provided to a patient. See A.R.S. § 36-509(13).

9.7.4.19 *Disclosure to Accreditation Organization*

Disclosure is permissible to a private entity that accredits a health care provider and with whom the health care provider has an agreement that requires the agency to protect the confidentiality of patient information. See A.R.S. § 36-509(14).

9.7.4.20 *Disclosure of Communicable Disease Information*

A.R.S. § 36-661 et seq., includes a number of provisions that address the disclosure of communicable disease information. The general rule is that a person who obtains communicable disease related information in the course of providing a health service or pursuant to a release of communicable disease related information must not disclose or be compelled to disclose that information. See A.R.S. § 36-664(A). Certain exceptions for disclosure are permitted to:

- The individual or the individual's health care decision maker;
- AHCCCS or a local health department for the purpose of notifying a Good Samaritan;
- An agent or employee of a health facility or a health care provider;

- A health facility or a health care provider;
- A federal, State or local health officer;
- Government agencies authorized by law to receive communicable disease information;
- Persons authorized pursuant to a court order;
- The Department of Economic Security for adoption purposes;
- The Industrial Commission;
- The Department of Health Services to conduct inspections;
- Insurance entities;
- A private entity that accredits a health care facility or a health care provider; and
- A person or entity for research only if the research is conducted pursuant to applicable federal or State laws governing research.

A.R.S. § 36-664 also addresses issues with respect to Disclosures to the Department of Health Services or local health departments. These disclosures are also permissible under certain circumstances:

- Authorizations;
- Re-disclosures;
- Disclosures for supervision, monitoring and accreditation;
- Listing information in death reports;
- Reports to the Department; and
- Applicability to insurance entities.

An authorization for the release of communicable disease related information must be signed by the protected person or, if the protected person lacks capacity to consent, the person's health care decision maker (see A.R.S. § 36-664(F)). If an authorization for the release of communicable disease information is not signed, the information cannot be disclosed. An authorization must be dated and must specify to whom disclosure is authorized, the purpose for disclosure and the time period during which the authorization is effective. A general authorization for the release of medical or other information, including communicable disease related information, is not an authorization for the release of HIV-related information unless the authorization specifically indicates its purpose as authorization for the release of HIV-related information and complies with the requirements of A.R.S. § 36-664(F).

The HIPAA Rule does not preempt State law with respect to disclosures of communicable disease information; however, it may impose additional requirements depending upon the type, nature and scope of disclosure. It is advisable to consult with the HIPAA Compliance Officer and/or legal counsel prior to disclosure of communicable disease information.

For example, if a disclosure of communicable disease information is made pursuant to an authorization, the disclosure must be accompanied by a statement in writing which warns that the information is from confidential records which are protected by State law that prohibits further disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A.R.S. § 36-664(H) affords greater privacy

protection than 45 CFR § 164.508(c)(2)(ii), which requires the authorization to contain a statement to place the individual on notice of the potential re-disclosure of the Member and thus, is no longer protected. Therefore, any authorization for protected health information that includes communicable disease information must contain the statement that re-disclosure of that information is prohibited.

9.7.4.21 *Disclosure to Business Associates*

The HIPAA Rule allows a covered entity to disclose protected health information to a business associate if the covered entity obtains satisfactory assurances that the business associate will safeguard the information in accordance with 45 CFR § 164.502(e) and the HITECH Act. See the definition of “business associate” in 45 CFR § 160.103. Also see 45 CFR § 164.504(e) and Section 13404 of the HITECH Act for requirements related to the documentation of satisfactory assurances through a written contract or other written agreement or arrangement.

9.7.4.22 *Disclosure to the Arizona Center for Disability Law, Acting in its Capacity as the State Protection and Advocacy Agency Pursuant To 42 U.S.C. § 10805 is:*

- Allowed when an enrolled person is mentally or physically unable to consent to a release of confidential information, and the person has no legal guardian or other legal representative authorized to provide consent; and
- Allowed when a grievance has been received by the Center or the Center asserts that the Center has probable cause to believe that the enrolled person has been abused or neglected.

9.7.5 Disclosures of Alcohol and Drug Information

The Health Plan and its providers that provide drug and alcohol screening, diagnosis or treatment services are federally assisted alcohol and drug programs and must ensure compliance with all provisions contained in the federal statutes and regulations referenced in this section.

The Health Plan and its providers must notify persons seeking and/or receiving alcohol or drug abuse services of the existence of the federal confidentiality laws and regulations and provide each person with a written summary of the confidentiality provisions. The notice and summary must be provided at admission or as soon as deemed clinically appropriate by the person responsible for clinical oversight of the person.

The Health Plan or its providers may require enrolled persons to carry identification cards while the person is on the premises of an agency. The Health Plan or its provider may not require enrolled persons to carry cards or any other form of identification when off The Health Plan or its provider’s premises that will identify the person as a member of drug or alcohol services.

The Health Plan or its providers may not acknowledge that a currently or previously enrolled person is receiving or has received alcohol or drug abuse services without the enrolled person’s authorization as provided in this section.

The Health Plan or its providers must respond to any request for a disclosure of the records of a currently or previously enrolled person that is not permissible under this policy or federal

regulations in a way that will not reveal that an identified individual has been, or is being diagnosed or treated for alcohol or drug abuse.

The Health Plan or its providers must advise the person or guardian of the special protection given to such information by federal law.

Release of information concerning diagnosis, treatment or referral from an alcohol or drug abuse program must be made only as follows:

- The currently or previously enrolled person or their guardian authorizes the release of information. In this case:
 - The Health Plan or its providers must advise the person or guardian of the special protection given to such information by federal law;
 - Authorization must be documented on an authorization form which has not expired or been revoked by the patient. The proper authorization form must be in writing and must contain each of the following specified items:
 - The name or general designation of the program making the disclosure;
 - The name of the individual or organization that will receive the disclosure;
 - The name of the person who is the subject of the disclosure;
 - The purpose or need for the disclosure;
 - How much and what kind of information will be disclosed;
 - A statement that the person may revoke the authorization at any time, except to the extent that the program has already acted in reliance on it;
 - The date, event or condition upon which the authorization expires, if not revoked before;
 - The signature of the person or guardian; and
 - The date on which the authorization is signed.
 - Re-disclosure

Any disclosure, whether written or oral, made with the person's authorization as provided above must be accompanied by the following abbreviated written statement:

"Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records."

If the person is a minor, authorization must be given by both the minor and their parent or legal guardian.

If the person is deceased, authorization may be given by:

- A court-appointed executor, administrator or other personal representative;
- If no such appointments have been made, by the person's spouse; or
- If there is no spouse, by any responsible member of the person's family.

Authorization is not required under the following circumstances:

- Medical Emergencies – information may be disclosed to medical personnel who need the information to treat a condition which poses an immediate threat to the health of any individual, not necessarily the currently or previously enrolled person, and which requires immediate medical intervention. The disclosure must be documented in the person’s medical record and must include the name of the medical person to whom disclosure is made and their affiliation with any health care facility, name of the person making the disclosure, date and time of the disclosure and the nature of the emergency. After emergency treatment is provided, written confirmation of the emergency must be secured from the requesting entity;
- Payment and Health Care Operations: The Final Rule allows lawful holders of patient records to re-disclose the minimum amount of information necessary to contractors, subcontractors, and legal representatives for purposes of payment and health care operations. Disclosures to contractors, subcontractors, and legal representatives are not permitted to carry out other purposes, such as activities related to patient diagnosis, treatment, or referral for treatment. The list of the proposed payment and health care operations activities include the following:
 - Billing, claims management, collections activities, obtaining payment under a contract for reinsurance, claims filing and related health care data processing;
 - Clinical professional support services (e.g., quality assessment and improvement initiatives; utilization review and management services);
 - Patient safety activities;
 - Activities pertaining to:
 - The training of student trainees and health care professionals,
 - The assessment of practitioner competencies,
 - The assessment of provider and/or health plan performance, and
 - Training of non-health care professionals;
 - Accreditation, certification, licensing, or credentialing activities;
 - Underwriting, enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care;
 - Third-party liability coverage;
 - Activities related to addressing fraud, waste and abuse;
 - Conducting or arranging for medical review, legal services, and auditing functions;
 - Business planning and development, such as conducting cost-management and planning related analyses related to managing and operating, including formulary development and administration, development or improvement of methods of payment or coverage policies;
 - Business management and general administrative activities, including management activities relating to implementation of and compliance with the requirements of this or other statutes or regulations;
 - Customer services, including the provision of data analyses for policy holders, plan sponsors, or other customers;

- Resolution of internal grievances;
 - The sale, transfer, merger, consolidation, or dissolution of an organization;
 - Determinations of eligibility or coverage (e.g., coordination of benefit services or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - Risk adjusting amounts due based on enrollee health status and member characteristics; and
 - Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges.
- Research Activities – information may be disclosed for the purpose of conducting scientific research according to the provisions of 42 CFR § 2.52;
 - Audit and Evaluation Activities – information may be disclosed to individuals or entities who perform audits and evaluations on behalf of federal, state, and local governments providing financial assistance to, or regulating the activities of, lawful holders as well as 42 CFR Part 2 programs. If disclosures are made to an individual or entity under this section for a Medicare, Medicaid, or CHIP audit or evaluation, including a civil investigation or administrative remedy, further disclosures may be made to the individual's or entity's contractors, subcontractors, or legal representatives to carry out the audit or evaluation.;
 - Qualified Service Organizations – information may be provided to a qualified service organization when needed by the qualified service organization to provide services to a currently or previously enrolled person;
 - Internal Agency Communications - the staff of an agency providing alcohol and drug abuse services may disclose information regarding an enrolled person to other staff within the agency, or to the part of the organization having direct administrative control over the agency, when needed to perform duties related to the provision of alcohol or drug abuse diagnosis, treatment, or referral for treatment to a person. For example, an organization that provides several types of services might have an administrative office that has direct administrative control over each unit or agency that provides direct services; and
 - Information concerning an enrolled person that does not include any information about the enrolled person's receipt of alcohol or drug abuse diagnosis, treatment or referral for treatment is not restricted under this section. For example, information concerning an enrolled person's receipt of medication for a psychiatric condition, unrelated to the person's substance abuse, could be released as provided above in **Section 9.6.4**.
 - Court-ordered disclosures. A State or federal court may issue an order that authorizes an agency to make a disclosure of identifying information that would otherwise be prohibited. A subpoena, search warrant or arrest warrant is not sufficient standing alone, to require or permit an agency to make a disclosure.
 - Crimes committed by a person on an agency's premises or against program personnel. Agencies may disclose information to a law enforcement agency when a person who is receiving treatment in a substance abuse program has committed or threatened to commit a crime on agency premises or against agency personnel. In such instances, the agency must limit the information disclosed to the

circumstances of the incident. It may only disclose the person's name, address, last known whereabouts and status as a person receiving services at the agency.

- Child abuse and neglect reporting. Federal law does not prohibit compliance with the child abuse reporting requirements contained in A.R.S. § 13-3620.

A general medical release form or any authorization form that does not contain all of the elements listed above is not acceptable.

9.7.6 Telemedicine

To ensure confidentiality of telemedicine sessions, providers must do the following when providing services via telemedicine:

- The videoconferencing room door must remain closed at all times;
- If the room is used for other purposes, a sign must be posted on the door, stating that a clinical session is in progress;
- If a recording of the session is made, an authorization, signed by the Member, shall be obtained;
- All videoconferencing equipment shall be set to automatically mute its microphone(s) when answering any incoming calls;
- All videoconferencing equipment shall be set not to automatically answer multipoint calls;
- All videoconferencing equipment with internet access that is used for telemedicine shall be set to not allow remote monitoring; and
- All videoconferencing equipment in rooms used for telemedicine or Member services shall have the camera lens covered and the microphone muted or must be turned off whenever the equipment is not in use.

9.7.7 Security Breach Notification

The Health Plan and its providers, in the event of an impermissible use/disclosure of unsecured PHI, must provide notification to any and all persons affected by the breach in accordance with Section 13402 of the HITECH Act.

Any questions or incidents concerning Member rights, protected health information (PHI) and/or the use and disclosure of such information may be obtained by contacting The Health Plan Compliance Officer at 1-888-788-4408 or by writing to The Health Plan:

Arizona Complete Health – Complete Care Plan
Attn: Compliance Officer
1870 W. Rio Salado, 3A
Tempe, AZ 85281
1-888-788-4408
AzCHPrivacy@azcompletehealth.com

9.7.8 Pledge to Protect Confidential Information

If requested by the AHCCCS Procurement Office, providers must sign a “Pledge to Protect Confidential Information” and abide by the statements addressing the creation, use and disclosure of confidential information, including information designated as protected health information and all other confidential or sensitive information as defined in policy. In addition, if requested, providers must attend or participate in HIPAA training offered by AHCCCS or provide written verification that the provider has attended or participated in job-related HIPAA training that is: (1) intended to make the provider proficient in HIPAA for purposes of performing the services required and (2) presented by a HIPAA Privacy Officer or other person or program knowledgeable and experienced in HIPAA and who has been approved by the ADOA-ASET Arizona State Chief Information Security Officer.

9.8 Fraud, Waste and Program Abuse Reporting

The reporting of suspected fraud and program abuse is a requirement of the Arizona Health Care Cost Containment System (AHCCCS). Under the requirements of the Corporate Compliance Program, and in accordance with A.R.S. §36-2918.01, §36-2932, §36-2905.04 and [ACOM Policy 103](#), The Health Plan, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding all allegations of fraud, waste or abuse (FWA) involving the AHCCCS Program.

Providers must be cognizant of the potential for fraud, waste and abuse within the public health system. Fraud as defined by Federal law and as recognized in the State of Arizona is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.

Individuals and/or entities found to be submitting fraudulent claims for services will be reported to AHCCCS-Office of Inspector General (OIG) and may be subject to an investigation that will lead to an exclusion to participate in any program associated with federal Medicare/Medicaid funding.

Under the federal False Claims Act (FCA) provisions, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries.

In the context of this section of the Provider Manual, persons receiving care in the public health system can also commit acts of fraud, waste and abuse (e.g., by loaning or selling their AHCCCS identification card).

The Health Plan’s providers are responsible for ensuring that mechanisms are in place for the identification, prevention, detection and reporting of fraud, waste and abuse. All employees of providers must be familiar with the types of FWA that could occur during their normal daily

activities. The Health Plan. The Health Plan has designated a Compliance Officer and a Compliance Committee responsible for the development and implementation of the Corporate Compliance Program which addresses FWA prevention, detection, deterrence and reporting.

Under the applicable law of the state of Arizona, a person may not present cause to be presented to this state or to a contractor:

1. A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed.
 2. A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.
 3. A claim for payment that the person knows or has reason to know may not be made by the system because:
 - (a) The person was terminated or suspended from participation in the program on the date for which the claim is being made.
 - (b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.
 - (c) The patient was not a member on the date for which the claim is being made.
- ARS 36-2918

The state may impose civil penalties and assessments or both, pursuant to R9-22-1101. Basis for Civil Monetary Penalties and Assessments for Fraudulent Claims. This Article applies to prohibited acts as described under A.R.S. § 36-2918(A), and submissions of encounters to the Administration. The Administration considers a person who aids and abets a prohibited act affecting any of the AHCCCS programs or Health Care Group to be engaging in a prohibited act under A.R.S. § 36-2918(A).

9.8.2 Methods for Reporting Fraud, Waste and Abuse

The Health Plan providers are required to immediately report all suspected FWA involving any Title XIX/XXI and NTXIX/XXI funds, AHCCCS providers, or AHCCCS Members to the AHCCCS Office of Inspector General (OIG) in writing using the AHCCCS reporting form available at: <https://azahcccs.gov/Fraud/ReportFraud/>, and which may be submitted online, or via the following methods:

Mail: Arizona Health Care Cost Containment System (AHCCCS)
Inspector General
Office of Inspector General (OIG)
801 E. Jefferson St., Mail Drop 4500
Phoenix, AZ, 85034

To Report Provider Fraud:

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

To Report Member Fraud:

- In Maricopa County: 602-417-4193

- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

Email: AHCCCSFraud@azahcccs.gov

Fax: 602-417-4102

Website: <https://azahcccs.gov/Fraud/ReportFraud/>

This includes acts of suspected or confirmed FWA that were resolved internally but involved AHCCCS funds or AHCCCS providers. Failure to comply with the requirement to report suspected FWA may result in the penalty described in A.R.S. § 36-2992.

9.8.3 Reporting Fraud, Waste and Abuse to the Health Plan

In addition to notifying AHCCCS, all providers must immediately notify The Health Plan of all suspected or confirmed FWA. Health Plan providers must report suspected FWA to:

Arizona Complete Health-Complete Care Plan

Attn: Compliance Officer

1870 W. Rio Salado Parkway

Tempe, AZ 85281

Fraud and Abuse Hotline: (866) 685-8664

- Hotline is available 24/7, all calls are confidential and can be made anonymously

Fax Number: (800) 398-6182

Email: AZFWA@centene.com

The public, members, staff, and providers may report FWA cases confidentially and anonymously by submitting information to the above locations.

Providers are required to develop, maintain and publicize a confidential and anonymous reporting process for the public, members, employees and contractors to report FWA.

Once the Health Plan has referred a suspected case of fraud, waste or program abuse to AHCCCS's OIG, the Health Plan will take no action to recoup or otherwise offset any suspected overpayments until AHCCCS provides notice to The Health Plan of the case disposition status.

9.8.4 AHCCCS-OIG Communications

The Health Plan Providers shall report to The Health Plan (ATTN: Vice President, Compliance) and the AHCCCS-Office of Inspector General (OIG), immediately, but within ten (10) days of notification, any and all contact made by AHCCCS-OIG in reference to any open/closed FWA case, a voluntary self-disclosure or settlement, and/or any other type of FWA activity involving official communications by AHCCCS-OIG.

The Health Plan (ATTN: Vice President, Compliance) shall be advised of the final disposition of any case and/or settlement agreement made between a provider and AHCCCS-OIG.

9.8.5 Cooperation with AHCCCS and the Health Plan

Providers must respond timely to all The Health Plan, and AHCCCS-OIG requests for interviews, information, data or documents as a part of any investigation, inquiry, or audit. AHCCCS-OIG may conduct an audit review or investigation on-site without notice and the provider must provide access to all records, documents, and data related to the provider's contract at all times.

Upon request, providers must furnish any and all documents to include original copies, to representatives of The Health Plan and AHCCCS-OIG at no cost. The Health Plan or AHCCCS-OIG will establish the designated timeframe to copy the requested documents, which will not exceed twenty (20 business days, from the date of The Health Plan request.

In addition, providers must verify that all emergent phone calls from The Health Plan to the provider's point of contact are returned within 4 hours; all urgent phone calls returned within one work day and all routine calls are returned within two work days. Providers must verify that all emails sent from Health Plan staff are addressed timely with responses from the provider received within three work days.

9.9 Provider Corporate Compliance Program

9.9.1 Corporate Compliance Plan

Providers must maintain a Corporate Compliance Plan that is reviewed and updated annually. The current Corporate Compliance Plan must be made available to The Health Plan upon request.

The Corporate Compliance Plan must include, at a minimum, the following elements:

- Designated Compliance Officer.
- Provisions of the Deficit Reduction Act of 2007 and the Federal False Claims Act provisions, the administrative remedies for false statements State laws relating to civil or criminal penalties for false claims and statements; and whistleblower protections. Business Ethics and Conduct Policy, including the establishment of Codes of Conduct.
- Establishment of an effective training and education program as a systematic means for educating and training agency employees and subcontractor employees to identify and report suspected waste, fraud and abuse.
- A process to conduct periodic monitoring of claims/encounters, claims medical review and other operations for compliance with laws, regulations and payer requirements, such as conducting periodic internal audits.
- A process for employees to receive information on how to identify and report incidents of suspected waste, fraud and abuse through (The Health Plan's) Ethics and Compliance Hotline.
- Compliance committee to oversee the implementation of an effective compliance program.
- Verify all staff and subcontractor staff have been trained annually regarding fraud, waste, abuse, false claims act, whistleblower protections and State laws relating to civil or criminal penalties for false claims and statements.

9.9.2 Deficit Reduction and Federal False Claims Act

The Health Plan requires all providers to adhere to Deficit Reduction Act (DRA) requirements. The DRA requires that any entity that 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 federal 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. The following are 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 individual 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.
- 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.

9.9.3 Identifying Fraud, Waste and Abuse

Providers must conduct internal monitoring and auditing in accordance with 42 CFR 438.608 and must include elements and audit steps to discover or identify suspected fraud, waste and program abuse within the provider’s organization. Providers must develop and implement a data analytics tool to evaluate encounters/claims data or other administrative data to identify trends or behavior at all system levels that indicate fraud, waste and/or program abuse.

9.9.3.1 ***Additional Requirement for Behavioral Health Specialty Providers and Crisis Providers***

Behavioral health specialty providers and crisis care providers must also contract with an independent auditor to conduct an annual claims review to verify compliance with all State and federal laws, regulations and payer requirements.

9.9.4 **Corporate Compliance Program**

Providers must have a comprehensive Corporate Compliance Program, which meets the requirements in 42 CFR 438.608, supported by other administrative procedures, that is designed to deter, detect and prevent fraud, waste and program abuse. Providers must include, at a minimum, the following:

- Written policies, procedures, and standards of conduct that articulate the organization's commitment to processes for, complying with all applicable federal and State Standards;
- A Corporate Compliance Committee that meets regularly and reports to provider's senior management. The Corporate Compliance Committee members, at a minimum, shall include the Corporate Compliance Officer; staff with experience and expertise in finance and budgets; and other executive staff with the authority to commit resources;
- An effective education and training program for the Corporate Compliance Officer and provider's employees on the detection, prevention and reporting of fraud, waste and program abuse. The training must include the False Claims Act provisions, administrative remedies for false claims and statements, Arizona laws relating to civil or criminal penalties for false claims and statements and the whistleblower protections under such laws.
- A process for the monthly screening of all provider existing staff, potential staff and subcontractors against the List of Excluded Individuals and Entities (LEIE) & The System for Award Management (SAM) formerly known as The Excluded Parties List (EPLS) databases for those that have been debarred, suspended or otherwise excluded as well as any other databases as required/requested by The Health Plan, AHCCCS or Centers for Medicare and Medicaid Services (CMS). All potential staff and subcontractors must be checked before hire and all existing staff and subcontractors must be checked on a monthly basis;
- Unfettered access and open lines of communication between the Corporate Compliance Officer and the provider's employees;
- A mechanism for enforcement of standards through well-publicized disciplinary guidelines;
- In accordance with A.R.S. §36-2918.01 and ACOM Policy 103, have a process to, upon discovery, promptly address and notify The Health Plan and AHCCCS-OIG of any instances of an excluded provider or employee that is, or appears to be, in a prohibited relationship with the Subcontractor (42 CFR 455.17);
- Have a process to confirm the identity and determine the exclusion status of any person with an ownership or control interest in the Contractor and with regard to its fiscal agents, to identify, obtain and report the exclusion status on persons convicted of crimes; and

- Develop and maintain robust internal controls and mechanisms in order to consistently identify, prevent, deter and detect fraud, waste and program abuse that includes the implementation of corrective action plans (42 CFR 438.608).

9.9.5 **Compliance Officer**

Providers must establish written criteria for selecting a Compliance Officer and job description that clearly outlines the responsibilities and authority of the position. The Compliance Officer shall have the authority to assess records and independently refer suspected Member fraud, provider fraud, waste and Member abuse cases to The Health Plan and the AHCCCS-OIG. The Compliance Officer shall not have any title, duties or responsibilities that could constitute a potential or actual conflict of interest. Providers must require the Compliance Officer to be responsible for the following:

- Provide training and ongoing education to employees in identifying and reporting fraud, waste and program abuse.
- Oversee internal and external compliance audits
- Record, track and trend all fraud, waste and abuse related complaints received including those initiated by The Health Plan or a subcontractor, which shall capture and maintain the following information, at a minimum;
 - Contact information of complainant;
 - Name and identifying information of person or entity suspected of fraud, waste and/or program abuse;
 - Date and time complaint was received;
 - Nature of the allegations and summary of concern;
 - Potential estimated dollar loss amount and specific identification of funding source(s) involved;
 - Subcontractor's unique case identifying number;
 - The department or agency in which the complaint has been reported, and
 - Date in which the case was referred to The Health Plan or AHCCCS-OIG.

Providers must ensure the Compliance Officer has complete access to all information, databases, files, records and documents in order to conduct audits and to strategically structure the position to report suspected fraud, waste and program abuse directly The Health Plan and AHCCCS-OIG independently (42 CFR 455.17).

9.9.6 **Other Activities**

The provider must conduct additional activities, such as:

- Regular fraud, waste and abuse awareness activities (i.e. campaigns, newsletters)
- Develop and maintain internal control assessments
- Risk assessments
- The Health Plan responds to and coordinates responses made by the Health Plan Compliance Committee
- Notify The Health Plan of any CMS compliance issues related to HIPAA transactions and code set complaints or sanctions

- Communicate with The Health Plan and AHCCCS OIG on the final disposition of the research and advice of actions, if any, taken by the provider
- Contract with an independent auditor to conduct an annual claims review to verify compliance with all State and federal laws, regulations and payer requirements.

9.10 Encounter Validation Studies

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System (AHCCCS) to conduct encounter validation studies as a condition for receiving federal Medicaid funding. AHCCCS requires The Health Plan to conduct encounter validation studies of their providers.

The purpose of encounter validation studies is to compare recorded utilization information from a clinical record or other source with submitted encounter data. The review “validates” or confirms that covered services are encountered timely, correctly and completely. The purpose of this section is to:

- Inform providers that encounter validation studies may be performed by AHCCCS, The Health Plan and/or AHCCCS staff; and
- Convey the AHCCCS’ expectation that providers cooperate fully with any encounter validation review that AHCCCS, The Health Plan and/or AHCCCS may conduct.

9.10.1 Criteria Used in Encounter Validation Studies

The criteria used in encounter validation studies include timeliness, correctness and omission of encounters, in addition to encountering for services not 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. The Health Plan is required to provide specific information for providers on Timeliness standards;
- **Correctness** - A correct encounter contains a complete and accurate description of a covered behavioral health service provided to a person. 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; and
- **Lack of Documentation** - A description of adequate documentation is referenced in **Section 10.2 – Medical Records Standards**.

In addition, assessment compliance must be monitored by The Health Plan in accordance with **Section 12.5 - Assessment and Service Planning**. Providers may be subject to sanctions for failure to meet the criteria used in encounter audits, which may include timeliness, correctness, and omission of encounters.

9.11 Provider Reporting of Moral Or Religious Objection

Providers must notify The Health Plan if, on the basis of moral or religious grounds, the provider elects not to provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a)(2). If the provider elects not to provide coverage of a covered counseling or referral service pursuant to 42 CFR 438.102(a) (2), the provider is required to make alternative arrangements with another entity to provide the service. A provider must notify The Health Plan prior to entering into a contract or adopting a policy as described above during the term of the provider's contract with The Health Plan. The notification and policy must be consistent with the provisions of 42 CFR 438.10; must be provided to Members during their initial appointment; and must be provided to Members at least thirty (30) days prior to the effective date of the policy.

9.11.1 Provider Responsibilities

Providers must deliver covered services in accordance with the AHCCCS Covered Behavioral Health Service Guide located at

<https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/guidesandmanuals.html>

Providers must document adequate information in the clinical record and submit encounters to The Health Plan. Any audit findings that indicate suspected fraud, waste and/or program abuse must be reported to The Health Plan's Compliance Department.

Section 10 - QUALITY MANAGEMENT REQUIREMENTS

10.1 Advance Directives

An advance directive is a written set of instructions developed by an adult member in the event the member becomes incapable of making decisions regarding their health care. An advance directive instructs others regarding the member's wishes, if they become incapacitated and can include the appointment of a friend or relative to make health care decisions for the member. An adult member prepares an advance directive when competent and capable of making decisions, and the directive is followed when the member is incapable of making treatment decisions. This section outlines the requirements of providers with regard to advance directives (see 42 CFR 489.102).

10.1.1 Health Care Power of Attorney

A health care power of attorney gives an adult member, not under legal guardianship, the right to designate another adult person to make health care treatment decisions on their behalf. The designee may make health care decisions on behalf of the adult member if/when they are found incapable of making these types of health care decisions. However, the designee 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.

See A.R.S. § 36-3281 for additional information regarding a mental health power of attorney and a member who is "found incapable" of making their own health care decisions.

10.1.2 Power and Duties of Designees

The designee:

- May act in this capacity until their authority is revoked by the adult member, a legal guardian 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 health 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 or legal guardian as expressed in the mental health care power of attorney or health care power of attorney. However, if the adult member's wishes are not expressed in a mental health care power of attorney or 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 they believe to be in the adult member's best interest; and
- May consent to admitting the adult member to an Inpatient Facility licensed by the Arizona Department of Health Services if this authority is expressly stated in the mental 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 mental health care power of attorney.

10.1.3 Information Regarding Advance Directives

At the time of enrollment, all adult members, and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in **A.R.S. 36-3231**, must receive the following information regarding advance directives (see **42 CFR § 422.128** and [AHCCCS AMPM, Policy 640](#) Advance Directives):

- The member's rights, in writing, regarding advance directives under state law;
- A description of the applicable state law and information regarding the implementation of these rights;
- The member's right to file grievances 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 conscientious 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.

Written information regarding advance directives shall be provided to members at the time of enrollment with the member handbook. Refer to **The Member Handbook** and [AHCCCS ACOM Policy 404](#) (Member Information) for member information and [AHCCCS ACOM Policy 406](#) (Member Handbook and Provider Directory) for member handbook requirements.

If an adult member is incapacitated at the time of enrollment, providers may give advance directive information to the member's family or surrogate in accordance with state law. Providers must also follow up when the member is no longer incapacitated and verify that the information is given to the member directly.

10.1.4 Assistance with Developing and Executing an Advance Directive

Providers must assist adult members or their legal guardians who are interested in developing and executing an advance directive. Providers must maintain written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. Members must be provided information about formulating advance directives (see [AHCCCS AMPM, Policy 930](#) - Medical Records and Communication of Clinical Information).

For members in an Alternative Home and Community Based setting or a behavioral health residential setting that have completed an advance directive, the document must be kept confidential but be readily available. For example: in a sealed envelope attached to the refrigerator. Staff must have immediate access to executed Advance Directive documents to provide to first responder requests.

Providers shall reference the [AHCCCS AMPM Policy 640](#) (Advance Directives for additional information related to the requirements for providers and what must be disseminated to members upon enrollment and/or as needed).

Additional information regarding advance directives can be obtained by calling The Health Plan Customer Service at 1-866-796-0542.

10.1.5 Other Requirements Regarding Advance Directives

Providers must: (see [AHCCCS AMPM, Policy 640](#))

- Document in the adult member's medical record whether or not the adult member was provided the information and whether an advance directive was executed;
- Not condition provision of care or discriminate against an adult member because of their decision to execute or not execute an advance directive;
- Provide a copy of a member's executed advanced directive or documentation of refusal, to the acute care primary care provider (PCP) for inclusion in the member's medical record; and
- Provide education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care, hospice and personal care, of any advance directives executed by member's to whom they are assigned to provide services.

The above information shall also be provided to a member upon each admission to a hospital or nursing facility and each time the individual comes under the care of a home health agency, hospice or personal care provider. **(42 U.S.C. § 1396a (w) (2))**

9.1.6. Advance Care Planning and End of Life Care Concept

Advance care planning is in relation to the End of Life (EOL) care concept that is an ongoing and in person discussion between a qualified health care professional and the member to (see [AHCCCS AMPM Policy 310-HH](#)):

- Educate the member, legal guardian or designated representatives about the member's illness and the health care options that are readily available;
- Develop a written plan of care that identifies the member's choices for treatment; and
- Share the member's wishes with friends, family and providers.

Advance care planning often results in the development of an executed Advance Directive for the member (see [AHCCCS AMPM Policy 640](#)).

Advance care planning is initiated by the member's qualified health care professional (MD, DO, PA, or NP) for any member that is currently or expected to experience declining health or is diagnosed with a chronic, complex or terminal illness. It is meant to be an ongoing process for the duration of the member's life. Providers must perform the following requirements as part of the EOL care concept when providing services to qualifying members:

- Conduct an in person discussion with the member, legal guardian or designated representative to develop advance care planning;
- Educate the member, legal guardian or designated representative about the member's illness and health care options that are available to assist them to make educated decisions;
- Identify the member's healthcare, psychological, social and spiritual needs;
- Develop a member driven care plan that identifies the member's life goals and choices for care and treatment;
- Share the member's wishes with family, friends and providers;
- Complete an executed Advance Directive;
- Refer to community resources based on the member's needs such as pastoral/counseling services and legal services; and
- Assist the member, legal guardian or designated representative in identifying practical supports to meet the member's needs.

Practical supports are non-billable services provided by a family member, friend or volunteer to assist or perform functions such as housekeeping, personal care, food preparation, shopping, pet care and non-medical comfort measures.

10.2 Medical Record Standards

The purpose of this section is to ensure that providers maintain medical records that document medical needs, changes and the delivery of medically necessary services. Medical records must be complete accurate, accessible and permit systematic retrieval of information while

maintaining confidentiality. Documentation in the medical record facilitates diagnosis and treatment, coordination of care, supports billing reimbursement information, provides evidence of compliance during periodic medical record reviews and can protect practitioners against potential litigation.

The medical record contains clinical information pertaining to a member's physical and behavioral health. Maintaining current, accurate, well organized and comprehensive medical records assists providers in successfully treating and supporting member care. A member may have more than one medical record kept by various health care providers that have rendered services to the member.

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. Medical records must contain documentation of referrals to other providers, coordination of care and transfer of care to other providers.

10.2.1 Adequacy and Availability of Documentation

All 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 providers' contracts with The Health Plan, 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 The Health Plan or AHCCCS, 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 and 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 twenty-four (24) hours of the original request.

A provider's failure to prepare, retain and provide to The Health Plan or 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 The Health Plan.

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 provider as the result of a change of ownership or any other circumstance.

10.2.2 Paper or Electronic Format

Records may be documented in paper or electronic format. A treating provider must sign and date their progress notes after each appointment and/or procedure. A Health Professional must include licensure credentials as part of the signature. 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 person altering the record. Correction fluid or tape is not allowed; and
- If a rubber-stamp signature is used to authenticate the document or 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 and dated appropriately.

Electronic medical records and documentation must require that:

- Safeguards are in use to prevent unauthorized access;
- The date and time of an entry in a medical record is recorded as noted by the computer's internal clock;
- The record is recorded only by personnel authorized to make entries using The Health Plan or its providers' established policies and procedures;
- The record indicates the identity of the person making an entry including credentials; and
- Electronic signatures used to authenticate a document are 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.

Providers must meet all federal electronic health record requirements. The federal government may impose penalties on the provider of service in the form of rate reductions for non-compliance.

10.2.3 Comprehensive Clinical Record

The provider of care must verify the development and maintenance of a comprehensive clinical record for each member. The comprehensive clinical record, whether electronic or hard copy, may contain information contributed by several service providers involved with the care and treatment of a member. This section describes categories of information to be included in a member's comprehensive clinical record: (a) the minimum information; (b) physical health record; (c) the behavioral health record; and (d) information from Community Service Agencies, Home Care Training for the Home Care Client (HCTC) providers and Habilitation providers.

10.2.3.1 Minimum Information

The comprehensive clinical record must include the following to the fullest extent possible:

- Member identification information on each page of the record (i.e., member's name and AHCCCS /CIS identification number);
- Documentation of identifying member information including a member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin and, if applicable, guardian or authorized representative;
- Initial history for the member that includes family medical/behavioral health history, social history and laboratory screenings (the initial history of a member under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member);
- Past medical/behavioral health history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received;
- Current presenting concerns;
- Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) data base prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances;
- Documentation of any review of behavioral health record information by any person or entity (other than members of the clinical team) that includes the name and credentials of the person reviewing the record, the date of the review and the purpose of the review; and
- Identification of other Stakeholder involvement (DES/DDD, Juvenile Probation Officer/ Department of Corrections(DOC), Department of Child Safety(DCS), DES Adult Protective Services (APS), etc.).

10.2.3.2 Physical Health Record

In addition to the minimum information requirements above, the comprehensive clinical record must include the following physical health information:

- Initial history for the member as defined in **section 10.2.3.1**;
- Past medical history for the member as defined in **section 10.2.3.1**;
- Immunization records (required for children; recommended for adult members if available);
- Dental history, if available, and current dental needs and/or services;
- Current problem list;
- Current medications;
- Current and complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) forms (required for all members age 0 through 20 years);
- AHCCCS approved developmental screening tools for children ages 9, 18 and 24 months;
- Documentation in the comprehensive medical record must be initialed and dated by The Health Plan-contracted PCP, to signify review of:
 - Diagnostic information including:
 - Laboratory tests and screenings;
 - Radiology reports;
 - Physical examination notes;
 - Behavioral health information received from the behavioral health provider; and
 - Other pertinent data.
 - Reports from referrals, consultations and specialists;
 - Emergency and urgent care reports;
 - Hospital discharge summaries;
 - Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed;
 - Behavioral health history and behavioral health information received from a Regional Behavioral Health Authority/Managed Care Organization or a Health Plan behavioral health provider who is also treating the member.
- Documentation as to whether or not an adult member has completed advance directives and location of the document;
- Documentation that the PCP responds to behavioral health provider information requests within 10 business days of receiving the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations;
- Documentation related to requests for release of information and subsequent releases, including retaining consent and authorization for medical records as prescribed in **A.R.S. § 12-2297**. HIPAA related documents must be retained for a period of six years per **45 CFR 164.530(j)(2)**;
- Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to other providers, including

behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care;

- Obstetric providers complete a standardized, evidence-based risk assessment tool for obstetrics members (i.e. Mutual Insurance Company of Arizona [MICA] Obstetric Risk Assessment Tool or American College of Obstetricians and Gynecologists [ACOG]). Also, lab screenings for members requiring obstetric care must conform to ACOG guidelines;
- Contact information for the member's assigned Health Home if applicable;
- Ensure each organizational provider of services (e.g. hospitals, nursing facilities, rehabilitation clinics, transportation) maintains a record of the services provided to members including:
 - Physician or providers orders for the service;
 - Applicable diagnostic or evaluation documentation;
 - A plan of treatment;
 - Periodic summary of the member's progress towards treatment goals;
 - The date and description of services provided;
 - Signature/initials of the provider for each service.
- Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established;
- Consideration for professional and community standards and recognized and accepted evidence-based practice guidelines; and
- Require documentation in the member's medical record showing supervision by a licensed professional, who is authorized by the licensing authority to provide supervision, whenever health care assistants or para professionals provide services.

10.2.3.3 ***Behavioral Health Record***

Any information maintained in a behavioral health provider's record must also be maintained in the comprehensive clinical record. For General Mental Health/ Substance Abuse (GMH/SA) and Integrated Health where the provision of behavioral health services is separate from the provision of physical health services, in addition to the minimum information listed above, the following information must be maintained and forwarded for inclusion in the comprehensive clinical record:

Intake Paperwork documentation that includes:

- For members receiving substance abuse treatment services under the Substance Abuse Block Grant (SABG), 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 (See **Section 12.10 - Special Populations**);
- Receipt of the Member Handbook;
- Receipt of the Notice of Privacy Practice; and

- Contact information for the member's primary care provider (PCP), if applicable.

Assessment documentation that includes:

- Documentation of all information collected in the behavioral health assessment, any applicable addenda and required member information (see **Section 12.3 – Referral and Intake Process**, **Section 12.5 - Assessment and Service Planning**, and **Section 6.1 - Enrollment, Disenrollment and Other Data Submission**, [AHCCCS AMPM Policy 580](#), [AHCCCS AMPM Policy 320-O](#), and **AHCCCS Technical Interface Guidelines**)
- Documentation of all information collected in the annual update to the behavioral health assessment including any applicable addenda and updated member information;
- Diagnostic information including psychiatric, psychological and medical evaluations;
- Copy of [AHCCCS AMPM Policy 320-R, Attachment A Notification of Persons in Need of Special Assistance](#) (see **Section 12.11 – Special Assistance for Persons Determined to have a Serious Mental Illness**), as applicable;
- An English version of the assessment and/or service plan if the documents are completed in any language other than English; and
- For members receiving services via telemedicine, copies of electronically recorded information of direct, consultative or collateral clinical interviews.

Treatment and Service Plan documentation that includes:

- The member's treatment and service plan (see **Section 12.5 - Assessment and Service Planning** and [AHCCCS AMPM Policy 320-O](#));
- Child and Family Team (CFT) documentation;
- Adult Recovery Team (ART) documentation; and
- Progress reports or service plans from all other additional service providers.

Progress Note 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 (accurate to all digits of the specific ICD-10/DSM-V code that applies) should be included;
- The date the service was delivered;
- The date and time the progress note was signed;
- The signature and credentials of the staff member that provided the service;
- 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;
- In the event that 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:

- Physician or providers order for the service;
- Applicable diagnostic or evaluation documents;
- A plan of treatment;
- Periodic summary of the member's progress towards treatment goals;
- The date and description of the services provided;
- Signature and credentials of the provider for each service; and
- Medication record, when applicable.

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 for the member; and
- Documentation of any requests for and forwarding of behavioral health record information.

Financial documentation that includes:

- Documentation of the results of a completed Title XIX/XXI screening as required in **Section 12.1 – Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Low Income Subsidy Program**; and
- Information regarding establishment of any copayments assessed, if applicable (see **Section 7.22- Copayments**).

Legal documentation that includes:

- Documentation related to requests for release of information and subsequent releases;
- Copies of any advance directives, health care power of attorney or mental health care power of attorney as defined in **Section 10.1 - Advance Directives**, if applicable including:
 - 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 person 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; and
- Documentation of authorization of any mental health care power of attorney that appoints a designated person 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 **Section 12.7 – General and Informed Consent to Treatment** and **Section 12.8 – Psychotropic Medications: Prescribing and Monitoring**;
- Authorization to disclose information pursuant to **Section 9.6 - Confidentiality**; 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 their legal guardian or authorized representative if applicable (**see Section 8.4 - Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons**).

10.2.3.4 **Requirements for Community Service Agencies (CSA), Home Care Training to Home Care Client (HCTC) Providers and Habilitation Providers**

CSAs, HCTC Provider and Habilitation Provider clinical records must conform 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, HCTC 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 and the time increment;
 - Signature and the date the service was provided;
 - The name, title and credentials of the person providing the service;
 - The member's T/RBHA/Health Plan or CIS identification number and AHCCCS identification number;
 - The Health Plan ensures that services provided by the agency/provider are reflected in the member's behavioral health service plan. CSAs, HCTC Providers and Habilitation Providers must keep a copy of each member's behavioral health service plan in the member's record; and
 - Daily documentation of the service(s) provided and monthly summary of progress toward treatment goals.

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

10.2.4 **Transportation Service Documentation**

For providers that supply transportation services for members using provider employees (i.e. facility vans, drivers, etc.) and providers that use subcontracted transportation services, for non-emergency transport of members, that are not direct employees of the provider (i.e. cab companies, shuttle services, etc.) documentation for the member record must include a summary log of the transportation event received from the transportation provider that includes all elements listed as follows:

- 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 Cost Containment System (AHCCCS) identification number;
- Complete date of service, including month, day and year;
- Complete address of pick up site;
- Complete 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 their refusal to sign and this documentation must be placed into the comprehensive medical record.
- 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.

10.2.5 **PCP Medication Management and Coordination of Care with Behavioral Health Providers**

The Health Plan Primary Care Providers must maintain a medical record that incorporates behavioral health information when received from a behavioral health provider about an assigned member even if the provider has not yet seen the assigned member. In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established.

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 and The Health Plan that the

member should receive care through the behavioral health system for evaluation and/or continued medication management services, providers will assist the PCP with the coordination of the referral and transfer of care. The PCP will document in the medical record the coordination of care activities and transition of care. The PCP must document the continuity of care (See **Section 13.3 - Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers**).

10.2.6 Transition of Medical Records

Transfer of a member's medical records due to transitioning of the member to a new T/RBHA/Health Plan and/or provider (see **Section 13.1 - Transition of Persons** for additional information on Inter-RBHA/MCO transfers) or due to The Health Plan terminating the provider contract, is important to ensure that there is minimal disruption to the member's care and provision of services. The medical record must be transferred in a timely manner that ensures continuity of care.

When a member changes their provider, the member's medical record or copies of it must be forwarded to the new provider within ten (10) business days from receipt of the request for transfer of the medical record.

Federal and State law allow the transfer of 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)**, **45 C.F.R. § 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 (see **Section 9.6. – Confidentiality** for other situations that may require written authorization).

The original provider must send that portion of the medical record that is necessary to the continuing treatment of the member. In most cases, this includes all communication that is recorded in any form or medium and that relates to patient examination, evaluation or behavioral or physical 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, A.R.S. § 36-445, A.R.S. § 36-2402 or A.R.S. § 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. The cost of copying and transmitting the medical record to the new provider shall be the responsibility of the transitioning provider (see [AHCCCS ACOM, Policy 402](#)).

10.2.7 Medical Record Audits

The Health Plan will conduct routine medical record audits to assess compliance with established standards and audit tools in accordance with The Health Plan Provider Manual, AMPM, ACOM, Arizona Administrative Code and AHCCCS contract requirements. Medical records may be requested when The Health Plan or AHCCCS are conducting audits or

investigating quality of care issues. Providers must respond to these requests within seven (7) days. Medical records must be made available to AHCCCS for quality review upon request.

The Health Plan utilizes a collaborative and transparent audit approach with providers. For behavioral health providers, medical record reviews are conducted by The Health Plan on at least an annual basis per [AHCCCS AMPM Policy 920](#). For PCPs, Pediatricians and OB/GYNs medical records are conducted under the Arizona Association of Health Plans (AzAHP). AzAHP serves as an association of contracted AHCCCS health plans.

The following methodologies are utilized:

- Medical record reviews are conducted using standardized audit tools that have been reviewed and approved by AHCCCS;
- Medical record reviews are conducted a minimum of every three years;
- A collaborative approach is utilized (use of a vendor by AzAHP) that will result in only one medical record review for each provider;
- Results of the medical record review are available to all AHCCCS Health Plans who utilize AzAHP for this process and that contract with the audited provider;
- Deficiencies identified during the reviews are shared with all AzAHP AHCCCS Health Plans contracted with the provider;
- If quality of care issues are identified during the AzAHP medical review process, all health plans that contract with that provider will be notified promptly (within 24 hours) in order to conduct an independent on-site provider audit;
- Providers to be included in the AzAHP medical record review process shall include all PCPs that serve children (children defined as under 21 years of age) and obstetricians/gynecologists. The review process will include the following, unless a different methodology is reviewed and approved by AHCCCS:
- The review process consists of reviewing a maximum of eight charts per practitioner;
 - If the score after a maximum of eight charts is less than 90% Minimum Performance Standard (MPS) overall, technical assistance is provided to the practitioner by an assigned health plan and a corrective action plan (CAP) is issued to address any individual indicators that fell below 90% MPS. Assigned Provider Engagement Specialist will assist the provider in developing the CAP;
 - If the score after a maximum of eight charts is less than 90% MPS overall, the practitioner shall also be re-audited the following contract year; and
 - If the score after a maximum of eight charts is 90% MPS overall or greater, technical assistance is still provided to the practitioner by an assigned health plan on individual indicators that fell below 90% MPS.
- For PCPs that only treat adults, the following process will occur unless a different methodology is reviewed and approved by AHCCCS:
 - A random sample of 30 providers per Geographic Service Area (GSA) will be audited each year. A maximum of eight charts will be audited per provider;
 - If the score after a maximum of eight charts is less than 90% Minimum Performance Standard (MPS) overall, technical assistance is provided to the

practitioner by an assigned health plan and a corrective action plan (CAP) is issued to address any individual indicators that fell below 90% MPS. Assigned Provider Engagement Specialist will assist the provider in developing the CAP;

- If the score after a maximum of eight charts is less than 90% MPS overall, the practitioner shall also be re-audited the following contract year; and
- If the score after a maximum of eight charts is 90% MPS overall or greater, technical assistance is still provided to the practitioner by an assigned health plan on individual indicators that fell below 90% MPS.

Behavioral health providers must send copies of any information maintained in their own behavioral health record that must also be maintained in the comprehensive clinical record.

10.2.8 Disclosure of Records

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

Per AHCCCS requirement and Arizona Administrative Code (R9-22-512 (E)):

- A provider shall furnish records requested by AHCCCS or The Health Plan at no charge.

Health records must be maintained as confidential and must only be disclosed according to the following provisions:

- When requested by a member's behavioral health provider, primary care provider or the member's DES/DDD/ALTCS support coordinator, the member's health record or copies of health record information must be forwarded within ten (10) business days of the request. The response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit and recent hospitalizations (see **Section 13.3 – Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers and AHCCCS AMPM, Policy 940** for more information).
- Providers must obtain consent and authorization to disclose protected health information in accordance with **42 CFR 431, 42 CFR part 2, 45 CFR parts 160 and 164 and A.R.S. § 36-509**. Unless otherwise prescribed in federal regulations or statute, it is not necessary to obtain a signed release in order to share health related information with the member's parent/legal guardian, behavioral health provider, primary care provider (PCP), The Health Plan Health Coordinator acting on behalf of the PCP or authorized state social service agency.

AHCCCS or its designee may inspect Title XIX/XXI medical records at any time during regular business hours at the offices of AHCCCS, The Health Plan or its providers. The Department of Economic Security, Division of Developmental Disabilities (DES/DDD) or its designee may inspect the medical records of their enrolled Title XIX, Title XXI, and DES/DDD Arizona Long Term Care Services (ALTCS) members at any time during regular business hours at the offices of AHCCCS, The Health Plan or its providers.

The Health Plan has the discretion to obtain a copy of a member's medical records without written approval by the member if the reason for such request is directly related to the administration of service delivery. Furthermore, The Health Plan has the discretion to release information related to fraud and abuse so long as protected HIV-related information is not disclosed (see **A.R.S. § 36-664**) and substance abuse information is only disclosed consistent with federal and state law, including but not limited to **42 CFR 2.1, et seq.**

Additionally, providers must provide each member who makes a request one copy of their medical record free of charge annually.

Upon request, providers must allow members to view and amend their medical record as specified in **45 C.F.R. § 164.524, 45 C.F.R. § 164.526 and A.R.S. § 12-2293** and must have policies in place indicative of such.

10.2.9 Medical Record Maintenance

All providers must retain the original or copies of a member's 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 Health Plan or a provider; and
- For a child, either for at least three (3) years after the child's eighteenth (18th) birthday or for at least six (6) years after the last date the child received medical or health care services from The Health Plan or a provider, whichever occurs later.

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

10.3 Member Surveys

This policy is intended for contracted providers that deliver covered services to eligible persons. The information collected from the surveys is used to design quality improvement activities

10.3.1 Member Satisfaction Survey

As requested by the Health Plan, providers shall participate in member satisfaction surveys in accordance with the Statewide Consumer Survey protocol [42 CFR §438.10] and [A.A.C R9-22-522 (B) (1) and (5)]. For these surveys:

- The Health Plan may conduct surveys or authorize a third party to conduct surveys of a representative sample of the membership and providers.
- The Health Plan may provide the survey tool or require the providers to develop the survey tool, which shall be approved in advance.
- The results of the surveys will become public information and available to all interested parties on the Health Plan website. Providers may be required to participate in workgroups and efforts that are initiated as a result of the survey results.
- Providers shall participate in additional surveys requested by the Health Plan

10.3.2 Additional Member Surveys

In addition to the Member Satisfaction Survey addressed above, providers shall perform annual, general or focused member surveys. For these surveys:

- The Health Plan may conduct surveys of a representative sample of the membership and providers.
- The Health Plan may provide the survey tool or require the providers to develop the survey tool, which shall be approved in advance.
- A scope of work and a timeline for the survey project is submitted if the survey is not initiated by The Health Plan. The Health may require inclusion of certain questions.
- Data, results and the analysis of the results is submitted to The Health Plan within 45 days of the completion of the project.
- Providers shall bear all costs associated with the survey.
- Note that surveys may include Home and Community Based Services Member experience surveys, Health Effectiveness Data and Information Set (HEDIS) Experience of Care Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys.
- Survey findings may result in the provider being required to develop a corrective action plan (CAP) to improve any areas noted by the survey or a requirement to participate in workgroups and efforts as a result of the survey results. Failure of the provider to develop a Corrective Action Plan (CAP) and improve the area may result in regulatory action.

10.4 Performance Improvement Projects

10.4.1 Purpose

The Health Plan is committed to establishing high quality services. One method for achieving this is through adherence to the standards and guidelines set by the Centers for Medicare and Medicaid Services (CMS) and AHCCCS, which includes implementation of performance improvement projects (PIP) specific to member needs and data identified through internal/external surveillance of trends (42 CFR 438.240; AM/PM Section 980). PIP methodologies are developed according to CMS and AHCCCS requirements. This policy provides information regarding the responsibilities of The Health Plan and providers in implementing and reporting PIPs as required by CMS or AHCCCS, or The Health Plan topics approved by AHCCCS.

10.4.2 General Information about Performance Improvement Projects

A Performance Improvement Project (PIP) is a systematic, standardized process designed to identify, plan and implement system interventions through ongoing measurement and intervention to:

- Improve the quality of care and services provided to members;
- Evaluate and monitor the effectiveness of system interventions and data on an ongoing basis; and

Result in significant performance improvement sustained over time.

PIPs are designed to achieve two primary goals. The first goal is to demonstrate achievement and sustainment of improvement for significant aspects of clinical care and non-clinical services, with the expectation of improved health outcomes and member satisfaction. A second goal is to correct significant systemic issues.

A clinical study topic would be one for which outcome indicators measure a change in behavioral or physical health acute or chronic conditions, health status or functional status; high risk services; or continuity and coordination of care. A non-clinical or administrative study topic would be one for which indicators measure changes in availability, accessibility and adequacy of the service delivery system, cultural competency of service, inter-personal aspects of care, and appeals, grievances or complaints.

PIP topics may come to the attention of AHCCCS in part through data from the AHCCCS functional areas (e.g.: network, medical director's office); statewide contractor performance data and contract monitoring activities; tracking and trending of grievance and appeal data and quality of care concerns; provider credentialing and profiling as well as other oversight activities, such as chart reviews; Quality Management/Medical Management data analysis and reporting; and member and/or provider satisfaction surveys and feedback.

The Health Plan providers play an integral role in the implementation of AHCCCS PIPs. When applicable, contracted providers are expected to collaborate with The Health Plan, other providers, stakeholders, and community members to identify, plan and implement recommended improvement strategies that are developed as a result of an identified performance improvement project.

Specific information concerning current PIPs can be found in the AHCCCS and The Health Plan Quality Management Plans and AHCCCS Utilization Management Plans. The process for carrying out a PIP is documented in the AHCCCS Medical Policy Manual (AMPM), Section 980. The Health Plan and its providers will utilize a Plan-Do-Study-Act (PDSA) cycle, to test changes (interventions) quickly and refine them as necessary. It is expected that this process will be implemented in as short a time frame as practical based on the PIP topic. The process for carrying out a PIP is documented in the [AHCCCS AMPM, Section 980, Exhibit 980-1](#), Protocol for Conducting Performance Improvement Projects (PIP), including steps:

- i. Plan: Plan the change(s) or intervention(s), including a plan for collecting data. State the objective(s) of the intervention(s).
- ii. Do: Try out the intervention(s) and document any problems or unexpected results.
- iii. Study: Analyze the data and study the results. Compare the data to predictions and summarize what was learned.
- iv. Act: Refine the change(s)/intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).
- v. Repeat: Continue the cycle as new data becomes available until improvement is achieved.

All Performance Improvement Projects conducted by The Health Plan and its providers must use the Performance Improvement Project reporting templates included in the AHCCCS AMPM, Section 980-2.

10.5 Evidenced Based Practices and Practice Protocols

Evidenced Based Practices are interventions recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of care health professionals; and the unique needs, concerns and preferences of the person receiving services

(AHCCCS Contract General Requirements Exhibit 1-Definitions). Clinical practice guidelines are systematically developed statements to assist practitioners and member decisions about appropriate health care for specific circumstances.

Providers must ensure they coordinate and provide member access to quality health care services, regardless of type, amount, duration, scope, service delivery method and population served, that are informed and supported by evidence-based practice guidelines; will reasonably prevent injury and result in improved health outcomes; and are cost effective (AHCCCS Contract General Requirements 4.2.1 & 10.1.2.2). The delivery of services should be consistent with values, principles and goals of effective, innovation promoting, evidence-based practices. (AHCCCS Contract System Values and Guiding Principles 1.2). Providers should complete member service plans with written descriptions of all covered health services and other informal supports which reflect applicable evidence-based practice guidelines (AHCCCS Contract System Values and Guiding Principles 1.2).

10.5.1 Evidenced Based Practices and Protocols

The Health Plan and providers must ensure the following:

- Monitor, at a clinical and system level, each individual's health status and service utilization to determine use of evidence-based care and ensure all services to members are consistent with acuity, and evidenced-based outcome expectations (AHCCCS Contract Care Management 5.1);
- Review Clinical Practice Guidelines annually to determine that they remain applicable and reflect the best practice standards, 42 CFR 438.236 (b) (AHCCCS Contract Practice Guidelines 8.9);
- Ensure PCP providers treating members with anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD) are aware of clinical tool kits available in the AHCCCS AMPM and/or are utilizing other recognized, clinical tools/ evidenced-based guidelines. Also have a monitoring process in place to ensure that evidence-based guidelines/recognized clinical tools are used when prescribing medications to treat depression, anxiety, and ADHD (AHCCCS Contract 4.13.2).
- Behavioral health providers should receive training on the AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff person's hire date (protocol training is only required if pertinent to populations served) (<https://www.azahcccs.gov/> ; AHCCCS AMPM Policy 1060).

Providers are required to also verify all services are performed in accordance and in compliance with State Clinical and Recovery Practice Protocols and any revisions or additions to the State Clinical and Recovery Practice Protocols.

Providers must adopt and implement the following practices as appropriate:

- AHCCCS Clinical Practice Protocols with required service expectations selected by AHCCCS for targeted implementation on an annual basis; and incorporated by reference into the Agreement at <https://www.azahcccs.gov/>
- American Society of Addiction Medicine Patient Placement Criteria (ASAM) <http://www.asam.org/>
- [AHCCCS Covered Service Guide](#)

- American Psychiatric Association
<https://www.psychiatry.org/>
- Substance Abuse Mental Health Services Administration (SAMHSA)
<http://www.samhsa.gov/>

10.5.2 Dissemination of Evidenced Based Practices and Protocols

The Health Plan and providers shall disseminate to members and potential members upon request, Clinical Practice Guidelines based on valid and reliable clinical evidence or a consensus of health care professionals in the field that considers member needs, 42 CFR 438.236 (c) (AHCCCS Contract Practice Guidelines 8.9). Providers must be able to provide a basis for consistent decisions for utilization management, member education, coverage of services and other areas to which the guidelines apply, 42 CFR 438.236 (d) (AHCCCS Contract Practice Guidelines 8.9; AHCCCS Contract Drug Utilization Review 8.15).

10.5.3 Monitoring for Effectiveness

The effectiveness of AHCCCS Clinical Practice Protocols and Evidenced Based Practices are monitored by The Health Plan and contracted providers in the following ways:

- Monitor required service expectations selected by AHCCCS for targeted implementation annually using The Health Plan approved tools and methodologies as requested;
- Identify new or enhanced interventions that will be implemented in order to bring performance up to at least minimum level established by AHCCCS including evidence-based practices that will be effective in the same/similar populations (AHCCCS AMPM Policy 970.2.ii);
- Participate in the monitoring of the effectiveness of other Evidenced Based Practices using monitoring processes and methodologies approved by The Health Plan and AHCCCS and developed in collaboration with The Health Plan and AHCCCS;
- Implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance ([AHCCCS AMPM Policy 980](#)).

10.6 Peer Review

Peer Review Committee (PRC) scope includes member treatment concerns where there is evidence that a provider has not met standard of care, or there was omission of care or services by a participating or non-participating health care professional or provider whether delivered in or out of state. The Chief Medical Officer may, at their discretion, refer other cases and/or practitioner reviews to the PRC for evaluation and corrective action recommendation. All Peer Review proceedings are protected by statute from discovery in any legal proceeding. Any correspondence pertaining to a peer review is labeled “Privileged and Confidential, Peer Review” thus maintaining the protection under applicable State and Federal laws. Adverse actions taken as a result of the Peer Review Committee must be reported to AHCCCS within 24 hours of an adverse decision being made. The Health Plan also must implement recommendations made by the AHCCCS Peer Review Committee. Some AHCCCS Peer Review recommendations may be appealable agency actions under State law. A The Health Plan provider may appeal such a decision through the administrative process described in A.R.S. § 41-1092, et seq.

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;
- Trends of over or under utilization of services;
- Information from fraud and abuse investigations by AHCCCS;
- Physical, psychological, verbal, 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.

The Peer Review Committee, using their clinical judgment, is responsible for making recommendations to the Chief Medical Officer. The assigned lead reviewer for each case gives a clinical summation of the case and highlights any points of concern or discussion to the committee. The peer review process ensures that providers of the same or similar specialty participate in the review. If the PRC requires additional information prior to making a determination, the case is pended and information is obtained for review at a future PRC. The Peer Review Committee must determine appropriate action and next steps. The Chief Medical Officer is responsible for implementing all peer review actions.

Within 15 calendar days of the PRC meeting, the reviewed provider will receive a written notification informing them of the outcome of the review including corrective action and timeframes for completion if applicable. This letter will also notify provider of the procedure for provider appeals and hearings related to peer review committee. Providers are informed in the written notification that any appeal must be received within 30 days of receipt of the notification. The provider is entitled to an opportunity for a hearing in the event the PRC recommends corrective action(s) for reasons relating to the competence or professional conduct of the provider, or in the event the provider is entitled by law to an opportunity for a hearing. The Procedure for Provider appeals and hearings related to Peer Review corrective actions is the same as that outlined in the Credentialing Practitioner Appeal Hearing Process. Upon completion of the corrective actions and satisfactory behavioral changes by the provider, the provider is notified of completion in writing. If the Peer Review Committee review results in a recommendation for termination of a provider, the recommendation is presented to the Credentialing Committee for final determination. Reviews resulting in the reduction, suspension, or termination of a provider's participation are reported to appropriate boards, regulatory agencies and the National Practitioner's Data Bank.

10.7 Quality of Care Concerns

The Quality Management department responds to quality of care concerns received from Members and providers or issues identified during routine clinical review of Members' care, or received from anywhere within The Health Plan or from anywhere in the community. If substantiated as a true quality of care issue, the concern will be tracked and trended or may be forwarded to the Peer Review Committee. Summary information on quality of care reviews is furnished to the Credentialing Committee at the time of the providers' re-credentialing. All of these activities concerning provider information may be used for future Performance Improvement Projects.

10.7.1 Documentation Related to Quality of Care Concerns

Quality of Care (QOC) concerns may be referred by State agencies, internal AHCCCS sources (e.g., Customer Service, the Office of the Deputy Director), and external sources (e.g., Members; providers; other stakeholders; Incident, Accident, and Death reports).

Upon receipt of a QOC concern, The Health Plan follows the procedures below.

First, The Health Plan documents each issue raised, when and from whom it was received, and the projected time frame for resolution. The Health Plan then promptly determines whether the issue is to be resolved through one or more of the following operational areas: Quality of Care; Customer Service; Grievance and Appeal process; and/or Fraud, waste, and program abuse.

The Health Plan then acknowledges receipt of the issue and explains to the Member or provider the process that will be followed to resolve the issue through written correspondence. If the issue is being addressed as other than a QOC investigation, The Health Plan explains to the Member or provider the process that will be followed to resolve their issue using written correspondence. QOC related concerns remain with the Quality Management department due to 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.

The Health Plan assist the Member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue. The Health Plan ensures the confidentiality of all Member information and informs the Member or provider of all applicable mechanisms for resolving the issue.

The Health Plan documents all processes (including detailed steps used during the investigation and resolution stages) implemented to verify complete resolution of each issue, including but not limited to the following:

- Corrective action plan(s) or action(s) taken to resolve the concern;
- Documentation that education/training was completed (including but not limited to in-service training objectives and attendance sheets, and
- New policies and/or procedures.

Finally The Health Plan documents all follow-up with the Member that includes, but is not limited to: assistance as needed to verify that the immediate health care needs are met, and a closure/resolution letter that provides sufficient detail to verify all covered, medically necessary

care needs are met and a contact name/telephone number to call for assistance or to express any unresolved concerns.

10.7.2 Process of Evaluation and Resolution of Quality of Care Concerns

The quality of care concern process at The Health Plan 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 must be a standalone process and shall not be combined with other agency meetings or processes.

The Health Plan 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.
- 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 determinations should be used for each allegation in a QOC concern:

- **Substantiated** – The alleged complaint (allegation) or reported incident was verified or proven to have happened based on evidence and had a direct effect on the quality of the Members health care. Substantiated allegations require a level of intervention such as a corrective action plan of steps to be taken to improve the quality of care or service delivery and/or to verify the situation will not likely happen again.
- **Unable to Substantiate** – There was not enough evidence at the time of the investigation to show whether a QOC allegation did occur or did not occur. The

evidence was not sufficient to prove or disprove the allegation. No intervention or corrective action is needed or implemented.

- **Unsubstantiated** – There was enough credible evidence (preponderance of evidence) at the time of the investigation to show that a QOC allegation did not occur. The allegation is based on evidence, verified or proven, to have not occurred. No intervention or corrective action is needed or implemented.

The Health Plan, as an active participant in this process, will use the following to determine the level of severity of the quality of care issue:

- **Level 0 (Track and Trend Only)** – An issue no longer has an immediate impact and has little possibility of causing, and did not cause, harm to the recipient and/or other recipients, an allegation that is unsubstantiated or unable to be substantiated when the QOC is closed.
- **Level 1** – Concern that MAY potentially impact the Member and/or other Members if not resolved.
- **Level 2** – Concern that WILL LIKELY impact the Member and/or other Members if not resolved promptly.
- **Level 3** – Concern that IMMEDIATELY impacts the Member and/or other Members and is considered potentially life threatening or dangerous.
- **Level 4** – Concern that NO LONGER impacts the Member. Death or an issue no longer has an immediate impact on the Member, an allegation that is substantiated when the QOC is closed.

The Health Plan, as an active participant in the process, will report issues to the appropriate regulatory agency including Adult Protective Services, AHCCCS, Department of Child Safety, the Attorney General's Office, or law enforcement for further research/review or action. Initial reporting may be made verbally, but must be followed by a written report within one business day.

Cases are referred to the Peer Review Committee when appropriate. Referral to the Peer Review Committee shall not be a substitute for implementing interventions. (See **Section 10.6, Peer Review**)

The Health Plan, as an active participant in the process, must notify AHCCCS of any adverse action taken against a provider.

Upon receiving notification that a health care professional's organizational provider or other provider's affiliation with their network is suspended or terminated as a result of a quality of care The Health Plan, as an active participant in the process, is required to notify AHCCCS of the same.

The Health Plan, as an active participant in the process, is expected to submit a closing letter to AHCCCS. These letters will include the following:

- A description of the issues/allegations, including new issues/allegations identified during the investigation/review process,
- A substantiation determination and severity level for each allegation

- An overall substantiation determination and level of severity for the case.
- Written response from or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or medical examiner.

10.7.3 Tracking/Trending of Quality of Care Issues

The Health Plan uses data pulled from the QOC database to monitor the effectiveness of QOC-related activities to include grievances and allegations received from Members and providers, as well as from outside referral sources. The Health Plan, as an active participant in the QOC process, also tracks and trends QOC data and reports trends and potential systemic problems to AHCCCS.

The data from the QOC database will be analyzed and evaluated to determine any trends related to the quality of care or service in The Health Plan's service delivery system or provider network, and aggregated for AHCCCS. When problematic trends are identified through this process, The Health Plan will incorporate the findings in determining systemic interventions for quality improvement. The Health Plan, as an active participant in the QOC process, also incorporates trended data into systemic interventions.

As evaluated trended data is available, The Health Plan 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 Chairperson of the Quality Management Committee.

Quality tracking and trending information from all closed quality of care issues within the reporting quarter will be submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/DHCM/CQM) utilizing the Quarterly Quality Management Report. The report will be submitted within 45 days after the end of each quarter and will include the following reporting elements:

- Types and numbers/percentages of substantiated quality of care issues
- Interventions implemented to resolve and prevent similar incidences, and
- Resolution status of "substantiated", "unsubstantiated" and "unable to substantiate" QOC issues.

If a significant negative trend is found, The Health Plan 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.

The Health Plan will submit to AHCCCS Clinical Quality Management all pertinent information regarding an incident of abuse, neglect, exploitation, serious incident (including suicide attempts) and unexpected death (including all unexpected transplant deaths) as soon as The Health Plan becomes aware of the incident, and no later than 24 hours. 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 The Health Plan. As The Health Plan receives delayed autopsy results, it will use them to confirm the resolution of the QOC concern. If the cause and manner of death gives reason to change the findings of the QOC concern, The Health

Plan will notify AHCCCS and resubmit a revised resolution report. The Health Plan will also revise closing letters to AHCCCS if the cause and manner of death changes the findings of a QOC investigation.

The Health Plan, as an active participant in the QOC process, must verify 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, grievance and appeals, allegations of abuse, neglect, exploitation grievances and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with 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.

10.7.4 Provider-Preventable Conditions

If a Health Care Acquired Condition (HCAC) or Other Provider-Preventable Condition (OPPC) is identified, The Health Plan will conduct a quality of care investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

All Health Care Acquired Conditions and Other Provider-Preventable Conditions are reported to the AHCCCS Quality Management Team on a quarterly basis.

10.8 Medical Institution Reporting of Medicare Part D

Medicare eligible Members, including persons who are dually eligible for Medicare (Title XVIII) and Medicaid (Title XIX) receive Medicare Part D prescription drug benefits through Medicare Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA- PDs). Medicare Part D coverage includes copayment and coinsurance requirements. However, Medicare Part D copayments are waived when a dual eligible person enters a Medicaid funded medical institution for at least a full calendar month. The facility must notify the Arizona Health Care Cost Containment System (AHCCCS) when a dual eligible person is expected to be in the medical institution for at least a full calendar month to verify copayments for Part D are waived. See **AHCCCS ACOM Policy 201, Attachment A Notification to Waive Medicare Part D Co-Payments for Members in a Medicaid Funded Medical Institution**. The waiver of copayments applies for the remainder of the calendar year, regardless of whether the person continues to reside in a medical institution. Given the limited resources of many dual eligible persons and to prevent the unnecessary burden of additional copay costs, it is imperative that these individuals are identified as soon as possible.

The objective of this policy is to inform providers designated as medical institutions of reporting and tracking requirements for dual eligible persons to verify Medicare Part D copays are waived.

10.8.1 Reporting Requirements

To verify that dual eligible persons' Medicare Part D copayments are waived when it is expected that dual eligible persons will be in a medical institution, funded by Medicaid, for at least a full calendar month, the facility must notify AHCCCS immediately upon admittance.

Reporting must be done using BHS Policy Form 1701.1: AHCCCS Notification to Waive Medicare Part D Copayments for Members in a Medical Institution That Is Funded by Medicaid. Providers must not wait until the person has been discharged from the medical institution to submit the form. Reporting must be done on behalf of the following:

- Persons who have Medicare Part “D” only;
- Persons who have Medicare Part “B” only;
- Persons who have used their Medicare Part “A” lifetime inpatient benefit; and
- Persons who are in continuous placement in a single medical institution or any combination of continuous placements that are identified below.

Medical institutions include the following providers:

- Acute Hospital
- Psychiatric Hospital – Non-Institute of Mental Disease
- Psychiatric Hospital – Institute of Mental Disease
- Residential Treatment Center – Institute of Mental Disease
- Residential Treatment Center – Non- Institute of Mental Disease
- Skilled Nursing Facility

Additional information regarding Medicare cost sharing for members covered by Medicare and Medicaid can be found in [AHCCCS ACOM, Policy 201](#).

10.9 Seclusion and Restraint Reporting

Seclusion and restraint are high-risk interventions that must be used to address emergency safety situations only when less restrictive interventions have been determined to be ineffective, in order to protect Members, staff members or others from harm. All persons have the right to be free from seclusion and restraint, in any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Seclusion or restraint may only be imposed to ensure the immediate physical safety of the person, a staff member or others and must involve the least restrictive intervention, and be discontinued at the earliest possible time (42 CFR §482.13).

This section includes seclusion and restraint reporting requirements for contracted behavioral health inpatient facilities (42 CFR §482.13) (A.A.C. R9-21) and behavioral health inpatient facilities serving persons under the age of 21 (42 CFR §483 Subpart E).

10.9.1 Additional Information

- Trauma associated with seclusion and restraint can trigger Post Traumatic Stress Disorder;
- Each state has a designated protection and advocacy system. In Arizona, the Arizona Center for Disability Law serves as the designated protection and advocacy agency;
- R9-21-204 require that all staff members and medical professionals involved in ordering, providing, monitoring or evaluating seclusion or restraint complete and document education and training to include: understanding behavioral and environmental risk

factors, nonphysical interventions, the safe use of seclusion or restraint and responding to emergency situations;

- In 2003, the Substance Abuse and Mental Health Services Administration (SAMHSA) published the Roadmap to Seclusion and Restraint Free Mental Health Services. Developed by administrations, experts and Members, the training is a resource for mental health service direct care staff, administrators, and Members on alternatives to the use of seclusion or restraint, as well as a tool for mental health system transformation;
- A staff member employing any method that results in a person either being precluded from exiting an area in fact or left with the reasonable belief of being prohibited from being able to exit freely (for example – a staff member’s use of their body to block an individual’s exit from a specified area) constitutes seclusion, R9-21-101.B.56;
- A.R.S. § 36-513 and A.R.S. § 36-528 require that a person under emergency detention or court ordered evaluation may not be treated without consent, except that pharmacological restraint may be used to protect the safety of that person and others in an emergency. Therefore, psychiatric medications given involuntarily to persons under emergency detention or court ordered evaluation must be considered chemical restraint and documented as such;
- 42 CFR 482.13 clarifies that a drug or medication used as a restraint is not a standard treatment or dosage for a Member’s condition. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN); and
- The Health Plan is also required to collect certain aggregate data that compiles total seclusion and restraints for the reporting period, and forward that data to the State.

10.9.2 Reporting to The Health Plan

Contracted behavioral health inpatient facilities shall follow local, state and federal regulations and requirements related to seclusion and restraint.

Contracted behavioral health inpatient facilities authorized to use seclusion and restraint shall report the following to The Health Plan:

- Each occurrence of seclusion and restraint to The Health Plan within five (5) calendar days of the occurrence, via email AzCHQualityManagement@azcompletehealth.com, attention Quality Management. Failure to submit seclusion and restraint reports timely may result in a financial sanction for late submission of a contract deliverable.
- Reports of seclusion and restraint are to be submitted using **Provider Manual Form 9.9.1 Seclusion and Restraint Reporting Form** which can be obtained from the Provider Services Call Center at 866-796-0542.
- The **Provider Manual Form 9.9.1, Seclusion and Restraint Reporting Form** must be completed in its entirety and include the required information detailed on AHCCCS Policy Attachment 1702A.
- In the event that a use of seclusion or restraint requires face-to-face monitoring, a report detailing face-to-face monitoring must be completed using the **Provider Manual Form 9.9.1, Seclusion and Restraint Reporting Form** or attached to the reporting form.

The face-to-face monitoring form must include the requirements as per 42 CFR 482.13, 42 CFR § 483 Subpart 12, and R9-21-204.

- The Health Plan may also request copies of provider agency Policies and Procedures pertaining to the use of seclusion and restraint, evidence of staff trainings, and any corrective actions taken to reduce the frequency of usage.

Providers are directed to call the Provider Service Center to obtain a copy of these forms, if needed, at 1-866-796-0542.

10.9.3 Reporting a Serious Occurrence or Death

Because of the high-risk nature of seclusion and restraint interventions, it is possible that a person may be injured or that a serious occurrence may occur during a seclusion and restraint event.

Contracted behavioral health inpatient facilities authorized to use seclusion and restraint shall report any occurrence of injury or serious occurrence during a seclusion and restraint following the guidelines in **Section 10.10 - Reporting of Incidents, Accidents and Deaths**.

Behavioral health inpatient facilities must be aware of what constitutes an event that requires reporting to the following entities:

The Health Plan

Behavioral health inpatient facilities must report any incident, accident or death that pertain to the following, of an enrolled Member to The Health Plan within 2 business days, following the guidelines in **Section 10.10 – Reporting Of Incidents, Accidents and Deaths**.

AHCCCS

Licensed behavioral health inpatient facilities are required to report a serious occurrence, including a death, following a seclusion and/or restraint event, to AHCCCS no later than one working day following the serious occurrence. Staff must document in the person's record and in the incident/accident report log that the serious occurrence was reported to AHCCCS, and include the names of the individuals who received the report. For reporting of serious occurrences:

- AHCCCS: fax number 602-417-4162 Attention DHCM Senior Clinical and Quality Consultant.

ADHS Division of Licensing

Licensed behavioral health inpatient facilities must notify the ADHS Division of Licensing within one working day of discovering a serious occurrence that requires medical services, or death that occurs as a result of a seclusion and/or restraint. This notification must be followed up by a written ADHS Division of Licensing report within five days of initial notification. Reporting to ADHS Licensing would not utilize the QMS Portal or the AHCCCS Incident, Accident, Death report form.

Arizona Center for Disability Law (ACDL)

Licensed behavioral health inpatient facilities are required to report a serious occurrence, including a death, following a seclusion and/or restraint event, to The ACDL no later than one working day following the serious occurrence. Staff must document in the person's record and

in the incident/accident report log that the serious occurrence was reported to The ACDL, and include the names of the individuals who received the report. For reporting of serious occurrences:

- The Arizona Center for Disability Law: fax number 602-274-6779 Attention Mental Health Team

Centers for Medicare and Medicaid Services (CMS)

In the case of a person's death, the information must be reported to the Center for Medicare and Medicaid Services (CMS) Regional Office. The program must report:

- Each death that occurs while a resident is in restraint or seclusion;
- Each death that occurs within 24 hours after the resident has been removed from restraint or seclusion; and
- Each death known to the facility that occurs within one week after the restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a resident's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or deaths related to chest compression, restriction of breathing or asphyxiation.

Each death must be reported to CMS by telephone within one working day following knowledge of the resident's death. All staff must document the death in the program's incident/accident log. Staff must document in the member's medical record the date and time the death was reported to CMS, and the names of the individuals who received the report.

- CMS Regional Office (to report a death only): Division of Survey & Certification phone: 415-744-3501.

Licensed behavioral health inpatient facilities must know what information is to be reported, including any applicable forms and/or reports; where the requisite information must be sent within the agencies identified above and the reporting timeframes.

10.10 Reporting of Incidents, Accidents and Deaths

Significant events, such as accidents, injuries, allegations of abuse, human rights violations, and deaths require careful examination and review to ensure the protection of Members. AHCCCS, as well as other federal and State agencies, require the prompt reporting of significant events involving persons receiving services within the public health system. The reporting of significant events to the State, such as incidents, accidents, and deaths, serves the following purposes:

- The collection of relevant information facilitates a comprehensive review and investigation when indicated;
- Compliance with notification requirements to the Centers for Medicare and Medicaid Services (CMS), Arizona Health Care Cost Containment System (AHCCCS), the Arizona Center for Disability Law, and ADHS Division of Licensing as applicable; and
- The trending and analysis of significant events can identify opportunities for behavioral health system improvements.

The intent of this section is to identify reporting requirements for providers following an incident, accident, or death involving a Member. In addition, The Health Plan may require providers to submit a written summary of their review of deaths of adult Non-Seriously Mentally Ill Members.

Providers must be aware of what constitutes an event that requires reporting to:

- CMS;
- AHCCCS;
- The Arizona Center for Disability Law; or
- ADHS Division of Licensing
- Division of Developmental Disabilities (DDD)

Providers must know what information is to be reported, including any applicable forms and/or reports; and where the requisite information must be sent within the agencies identified above.

10.10.1 Additional Information

- All deaths, regardless of whether the enrolled Member is a child, adult with SMI or adult without SMI, are reviewed by the State Medical Director or designee, and selected cases are reviewed for potential action, in accordance with the State's established quality assurance process;
- ADHS Division of Licensing Behavioral Health Inpatient Facilities are required to report any serious occurrence that occurs as a result of a seclusion and restraint event, in accordance with **Section 10.9 - Seclusion and Restraint Reporting**;
- Upon recognition of abuse, neglect or exploitation of an incapacitated person, providers must immediately report the allegation to the appropriate authorities (i.e., police or protective services worker) in accordance with A.R.S. § 46-454. The oral reports must be followed up by a written report within 48 hours. See **Section 9.4 - Duty to Report Abuse, Neglect or Exploitation**; and
- Each state has a designated protection and advocacy system. In Arizona, the Arizona Center for Disability Law serves as the designated protection and advocacy agency.

10.10.2 Reporting Incidents, Accidents and Deaths to The Health Plan Behavioral Health Providers must report any incident, accident or death that pertain to the following, of an enrolled Member to The Health Plan within 48 hours:

- Deaths;
- Medication error(s);
- Abuse or neglect allegation made about staff member(s);
- Suicide attempt;
- Self-inflicted injury;
- Injury requiring emergency treatment;
- Physical injury that occurs as the result of personal, chemical or mechanical restraint;

- Unauthorized absence from a licensed behavioral health facility, group home or HCTC of children or recipients under court order for treatment;
- Suspected or alleged criminal activity;
- Discovery that a client, staff member, or employee has a communicable disease as listed in R9-6-202 (A) or (B);
- Incidents or allegations of violations of the rights as described in [A.A.C. R9-20-203](#) or in [A.A.C. R9-21, Article 2](#);
- Discrimination;
- Exploitation;
- Coercion;
- Manipulation;
- Retaliation for submitting grievances to authorities;
- Threat of discharge/transfer for punishment;
- Treatment involving denial of food;
- Treatment involving denial of opportunity to sleep;
- Treatment involving denial of opportunity to use toilet;
- Use of restraint or seclusion as retaliation; and/or
- Health Care-Acquired and Provider Preventable Conditions as described in the AHCCCS AMPM Chapter 900.

Additionally, providers must submit incident, accident, or death reports involving “sentinel events” within 6 hours of the occurrence. A “sentinel event” is defined as any of the following:

- Suicide or significant suicide attempt by a Member;
- Homicide committed by a Member;
- Unauthorized absence of a Member from a locked behavioral health inpatient facility;
- Sexual assault while a Member is a resident of a locked behavioral health inpatient facility; or
- Death while a Member is a resident of a Behavioral Health Inpatient Facility or other psychiatric hospital or other inpatient institution.

Providers are responsible for reporting incidents, accidents, and deaths of behavioral health Members through the QMS Portal. The QMS Portal is intended for the use of providers reporting IADs to The Health Plan. This system is administered by AHCCCS. Access to the QMS Portal is at: https://qmportal.azahcccs.gov/WF_Public_Default.aspx

The QMS Portal has links for: Registration Guide, Quick Start-Creating an IAD (Incident, Accident, Death Reports), Current Build Release Notes and Technical Assistance.

10.10.3 Reporting Incidents, Accidents and Deaths During Prevention Activities

Providers are required to report to The Health Plan any incident, accident or death of a Member participating in the health plan provider sponsored prevention activity, as defined in this section, regardless of their enrollment status with The Health Plan, within 48 hours.

10.10.4 **Reporting to Office of Human Rights**

The Health Plan submits all behavioral health incident reports involving enrolled children and adults to the Office of Human Rights upon review of the incident report.

10.10.5 **Reporting Deaths and Serious Occurrences in ADHS Division of Licensing Behavioral Health Inpatient Facilities**

This subsection is applicable to Title XIX/XXI certified ADHS Division of Licensing Behavioral Health Inpatient Facilities that provide inpatient psychiatric services to persons under the age of 21.

10.10.5.1 ***Reporting Serious Occurrences Of Members:***

Title XIX/XXI certified/ADHS Division of Licensing Behavioral Health Inpatient Facilities that provide inpatient psychiatric services to persons under the age of 21 are required to report any serious occurrences involving a Member to:

- AHCCCS;
- The Arizona Center for Disability Law; and
- CMS Regional Office (for deaths only).

10.10.5.2 ***Timeframes***

Any serious occurrence involving a Member in a Behavioral Health Inpatient Facility must be reported to AHCCCS, the Arizona Center for Disability Law, and the CMS Regional Office (for deaths only) no later than close of business of the next business day following the serious occurrence.

10.10.5.3 ***Where to Send the Report***

For serious occurrence reporting, send information to:

- AHCCCS: fax number 602-417-4162 Attention DHCM Behavioral Health Administrator;
- The Arizona Center for Disability Law: fax number 602-274-6779 Attention Investigator; and
- CMS Regional Office (to report a death only): fax number 415-744-2692 Attention Survey & Certification Coordinator.

10.10.5.4 ***Other Considerations***

Specific documentation requirements apply to ADHS Division of Licensing licensed provider records. Please see **Section 10.2 - Medical Record Standards**.

In the case of a minor (person under the age of 18), the behavioral health inpatient facility must also notify the person's parent(s) or legal guardian(s) as soon as possible, but no later than 24 hours from the serious occurrence.

Note that these reporting requirements pertain only to serious occurrences (see definition). Reports of non-serious occurrences and other events are not made to AHCCCS, the Arizona Center for Disability Law, or CMS.

10.11 Health Home Quality Management Plan Requirements

Health Home providers must develop, implement and maintain a quality management program that includes quality management processes to assess, measure, and improve the quality of care provided to Members in accordance with the AHCCCS Bureau of Quality and Integration Specifications Manual, Section 9.4 - Performance Improvement Projects, and the AHCCCS QM requirements in the [AHCCCS AMPM, Chapter 900](#).

Providers must utilize the Plan Do Study Act (PDSA) model of continuous quality improvement to identify and resolve systems issues or receive permission from The Health Plan to use an alternative system. Providers must use data to conduct comprehensive evaluation and analysis to develop and implement actions to continuously improve the quality of care provided to Members.

Providers must develop and maintain regular mechanisms to solicit feedback and recommendations from key system partners, providers, Members and family members to monitor service quality and develop strategies to improve Member outcomes and quality improvement activities related to the quality of care and system performance.

Providers must comply with reporting requirements for all quality management data submitted to The Health Plan for calculating contract performance measures and other quality reporting.

10.11.1 Minimum Performance Standard

Health Home providers must meet each Minimum Performance Standard (MPS) for both the Integrated and Non-Integrated Plans as identified below.

Performance Measures for Contract Year 2018

Behavioral Health Performance Measures

Measure	Source	MPS
Follow-Up After Hospitalization for Mental Illness, 7 Days	CMS	85%
Follow-Up After Hospitalization for Mental Illness, 30Days	CMS	95%
Mental Health Utilization	HEDIS	TBD
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	CMS	<2.5%
Use of Opioids at High Dosage in Persons Without Cancer	CMS	TBD
Use of Opioids From Multiple Providers	HEDIS	TBD
Access to Behavioral Health Professional Services, 7 days	AHCCCS	Tabled
Access to Behavioral Health Professional Services, 30 days	AHCCCS	Tabled
Follow-Up After Emergency Department Visit for Mental Illness or	CMS	TBD

Alcohol and Other Drug		
------------------------	--	--

Integrated Performance Measures

Measure	Source	MPS
Inpatient Utilization (IPU)	HEDIS	<50
Ambulatory Care (AMB)-ED Utilization	HEDIS	<110
Hospital Readmission within 30 Days of Discharge	CMS	<20%
Follow-Up After Hospitalization for Mental Illness, 7 Days	CMS	85%
Follow-Up After Hospitalization for Mental Illness, 30Days	CMS	95%
Adult's Access to Preventive Services	HEDIS	75%
Breast Cancer Screening (BCS)	CMS	50%
Cervical Cancer Screening (CCS)	CMS	64%
Chlamydia Screening in Women (CHL)	CMS	63%
Colorectal Cancer Screening (COL)	HEDIS	65%
CDC-HbA1c Testing	CMS	77%
CDC-HbA2c Poor Control (>9.0%)	CMS	<43%
CDC-Eye Exam	HEDIS	49%
Timeliness of Prenatal Care: Prenatal Care Visit in the First Trimester or Within 42 Days of Enrollment (PPC)	CMS	80%
Timeliness of Postpartum Care: Postpartum Care Rate (PPC)	CMS	64%
Mental Health Utilization (MPT)	HEDIS	TBD
Use of Opioids at High Dosage in Persons Without Cancer	CMS	TBD
Use of Opioids from Multiple Providers	CMS	TBD
Access to Behavioral Health Professional Services, 7 days	AHCCCS	Tabled
Access to Behavioral Health Professional Services, 30 days	AHCCCS	Tabled
Diabetes Admissions, Short-Term Complications (PQI-01)	CMS	<72.20
Flu Vaccinations for Adults, Ages 18-64 (FVA)	CMS	50%
Annual Monitoring for Patients on Persistent Medications, Combo Rate	CMS	75%
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI-05)	CMS	<324
Asthma in Younger Adults Admissions	CMS	<494
Heart Failure Admission Rate (PQI-08)	CMS	<215.53
EPSDT Participation, members aged 18-21	CMS	68%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	CMS	80%
Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence (FUA-AD)	CMS	TBD

10.11.1.1 Integrated Care Performance Measures Member Outreach

Health Homes providing Integrated Care must conduct member outreach at least quarterly on the following performance measures to ensure provision of services:

- Diabetic Care: HbA1C Testing

- Diabetic Care: Eye Exam
- Adult Access to Preventive/Ambulatory Care
- Colorectal Cancer Screening
- Chlamydia Screening
- Breast Cancer Screening
- Cervical Cancer Screening

Outreach must be tracked using EC-324 Deliverable: Integrated Performance Measures Outreach Monitoring Tool and reported to The Health Plan on the 5th day following each quarter (e.g. January 5th, 2017 for reporting period Q1, October – December 2016).

10.11.2 Improvement Activities

Health Home providers must participate in The Health Plan or State process improvement projects as requested and engage in Practice Improvement Processes to generate positive improvement in provider practices. Providers must participate in clinical quality improvement activities that are designed to improve outcomes for Arizona Members. Providers are also required to participate in the Children's System of Care Practice Reviews; including, at a minimum, participation in family interviews, chart reviews, team observation, providing accurate contact information, and participating in Feedback Meetings, as requested.

10.11.3 Corrective Action and Audits

Health Home providers must respond to all Corrective Action Letters as requested and develop effective Corrective Action Plans, utilizing PM Form 9.11.4 Corrective Action Plan Template, to overcome the identified problems. Providers must cover the cost of a second The Health Plan audit resulting from provider's failure to pass the minimum performance standards associated with a The Health Plan audit, and must cover the travel costs associated with the repeat/second audit which may include hotel, meals, car rental and gasoline.

Section 11 - PHYSICAL HEALTH PROVIDER

The Health Plan's network includes various different behavioral and physical health care providers to meet the needs of the membership, including Primary Care Providers, Health Homes and Specialty Providers.

11.1 Primary Care Physician (PCP) Assignment

11.1.1 Member Capacity

PCPs must follow the below guidelines regarding member capacity:

- The PCP must contact their Health Plan Services representative if they declare a specific member capacity for their practice and want to make a change to that capacity.
- The PCP must not refuse to treat members as long as the PCP has not reached requested member capacity.

- Providers must notify the Health Plan at least 45 days in advance of their inability to accept additional Medicaid members.

The Health Plan prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members.

11.2 Primary Care Provider (PCP) Requirements

The Health Plan's contracted PCPs provide integrated delivery of behavioral and physical health care Members. PCPs are required to meet various requirements, which are described below.

11.2.1 Provider Type

PCPs are required to be: (a) Arizona licensed as allopathic or osteopathic physicians that generally specialize in family practice, internal medicine, obstetrics, gynecology, or pediatrics; (b) certified nurse practitioners or certified nurse midwives; or (c) physician's assistants.

11.2.2 PCP Assignments

Members are auto-assigned to PCPs based on PCP and member location. Auto-assignment is also based on PCP Panel size. Members are auto-assigned to PCPs that have panel sizes under 1000 members. When determining assignments to a PCP, The Health Plan also considers the PCP's ability to meet AHCCCS appointment availability, wait times and Quality of Care (QOC) standards. The Health Plan PCP Panel Size and will adjust the size of a PCP's panel, as needed, for the PCP to meet AHCCCS appointment and clinical performance standards. The Health Plan will only assign Members diagnosed with AIDS or as HIV positive to PCPs that comply with criteria and standards set forth in the AHCCCS Medical Policy Manual.

11.2.3 Freedom of Choice Within Network

The Health Plan offers Members freedom of choice in selecting a PCP within the network and does not restrict PCP choice unless a Member has shown an inability to form a relationship with a Primary Care Provider (PCP), as evidenced by frequent changes, or when there is a medically necessary reason.

The Health Plan informs each Member in writing of their enrollment and PCP assignment within five days of The Health Plan's receipt of notification of a new member assignment by AHCCCS. The Health Plan informs each Member in writing of any PCP change, and allows Members to make the initial PCP selection and any subsequent PCP changes verbally or in writing.

11.2.4 Primary Care Provider (PCP) Responsibilities

PCPs shall be responsible for:

- Consent form requirements;
- Supervising, coordinating and providing of care to each assigned Member (except for dental services provided to EPSDT Members without a PCP referral);
- Initiating referrals for medically necessary specialty care in accordance to [AHCCCS AMPM Policy 510](#) ;
- Maintaining continuity of care for each assigned Member;

- Maintaining each assigned Member's medical record, including documentation of all services provided to the Member by the PCP, as well as any specialty or referral services;
- Utilizing the AHCCCS-approved AHCCCS AMPM, Appendix B, EPSDT Tracking Forms to document services provided and compliance with AHCCCS standards when serving EPSDT Members (see **Section 2.4 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT)**);
- Providing clinical information regarding a Member's health and medications to a treating provider, including behavioral health providers, within ten business days of a request from the provider;
- In lieu of developing a medical record when a PCP receives behavioral health information on a Member before seeing the Member, a PCP may establish a separate file to hold behavioral health information. The behavioral health information must, however, be added to the Member's medical record when the Member becomes an established patient (see **Section 10.2 - Medical Record Standards**);
- Enrolling as a Vaccines for Children (VFC) provider for Members, age eighteen only;
- Providing health care services to the Health Plan members within the scope of the provider's practice and qualifications;
- Providing care that is consistent with generally accepted standards of practice prevailing in the provider's community and the health care profession;
- Accepting the Health Plan Members as patients on the same basis that the provider accepts other patients (non- discrimination);
- When consistent with provision of appropriate quality of care, referring the Health Plan Members only to participating providers in compliance with the Health Plan written policies and procedures;
- Obtaining current insurance information from the Member;
- Cooperating with the Health Plan in connection with plan performance of utilization management and quality improvement activities, including prior authorization of necessary service and referrals;
- Informing the member that referral services may not be covered by the Health Plan when referring to non-participating providers;
- Providing The Health Plan with medical record information if requested for a member for processing their application for coverage; prior authorizing services or processing claims for benefits; or for purposes of health care provider credentialing, quality assurance, utilization review, case management, peer review, and audit. The Health Plan has a valid signed authorization from our members authorizing any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau, Inc. (MIB), or other insurance information exchange to release information to The Health Plan if requested. Participating providers may obtain a copy of this authorization by contacting The Health Plan. The Health Plan does not reimburse for the cost of retrieval, copying and furnishing of medical records.

Cooperating with any authorized The Health Plan employee who may need to access member records that may include payment or medical records to determine

the proper application of benefits, as well as the propriety of payments (including any claims payment recovery actions performed on behalf of The Health Plan.

- In the event of provider termination, cooperating with The Health Plan and other participating providers to provide or arrange for continuity of care to members undergoing an active course of treatment, subject to the requirements and limitations of Arizona statute.
- Operating and providing contracting services in compliance with all applicable local, state and federal laws, rules, regulations, and institutional and professional standards of care, including federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), the anti-kickback statute (section 1128B(b)) of the Social Security Act), and Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules at 45 CFR parts 160, 162, and 164.

The following 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 Health Plan, provider contract and requirements in this manual. The Health Plan s 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.

Participating providers must ensure the following, described below in detail:

- Adhere to the Arizona Health Care Cost Containment Systems (AHCCCS) appointment standards; refer to Appointment Standards section for more information;
- Provide service coverage on a 24/7 basis (including on-call);
- Respect AHCCCS member rights;
- Provide services in a culturally sensitive manner;
- Adhere to Americans with Disability Act (ADA) requirements;
- Provide services in a non-discriminatory manner;
- Report suspected fraud, waste and abuse;
- PCPs must utilize the AHCCCS-approved and Periodic Screening, Diagnosis and Treatment (EPSDT) tracking form;
- PCPs must provide clinical information regarding a member's health and medication to a treating physician (including behavioral health) within 10 business days of the request;
- If treating children, enroll as a Vaccines for Children (VFC) provider; and
- Provider complaint and appeal procedures.

Participating providers must complete initial, annual and ongoing Health Plan trainings that include, but are not limited to, the following topics:

- Member appeals and grievances;
- Appointment standards and wait times;
- Language line services;
- Proper emergency department usage;

- Fraud, waste and abuse/ false claims act training;
- Contacting the health plan; and
- How to file claims and claim disputes.

11.2.5 Second Opinion

Health Plan members have the right to seek a second opinion for diagnosis and treatment at no cost from a qualified health care provider in or out of The Health Plan's participating provider network. Prior authorization is required to access a non-participating provider.

11.3 PCP After-Hours Access Guidelines

As required by applicable statutes, under Code of Federal Regulations (CFR) 42 Section 422.112(a)(7) and 42 Section 438.206(c)(1)(iii)) and according to the signed Health Plan Contract, The Health Plan participating providers must ensure that, when medically necessary, services are available 24 hours a day, seven days a week; and primary care providers are required to have appropriate back-up for absences. Medical groups and PCPs who do not have services available 24 hours a day may use an answering service or answering machine to provide members with clear and simple instruction on after-hours access to medical care.

After office hours (outside of normal business hours or when the offices are closed), PCPs or on-call physicians are required to return calls and pages within four hours. If an on-call physician cannot be reached, the after-hours answering service or machine must direct the member to a medical facility where emergency or urgent care treatment can be provided. According to Arizona Administrative Code (AAC) Section R-20-6-1914(4), in-area urgent care services from a participating provider must be available seven days per week.

The PCP or the on-call physician designee must provide urgent and emergency care. The member must be transferred to an urgent care center or hospital emergency room as medically necessary.

11.3.1 Answering Services

The provider is responsible for the answering service they use. There must be a message immediately stating, "If this is an emergency, hang up and call 911 or go to the nearest emergency room." If a member calls after hours or on a weekend for a possible medical emergency, the practitioner is liable for authorization of, or referral to, emergency care given by the answering service. After office hours (outside of normal business hours or when the offices are closed) physicians are required to return calls and pages within four hours. If the member indicates a need to speak with the physician or calls for an urgent matter, PCPs or on-call physicians should return telephone calls and pages within four hours and be available 24 hours a day, seven days a week.

Answering service staff handling member calls cannot provide telephone medical advice if they are not a licensed, certified or registered health care professional. Staff members may ask questions on behalf of a licensed professional in order to help ascertain the condition of the member so that the member can be referred to licensed staff; however, they are not permitted, under any circumstance, to use the answers to questions in an attempt to assess, evaluate, advise, or make any decision regarding the condition of the member, or to determine when a member needs to be seen by a licensed medical

professional. Unlicensed staff should have clear instructions on the parameters relating to the use of answers in assisting a licensed provider.

Additionally, non-licensed, non-certified or non-registered health care staff cannot use a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified or registered health care professional. Answering services frequently have high staff turnover, so providers should monitor the answering service to be sure that it follows emergency procedures.

The Health Plan encourages answering services to follow these steps when receiving a call:

- Inform the member that if they are experiencing a medical emergency, they should hang up and call 911 or proceed to the nearest emergency medical facility.
- Question the member according to the PCP's or medical group's established instructions (who, what, when, and where) to assess the nature and extent of the problem and offer interpreter services assistance as needed.
- Contact the on-call physician with the facts as stated by the member.
- After office hours, the on-call physician must return telephone calls and pages within four hours. If an on-call physician cannot be reached, direct the member to a medical facility where they can receive emergency or urgent care treatment. This is considered authorization, which is binding and cannot be retracted.
- In the event of a hospitalization, the medical group/ independent practice association (IPA) or hospital must contact The Health Plan Hospital Notification Unit within 24 hours or the next business day of the admission
- Document all calls.

11.4 Conditions of PCP Practice Closure

Participating primary care physicians (PCPs) may close their practices to new Health Plan members while remaining open to members of other insured or managed health care plans, provided that the PCP meets The Health Plan threshold of 300 Health Plan members before closing the panel.

If a patient of the PCP, while a member of another health care plan, joins The Health Plan, the PCP must continue to accept the member as a patient even if their practice is closed to new The Health Plan members.

A PCP may close their practice to all new patients from all insurance or health plans at any time.

11.5 Covering and Collaborating Physicians

Health Plan providers who use other physicians to cover their practice while on vacation or leave must use their best efforts to find a The Health Plan participating physician within the same specialty. If a Health Plan participating physician is unable to cover the practice, the following must occur:

- The non-participating physician must agree in writing to abide by the terms of the Health Plan contract and all Health Plan policies and procedures.
- The Health Plan must give prior approval for the use of a non-participating physician.

Providers may request approval to use a non-participating, covering physician by contacting The Health Plan's Provider Network Management Department.

When choosing a provider to collaborate on a case, providers must use participating providers. Payment for surgical assistants as well as second opinions may be the responsibility of the requesting provider if the provider utilized is not participating with The Health Plan. Payment by The Health Plan for these services is dependent on medical appropriateness, contract status, member eligibility, and the member's benefit plan. Non-participating providers must have an AHCCCS ID number.

11.6 Additional Referral Requirements for SMI Members

For SMI Members receiving physical health care services, Providers must follow the following procedures for referrals to specialists or other services. Providers shall use the **Specialist Referral Form** and refer the Member to the appropriate provider (a provider directory is available on The Health Plan's website).

- Referrals to specialty physician services must be from a PCP, except as follows: Women will have direct access to in-network OB/GYN providers, including physicians, physician assistants and nurse practitioners within the scope of their practice, without a referral for preventive and routine services
- SMI Members that need a specialized course of treatment or regular care monitoring may directly access a specialist (i.e. through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. Specialty physicians cannot begin a course of treatment for a medical condition other than that for which the Member was referred, unless approved by the Member's PCP.

11.7 Social Determinants of Health

AHCCCS and the Health Plan collect and track member outcomes related to Social Determinants of Health. The use of specific International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnostic codes representing Social Determinants of Health are a valuable source of information that relates to member health.

The Social Determinants of Health codes identify the conditions in which people are born, grow, live, work, and age. They are often responsible, in part, to health inequities. They include factors like:

- Education
- Employment
- Physical environment
- Socioeconomic status
- Social support networks

As appropriate and within a scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Any identified social determinant diagnosis

codes should be provided on all claims for AHCCCS members in order to comply with state and federal coding requirements.

The following ICD-10-CM diagnosis codes are defined as Social Determinants of Health codes under ICD-10-CM. Please note that Social Determinants of Health codes may be added or updated on a quart.

ICD Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified

Z60.0	Problems of adjustment to life-cycle transitions
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified
Z62.0	Inadequate parental supervision and control
Z62.1	Parental overprotection
Z62.21	Child in welfare custody
Z62.22	Institutional upbringing
Z62.29	Other upbringing away from parents
Z62.3	Hostility towards and scapegoating of child
Z62.6	Inappropriate (excessive) parental pressure
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.819	Personal history of unspecified abuse in childhood
Z6.2820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62.822	Parent-foster child conflict
Z62.890	Parent-child estrangement NEC
Z62.891	Sibling rivalry
Z62.898	Other specified problems related to upbringing
Z62.9	Problem related to upbringing, unspecified
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family member from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support group
Z63.9	Problem related to primary support group, unspecified
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.4	Discord with counselors
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war and other hostilities

Z65.8	Other specified problems related to psychosocial circumstances
Z65.9	Problem related to unspecified psychosocial circumstances
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.42	Counseling for family member of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser
Z71.52	Counseling for family member of drug abuser
Z72.810	Child and adolescent antisocial behavior
Z72.811	Adult antisocial behavior
Z72.89	Other problems related to lifestyle
Z72.9	Problem related to lifestyle, unspecified
Z73.0	Burn-out
Z73.1	Type A behavior pattern
Z73.2	Lack of relaxation and leisure
Z73.3	Stress, not elsewhere classified
Z73.4	Inadequate social skills, not elsewhere classified
Z73.89	Other problems related to life management difficulty
Z73.9	Problem related to life management difficulty, unspecified

11.8 Referrals to Entities Where Providers Have a Financial Relationship

Providers shall comply with all applicable physician referral requirements and conditions defined in §§ 1903(s) and 1877 of the Social Security Act and corresponding regulations which include, but are not limited to, 42 CFR Part 411, Part 424, Part 435 and Part 455. §§ 1903(s) and 1877 of the Act prohibits physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician's family has a financial relationship. Designated health services include, at a minimum, clinical laboratory services physical therapy services; occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs, and inpatient and outpatient hospital services.

11.9 Appointment Requirements Applicable to Physical Health Providers (Non-Hospitalized Persons)

For SMI Members eligible to receive physical health care services, the following appointment requirements apply:

For Primary Care Appointments:

- Urgent care appointments as expeditiously as the member's health condition requires but no later than two (2) business days of the request
- Routine care appointments within twenty-one (21) calendar days of request.

For Specialty Care Appointments:

- Urgent care appointments as expeditiously as the member's health condition requires but no later than three (3) business days from the request or referral; and

- Routine care appointments within forty-five (45) calendar days of referral.

For Dental Appointments to SMI Members under age twenty-one (21).

- Urgent appointments as expeditiously as the member's health condition requires but no later than three (3) days of request; and
- Routine care appointments within forty-five (45) calendar days of request.

For Maternity Care Appointments, see Section 2.3 - Maternity Services for Title XIX/XXI Adults with SMI.

11.10 Audiology Coverage

The Health Plan covers medically necessary audiology services, within certain limitations, to evaluate hearing loss and rehabilitate persons with hearing loss through means other than medical/surgical procedures.

Covered services include:

- Exams or evaluations for hearing aids
- Exams or evaluations for cochlear implants
- Evaluations for prescription of speech-generating and non-speech-generating augmentative and alternative communicating devices
- Therapeutic service(s) for the use of speech-generating and non-speech-generating devices, including programming and modification, and devices such as hearing aids, cochlear implants, speech-generating and non- speech-generating
- Audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets federal requirements specified under 42 CFR 440.110.

Hearing aids can be dispensed only by a dispensing audiologist or an individual with a valid hearing aid dispensing license. Hearing aids, provided as a part of audiology services, are covered only for members under age 21 receiving Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services or those enrolled in KidsCare. The Health Plan does not cover hearing aids for members ages 21 and older.

Arizona Health Care Cost Containment Services (AHCCCS) eliminated coverage of bone-anchored hearing aid (BAHA), also known as osseointegrated implants, and cochlear implants for members ages 21 and older. Supplies, equipment maintenance and repair of component parts remain a covered benefit. Documentation that establishes the need to replace a component not operating effectively must be provided when requesting prior authorization

11.11 PCP Treatment and Referrals

11.11.1 Treatment of Behavioral Health Disorders

PCPs may provide medication management services for select behavioral health disorders, such as anxiety, mild depression, postpartum depression, and attention deficit hyperactivity disorder (ADHD). Medication management services may include medication monitoring, prescriptions, laboratory services, and other diagnostic tests necessary to diagnose and treat behavioral disorders PCPs may use the Arizona Health Care Cost Containment System (AHCCCS) approved

toolkits or other clinically approved tools or evidence-based guidelines for best practices addressing the treatment of these disorders. The AHCCCS toolkits include assessment tools, scoring instructions and recommended medication lists, and are available on the provider website at www.AzCompleteHealth.com or by contacting The Health Plan behavioral health coordinator.

11.11.2 Referrals

PCPs are required to comply with The Health Plan, AHCCCS and RBHA or T/RBHA guidelines for referring their assigned members for behavioral health services. Referrals are based on, but not limited to:

- member request (members may also self-refer to a behavioral health provider);
- sentinel event, such as a member-defined crisis episode;
- psychiatric hospitalization;
- identification of behavioral health diagnosis outside the scope of the PCP or substance abuse issues.

PCPs may refer members for the following services by contacting The Health Plan Behavioral Health Unit (for dual-eligible members) or T/ RBHA (for Medicaid-only members):

- Behavioral health services;
- Consultation with a The Health Plan or T/RBHA behavioral health provider;
- One-time, face-to-face psychiatric evaluation with The Health Plan or RBHA or T/RBHA
- Behavioral health provider for treatment, ongoing behavioral health care or medication management. To request this service, PCPs must complete and submit the behavioral health referral form and check one-time, face-to-face request.

PCPs must transfer the member to a behavioral health provider contracting with The Health Plan (for dual- eligible members) or the Regional Behavioral Health Authority (RBHA) or Tribal/Regional Behavioral Health Authority (T/RBHA) if symptoms become severe or if the member needs additional behavioral health services. PCPs must ensure members are not simultaneously receiving behavioral health medication from both the behavioral health provider and PCP. When the member is identified to be simultaneously receiving medications from the PCP and behavioral health provider, the PCP must immediately contact the behavioral health provider to coordinate care and agree on who will continue to medically manage the person's behavioral health condition.

PCPs must use step therapy as needed for ADHD, anxiety disorder, mild depression, and postpartum depression. Step therapy is required for medication not on the Arizona Health Care Cost Containment System (AHCCCS) or Division of Behavioral Health Services (DBHS) preferred drug list. This includes the requirement that if the PCP receives documentation from The Health Plan, or T/RBHA behavioral health providers regarding completion of step therapy, the PCP continues prescribing the same brand and dosage of current medication unless a change in medical condition is clearly evident.

Psychotropic medications are listed in The Health Plan Drug List, available on the provider website at www.azcompletehealth.com . For additional information regarding pharmacy benefits, contact Envolve Pharmacy Solutions.

11.12 Breast Reconstructive Surgery after Mastectomy

The Health Plan covers breast reconstruction surgery for eligible health plan members following a medically necessary mastectomy regardless of the member's eligibility status at time of the mastectomy. The Health Plan does not cover services provided solely for cosmetic purposes.

A member may elect to have breast reconstruction surgery immediately following a mastectomy or may choose to delay breast reconstruction, but the member must be enrolled in The Health Plan at the time of breast reconstruction surgery. The type of breast reconstruction performed is determined by the physician in consultation with the member.

Breast reconstructive surgery coverage includes:

- Reconstruction of the affected and the unaffected contralateral breast. Reconstructive breast surgery of the unaffected contralateral breast following mastectomy is considered medically necessary only when required to achieve relative symmetry with the reconstructed affected breast. The surgeon must determine medical necessity and request prior authorization for reconstructive breast surgery of the unaffected contralateral breast prior to the time of reconstruction or during the immediate post-operative period
- Medically necessary implant removal and implant replacement when the original implant was the result of a medically necessary mastectomy. Implant replacements are not covered when the purpose of the original implant was cosmetic, such as augmentation
- External prostheses, including a surgical brassiere, for members who choose not to have breast reconstruction, or who choose to delay breast reconstruction until a later time

Prior authorization is required for breast reconstruction surgery. Coverage for prosthetic devices and reconstructive surgery is subject to copayment that is applicable to the mastectomy and all other terms and conditions applicable to other benefits.

11.13 Conscious Sedation Coverage

The Health Plan covers conscious sedation for members receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function, as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Additional applications of conscious sedation for members receiving EPSDT services are considered on a case-by-case basis and require medical review and prior authorization by The Health Plan for enrolled members.

11.14 Hemodialysis and Peritoneal Dialysis Coverage

The Health Plan covers hemodialysis and peritoneal dialysis services provided by participating Medicare-certified hospitals or Medicare-certified end-stage renal disease (ESRD) providers. Hemoperfusion is covered when medically necessary. Services may be provided on an outpatient basis or on an inpatient basis if the hospital admission is not solely to provide chronic dialysis services. Hospital admissions solely to provide chronic dialysis are not covered.

Medically necessary outpatient dialysis treatments are covered, including:

- Supplies
- Diagnostic testing (including routine medically necessary laboratory tests)
- Medications

Inpatient dialysis treatments are covered when the hospitalization is for:

- Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)
- Medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program
- Placement, replacement or repair of the chronic dialysis route

11.15 Durable Medical Equipment Coverage

Durable medical equipment (DME) is paid for in accordance with the Provider Participation Agreement (PPA). Fee-for-service (FFS) providers may be directed to any participating The Health Plan DME provider, including Preferred Homecare.

Prosthetic and orthotic services are not available through The Health Plans' preferred DME provider (Preferred Homecare). They may be obtained through prosthetic and orthotic providers, such as Hanger Prosthetics and Orthotics.

11.15.1 Exclusions and Limitations

The Health Plan does not cover the following items:

- Personal care items, unless needed to treat a medical condition (except incontinence briefs and pads for members over age 3 and under age 21).
- First aid supplies (except under a prescription).
- Hearing aids for members ages 21 and older.
- Prescriptive lenses for members ages 21 and older (except if medically necessary following cataract removal).
- Penile implants or vacuum devices for members who are ages 21 and older.

11.15.2 Orthotics

Orthotics are rigid or semi-rigid devices affixed to the body externally and required to support or correct a defect of form or function of a permanently inoperative or malfunctioning body part, or to restrict motion in a diseased or injured part of the body.

11.15.2.1 Custom Orthotics

A prior authorization is required for custom orthotics. Coverage for Members Under Age 21

Orthotic devices are a covered benefit for The Health Plan members under age 21 when they are medically necessary and the orthotics cost less than other treatments that are as helpful for the condition.

11.15.2.2 Coverage for Members Ages 21 and Older

Orthotic devices are a covered benefit for The Health Plan members ages 21 and older when all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare guidelines.
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
- The member's primary care physician (PCP) or other physician orders the orthotic.

11.15.2.3 Prosthetics NOT Covered for Members Ages 21 and Older

- bone-anchored hearing aids (BAHA), also known as osseointegrated implants
- cochlear implants
- insulin pumps
- percussive vests

Orthotic services are not available through The Health Plans' preferred DME provider (Preferred Homecare). They may be obtained through prosthetic and orthotic providers, such as Hanger Prosthetics and Orthotics.

11.16 Foot and Ankle Services

The Health Plan covers medically necessary foot and ankle care services, including the following, when ordered by a member's primary care physician (PCP), attending physician or practitioner within certain limits for eligible The Health Plan.

Under age 21 - Bunionectomies, casting for the purpose of constructing or accommodating orthotics, medically necessary orthopedic shoes that are an integral part of a brace, and medically necessary routine foot care for patients with a severe systemic disease that prohibits care by a non-professional person Age 21 or older - Wound care, treatment of pressure ulcers, fracture care, reconstructive surgeries, and limited bunionectomy services. Medically necessary routine foot care services are only available for members with a severe systemic disease that prohibits care by a nonprofessional. Services are not covered when provided by a podiatrist or podiatric surgeon. Members can be referred to other contracting providers who can perform medically necessary foot and ankle procedures, including reconstructive surgeries. A prescription written by a podiatrist would not automatically disqualify the prescribed medication (device or service) from payment.

However, the prescribed medication, device or service may be subject to prior authorization to determine whether it is covered. Bunionectomies are covered only when the bunion is present with:

- Overlying skin ulceration;
- Neuroma secondary to bunion (neuroma to be removed at same surgery and documented by pathology report).

Bunionectomies are not covered if the sole indications are pain and difficulty finding appropriate shoes.

11.16.1 Routine Foot Care

Routine foot care is defined as services performed in the absence of localized illness, injury or symptoms involving the foot. Routine foot care is considered medically necessary in very limited circumstances. These services include:

- Cutting or removal of corns or calluses
- Nail trimming (including mycotic nails)
- Other hygienic and preventive maintenance care in the realm of self-care (such as cleaning and soaking the feet, and the use of skin creams to maintain skin tone of both ambulatory and bedfast patients)

Routine foot care is considered medically necessary when the member has a systemic disease of sufficient severity that performance of foot care procedures by a nonprofessional would be hazardous. Conditions that might necessitate medically necessary foot care include metabolic, neurological and peripheral vascular systemic diseases. Examples include, but are not limited to:

- Anticoagulation therapy in progress;
- Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis);
- Buerger's disease (thromboangiitis obliterans);
- Chronic thrombophlebitis;
- Diabetes mellitus;
- Peripheral neuropathies involving the feet;
- Chemotherapy in progress;
- Pernicious anemia;
- Hereditary disorder, such as hereditary sensory radicular neuropathy or Fabry's disease;
- Hansen's disease or neurosyphilis;
- Malabsorption syndrome;
- Multiple sclerosis;
- Traumatic injury;
- Uremia (chronic renal disease).

Treatment of a fungal (mycotic) infection is considered medically necessary foot care and is covered when the member has all of the following:

- A systemic condition
- Clinical evidence of mycosis of the toenail
- Compelling medical evidence documenting the member either:
 - Has a marked limitation of ambulation due to the mycosis, which requires active treatment of the foot
 - In the case of a nonambulatory member, has a condition that is likely to result in significant medical complications in the absence of such treatment.

11.16.2 Limitations

Coverage is limited as follows:

- Coverage for medically necessary routine foot care must not exceed two visits per quarter or eight visits per contract year (this does not apply to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) members)
- Coverage of mycotic nail treatments does not exceed one bilateral mycotic nail treatment (up to 10 nails) per 60 days (this does not apply to EPSDT members)
- Neither general diagnoses, such as arteriosclerotic heart disease, circulatory problems, vascular disease, venous insufficiency, or incapacitating injuries or illnesses, such as rheumatoid arthritis, CVA (stroke) or fractured hip, are diagnoses under which routine foot care is covered.

11.17 Flu Shots/Immunizations

Flu shots are available to all members. Copayments may only be collected for flu shots when given in conjunction with an office visit.

Primary care providers (PCPs) are responsible for immunizing members and maintaining all immunization information in the member's medical record. Local health departments (LHDs) may also immunize The Health Plan members.

PCPs must be available to administer immunizations during routine office hours. It is the PCP's responsibility to update the immunization record card or other form of immunization record, and enter all immunizations into the Arizona State Immunization Information System (ASIIS) registry.

At each visit, the PCP should inquire whether the patient has received immunizations from another provider. The PCP should also educate members regarding their responsibility to inform the PCP if they receive immunizations elsewhere (such as from an LHD or nonparticipating provider). This information is necessary for documentation and for the member's safety.

11.18 Hospital Observation Services

Observation services are reasonable and necessary services provided on a hospital's premises, on an outpatient basis, for evaluation to determine whether the member should be admitted for inpatient care, discharged or transferred to another facility. Observation services include use of a bed, periodic monitoring by a hospital's nursing staff or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of significant instability or disability on an outpatient basis.

Observation services do not apply when a member with a known diagnosis enters a hospital for a scheduled procedure or treatment that is expected to keep the member in the hospital for less than 24 hours. This is considered an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized or whether services were rendered after midnight. Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation services must be ordered in writing by a physician or other individual authorized to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for observation services as long as medical necessity exists. Factors taken into consideration when ordering observation services include:

- Severity of the patient's signs and symptoms;
- Degree of medical uncertainty where the patient may experience an adverse occurrence;
- Need for diagnostic studies that appropriately are outpatient services (their performance does not ordinarily require the member to remain in the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted;
- The availability of diagnostic procedures at the time and location where the patient presents;
- It is reasonable, cost-effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission length of stay observation services are medically necessary for the patient's condition.

The medical record must document the basis for the observation services and at a minimum must include:

- Physician notes;
 - Condition necessitating observation
 - Justification of need to continue observation
 - Discharge plan
- Medical records documentation;
 - Written orders for observation services
 - Written follow-up orders at least every 24 hours
 - Changes from observation to inpatient or inpatient to observation
 - Changes from inpatient to observation must occur within 12 hours after admission as an inpatient and have supporting medical documentation
 - Physician's daily written progress note.

11.19 Skilled Nursing Facilities

The Health Plan covers medically necessary services provided in contracting skilled nursing facilities (SNFs) for members who need defined nursing care 24 hours a day, but who do not require acute hospital care under the daily direction of a physician.

Prior authorization is required for SNF services prior to admission, except in those cases for which retro-eligibility precludes the ability to obtain prior authorization. In these cases, the case is subject to medical review.

Medically necessary SNF services are covered for a period not to exceed 90 days per contract year (October 1 to September 30). The following criteria apply:

- A participating physician has ordered SNF services.

- The medical condition of the member is such that if SNF services are not provided, it would result in hospitalization, or the treatment is such that it cannot be rendered safely in a less restrictive setting, such as at home by a home health services provider;
- The 90 days of coverage is per member, per contract year and does not restart if the member transfers to a different nursing facility. The Health Plan members residing in a SNF at the beginning of a new contract year begin a new 90-day coverage period. Unused days do not carry over.
- The 90 days of coverage begins on the day of admission regardless of whether the member is covered by a third-party insurance carrier, including Medicare.
- If the member has applied for Arizona Long Term Care System (ALTCS) and a decision is pending, the Health Plan must notify the ALTCS eligibility administrator when the member has been residing in the nursing facility for 60 days. This allows time to follow-up on the status of the ALTCS application.

If the member becomes ALTCS-eligible and is enrolled with the ALTCS program before the end of the maximum 90 days of coverage, the Health Plan is only responsible for the SNF coverage during the time the member is enrolled with The Health Plan. The SNF must coordinate with the member or their representative on alternate methods of payment for continuation of services beyond the 90-day coverage with the Health Plan until the member is enrolled in the ALTCS program or until the beginning of the new contract year.

11.19.1 Care Coordination

Participating providers should identify and refer potentially eligible The Health Plan members to ALTCS. If a The Health Plan member is referred to and approved for ALTCS enrollment, the Health Plan coordinates the transition with the assigned ALTCS contractor to assure continuity and quality of care is maintained during and after the transition.

11.19.2 Limitations

Services that are not covered separately when provided in a Skilled Nursing Facility include:

- Nursing services, including:
 - o medication administration
 - o tube feedings
 - o personal care services
 - o routing testing of vital signs and blood glucose monitoring
 - o assistance with eating
 - o catheter maintenance
- Basic patient care equipment and sickroom supplies, such as bedpans, urinals, diapers, bathing and grooming supplies, walkers, and wound dressings or bandages;
- Dietary services, including, but not limited to, preparation and administration of special diets and adaptive tools for eating;
- Administrative physician visits made solely for the purpose of meeting state certification requirements;
- Non-customized durable medical equipment (DME) and supplies, such as manual wheelchairs, geriatric chairs and bedside commodes;

- Rehabilitation therapies ordered as a maintenance regimen;
- Administration, medical director services, plant operations, and capital;
- Over-the-counter medications and laxatives;
- Social activity, recreational and spiritual services.
- Any other services, supplies or equipment that are state or county regulatory requirements or are included in the SNF's room and board charge.

11.20 Polysomnography-Inpatient and Outpatient

The Health Plan provides benefits for standard polysomnography inpatient and outpatient sleep studies in the following settings:

- A licensed and certified hospital facility;
- A nonhospital facility that meets one of the following sets of criteria:
 - o Is licensed by the Arizona Department of Health Services (ADHS) and the facility is accredited by the American Academy of Sleep Medicine
 - o Has a medical director who is certified by the American Board of Sleep Medicine and has a managing sleep technician who is registered by the Board of Registered Polysomnographic Technologists;
 - o For sleep electroencephalogram (EEG) only, the facility must have a physician who is a board- certified neurologist. No ADHS license is required.

11.20.1 Criteria for Coverage

Standard polysomnography is covered in the following indications.

Suspected sleep-related breathing disorders, such as obstructive sleep apnea (OSA), when one of the following two criteria are met:

- o Witnessed apnea during sleep greater than 10 seconds in duration
- o Suspected sleep-related breathing disorders, such as obstructive sleep apnea (OSA) when one of the following two criteria are met:
 - Excessive daytime sleepiness - Must rule out as a cause for these symptoms: poor sleep hygiene, medication, drugs, alcohol, hypothyroidism, other medical diagnoses, psychiatric or psychological disorders, social or work schedule changes;
 - Persistent or frequent snoring;
 - Obesity (body mass index (BMI) greater than 30 kg/M2 or hypertension);
 - Choking or gasping episodes associated with awakenings.
- o Suspected narcolepsy, demonstrated by symptoms, such as sleep paralysis, hypnagogic hallucinations and cataplexy;
- o Suspected period movement disorder, including excessive daytime sleepiness together with witnessed periodic limb movements of sleep;
- o Suspected parasomnias that are unusual or atypical based on patient's age, frequency or duration of behavior;
- o Suspected restless leg syndrome, when uncertainty exists in the diagnosis;
- o To assist with the diagnosis of paroxysmal arousals or other sleep disruptions that are

- thought to be seizure-related when the initial clinical evaluation and results of a standard EEG are inclusive;
- o Under limited circumstances, titration of positive airway pressure in adults with a documented diagnosis of OSA for whom positive airway pressure has been approved;
- o Other health conditions in which sleep studies have been shown to be medically necessary for their proper diagnosis or treatment.

The preferred method is a split night study in which the sleep study is performed during the first half of the night and positive air pressure system, such as continuous positive airway pressure (CPAP) or biphasic intermittent positive airway pressure (BiPAP), titration is performed during the second half of the night. In cases where testing and titration cannot be completed in one session, the Health Plan may authorize a second night subject to medical necessity criteria.

11.20.2 Limitations

Polysomnography is not covered for the following symptoms or conditions existing alone in the absence of other features suggestive of OSA:

- Snoring;
- Obesity;
- Hypertension;
- Morning headaches;
- Decrease in intellectual functions;
- Memory loss;
- Frequent nighttime awakenings;
- Other sleep disturbances, such as insomnia (acute or chronic), night terrors, sleep walking, epilepsy where nocturnal seizures are not suspected;
- Common uncomplicated non-injurious parasomnias;
- Follow-up sleep studies are not covered unless the member's condition has changed significantly and those changes are likely to modify the need for CPAP or other treatments;
- Sleep studies performed in the home or in a mobile unit are not covered;
- Pulse oximetry alone as a sleep study is not covered;
- Repeat polysomnography in follow-up patients with OSA treated with CPAP when symptoms attributable to sleep study have resolved is not covered.

11.21 Telemedicine Services

The Health Plan covers medically necessary consultative and/or treatment telemedicine services for all eligible members within the limitations described in this policy when provided by an appropriate Arizona Health Care Cost Containment System (AHCCCS) registered provider.

11.21.1 Definitions

Term	Definition
Consulting provider	Any AHCCCS provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member
Store and forward	The transmission of a patient's medical information from the originating site to the distant site. The physician or practitioner at the distant site can review the medical case without the patient being present
Telehealth	<p>The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance</p> <ul style="list-style-type: none"> • Telemedicine - The practice of health care delivery, diagnosis, consultation and treatment, and the transfer of medical data between the originating and distant sites through real-time interactive audio, video or data communications that occur in the physical presence of the member • Telecommunications technology (which includes store and forward) - Transfer of medical data from one site to another through the use of a camera, electronic data collection system, such as an electrocardiogram (ECG) or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation. Services delivered using telecommunications technology, but not requiring the member to be present during their implementation, are not considered telemedicine
Distant site	The location of the telemedicine consulting provider, which is considered the place of service
Originating site	The location where the member is receiving the telemedicine service
Telepresenter	A designated individual who is familiar with the member's case and has been asked to present the member's case at the time of telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily medically expert, with the member's medical condition in order to present the case accurately

11.21.2 Use of Telemedicine

For the services listed below, The Health Plan provides benefits for medically necessary services provided via telemedicine. Services must be real-time visits otherwise reimbursed by The Health Plan. Both the member and the originating provider or knowledgeable telepresenter must be present. Prior authorization is not required when covered services are provided as described in this section.

The following medical services are covered:

- Cardiology;
- Dermatology;
- Endocrinology;
- Hematology/oncology;
- Infectious diseases;

- Neurology;
- Obstetrics/gynecology;
- Oncology/radiation;
- Ophthalmology;
- Orthopedics;
- Pain clinic;
- Pathology;
- Pediatrics and pediatric subspecialties;
- Radiology;
- Rheumatology.

11.21.3 Use of Telecommunications

Services delivered using telecommunications are generally not covered by The Health Plan as telemedicine services. The exceptions to this are described below:

- A provider in the role of telepresenter may be providing a separately billable service under the scope of practice, such as performing an ECG or an X-ray. In this case, the separately billable service is covered, but the specific act of telepresenting is not covered
- A consulting provider at the distant site may offer a service that does not require real-time interaction with the member. Reimbursement for this type of service is limited to dermatology, radiology, ophthalmology, and pathology, and is subject to review by The Health Plan medical management. The consulting physician should bill covered services using modifier GQ
- In the special circumstance of the onset of acute stroke symptoms within three hours of presentation, The Health Plan recognizes the critical need for a neurology consultation in rural areas to aid in the determination of suitability for thrombolytic administration. Therefore, when the member presents within three hours of onset of stroke symptoms, The Health Plan reimburses the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patient's condition is such that real-time video interaction cannot be achieved due to an effort to expedite care

11.21.4 Conditions, Limitations and Exclusions

Both the referring and consulting providers must be registered with AHCCCS.

A consulting service delivered via telemedicine by other than an Arizona registered provider licensed to practice in the state or jurisdiction from which the consultation is provided or, if employed by an Indian Health Services (IHS), tribal or urban Indian health program, be appropriately licensed based on IHS and 638 tribal facility requirements.

At the time of service delivery via real-time telemedicine, the member's health care provider may designate a trained telepresenter to present the case to the consulting provider if the member's primary care physician (PCP) or attending physician, or other medical professional who is familiar with the member's medical condition, is not present. The telepresenter must be

familiar with the member's medical condition in order to present the case accurately. Medical questions may be submitted to the referring provider when necessary, but no payment is made for such questions.

The Health Plan provides benefits for nonemergency transportation to and from the telemedicine originating site to receive a medically necessary covered consultation or treatment service

11.22 Transplants

The following describes covered services for transplants under The Health Plan product:

- The Health Plan covers medically necessary transplants based on Arizona Health Care Cost Containment System (AHCCCS) direction. In order to be covered, a transplant must be medically necessary, cost effective, and federally and state reimbursable. Arizona state laws and regulations specifically address transplant services and related topics as follows: Specific non-experimental transplants which are approved for reimbursement are covered services (Arizona Revised Statute (ARS) §36-2907);
- Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (Arizona Administrative Code (AAC) R9-22-202);
- Medically necessary is defined as those covered services "provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions, or their progression, or prolong life" (AAC R9-22-101);
- Experimental services as defined in AAC R9-22-203;
- Standard of care is defined as "a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community" (AAC R9-22-101)
- Transplant coverage is limited for members ages 21 and older; however, the Health Plan covers all medically necessary, non-experimental transplants for members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Transplants are excluded for members who are eligible for only emergency services under the Federal Emergency Services Program;
- Covered transplants must meet nationally recognized criteria for nonexperimental, non-investigational and not primarily for purposes of research. Details of transplant coverage and criteria are available in the AHCCCS Medical Policy Manual Chapter 300, Policy 310-DD.

11.22.1 Covered Transplants for Members Ages 21 and Older

The following organ and tissue transplant services are covered for members ages 21 and older if prior authorized and coordinated with The Health Plan:

- o Heart, including transplants for the treatment of non-ischemic cardiomyopathy;
- o Lung;
- o Liver, including transplants for patients with Hepatitis C;
- o Kidney (cadaveric and liver donor);

- o Simultaneous pancreas/kidney (SPK);
- o Pancreas after a kidney transplant (PAK);
- o Autologous and allogeneic related and unrelated hematopoietic cell transplants;
- o Cornea;
- o Bone.

The Health Plan may consult with the AHCCCS consultant for guidance in those cases requiring medical determinations. If The Health Plan does not use the AHCCCS consultant, the Health Plan obtains its own expert opinion.

11.22.2 Non-Covered Transplants for Members Ages 21 and Older

- Pancreas only, if not performed simultaneously with or following a kidney transplant
- Partial pancreas (including autologous and allogeneic islet cell transplants)
- Visceral transplantation of:
 - o Intestine alone;
 - o Intestine with pancreas;
 - o Intestine with liver;
 - o Intestine, liver, pancreas en bloc.

Any other transplants not specifically listed under Covered Transplants for Members Ages 21 and Older

Where there is a transplant of multiple organs, only the covered transplants are reimbursed.

The following transplant and transplant-related services are not covered when the transplant procedure itself is not covered:

- Artificial or mechanical hearts or xenografts
- Workups to evaluate the patient as a possible transplant candidate
- Hospitalization for the above procedures
- Organ procurement

11.22.3 Transplant Services and Settings

Transplant services are covered only when performed in specific settings, as follows:

- Solid organ transplantation services must be provided in a Centers for Medicare and Medicaid Services (CMS) certified transplant center that is contracted with AHCCCS and that is also a United Network for Organ Sharing (UNOS) approved transplant center, unless otherwise approved by the Health Plan, and/or the AHCCCS chief medical officer (AHCCCS medical director or designee)
- Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation and is contracted with AHCCCS, unless otherwise approved by The Health Plan and/or the AHCCCS chief medical officer), AHCCCS medical director or designee

11.22.4 Assessment for Transplant Considerations

The first step in the assessment for transplant consideration is the initial evaluation by the member's primary care physician (PCP) and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral

for transplant consideration, the PCP and/or specialist must determine that all of the following conditions are satisfied:

- The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant
- There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member
- There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (such as, chemotherapy and immunosuppressive therapy)
- There is sufficient social support to ensure the member's compliance with treatment recommendations, such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits. For a pediatric/adolescent member, there is adequate evidence that the member and parent or guardian will adhere to the rigorous therapy, daily monitoring and re-evaluation schedule after transplant
- The member has been adequately screened for potential comorbid conditions that may impact the success of the transplant. When the member's medical condition is such that the evaluation must proceed immediately, the screenings may be provided by the PCP concurrent with the transplant evaluation
- The member's condition has failed to improve with all other conventional medical and surgical therapies. The likelihood of survival with transplantation, considering the member's diagnosis, age and comorbidities, is greater than the expected survival rate with conventional therapies. This information must be documented and submitted to the Health Plan at the time of request for evaluation

11.22.5 Exceptions for Transplant and Cancer

For members who require medically necessary dental services as a prerequisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions, and the provision of simple restorations. A simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. Benefits are provided for these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation.

11.22.6 AHCCCS Covered Solid Organ and Hematopoietic Stem Cell Transplants

Only solid organ and hematopoietic stem cell transplants that are AHCCCS covered services when medically necessary, cost effective, nonexperimental, and not primarily for purposes of research, are covered under The Health Plan product. Live donor kidney transplants are covered for pediatric and adult members. Live donor transplants may be considered on a case-by-case basis for solid organs, other than kidney, when medically appropriate and cost effective. Detailed criteria regarding specific transplants are found under the heading Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations located in the AHCCCS AMPM Chapter 300, Policy 310-DD.

11.22.7 Other Transplants and Devices

Following is additional information on coverage for other transplants and devices under the Health Plan product:

- Circulatory Assist Device (CAD) is an AHCCCS covered service when used as a bridge to transplantation and other specific criteria are met, when medically necessary and prior authorized by The Health Plan. Refer to Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations located in the Medical Policy Manual Chapter 300, Policy 310-DD;
- Bone grafts and corneal transplants are AHCCCS covered services, based on medical necessity and prior authorized by the Health Plan.

11.23 Emergency Transportation Services

The Health Plan covers emergency ground and air ambulance transportation services within certain limitations. Covered transportation services include:

- Emergency ground and air ambulance services required to manage an emergency medical condition at an emergency scene and in transport to the nearest appropriate facility

Maternal transport program (MTP), newborn intensive care program (NICP), basic life support (BLS), advanced life support (ALS), and air ambulance services depending upon the member's medical needs.

11.23.1 Coverage Limitations and Exclusions

The following limitations and exclusions apply to emergency transportation services:

- Coverage of ambulance transportation is limited to those emergencies in which specially equipped transportation is required to safely manage the member's medical condition
- Emergency transportation is covered only to the nearest appropriate facility medically equipped to provide definitive medical care
- Emergency transportation to an out-of-state facility is covered only if it is to the nearest appropriate facility
- Mileage reimbursement is limited to loaded mileage. Loaded mileage is the distance traveled, measured in miles while a member is on board the ambulance and being transported to receive emergency services

A provider who responds to an emergency call and provides medically necessary treatment at the scene, but does not transport the member is eligible for reimbursement limited to the approved base rate and medical supplies used

- A provider who responds to an emergency call, but does not treat or transport a member as a result of the call is not eligible for reimbursement
- When two or more members are transported in the same ambulance, each shall be charged an equal percentage of the base rate and mileage charges
- Air ambulance services are covered under the following conditions:
 - o The point of pick-up is inaccessible by ground ambulance
 - o Great distances or other obstacles are involved in getting the member to the nearest

- hospital with appropriate facilities
 - o The member's medical condition requires air ambulance services and ground ambulance services will not suffice
- Details regarding emergency transportation services are available in the [AHCCCS AMPM Chapter 300](#)

11.23.2 Non-Emergency Medical Transportation Services

The Health Plan covers medically necessary non-emergency ground and air transportation to and from a required medical service.

Round-trip air or ground ambulance transportation services may be covered when a hospitalized member is transported to another facility for necessary specialized diagnostic and/or therapeutic services, if all of the following requirements are met:

- The member's condition is such that the use of any other method of transportation is not appropriate
- Services are not available in the hospital in which the member is an inpatient
- The hospital furnishing the services is the nearest one with such facilities
- The member returns to the point of origin

Medically necessary nonemergency transportation to and from participating The Health Plan providers is a covered service for members who are not able to arrange or pay for transportation. Transportation is limited to the cost of transporting the member to the nearest The Health Plan provider capable of meeting the member's medical needs. Transportation is only provided to transport the member to and from the required Access-covered medical service.

Details regarding nonemergency medical transportation services are available in the AHCCCS Medical Policy Chapter 300, Policy 310-BB.

11.24 Genetic Testing Provisions

All genetic testing requires prior authorization. Prior authorization requests must include documentation regarding how the genetic testing is consistent with the genetic testing coverage limitations.

Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment option specific diagnoses or syndromes

Genetic testing is not covered to determine the likelihood of associated medical conditions occurring in the future.

Routine, non-genetic testing for other medical conditions (such as renal disease and hepatic disease) that may be associated with an underlying genetic condition is covered when medically necessary.

Genetic testing is not covered as a substitute for ongoing monitoring or testing of potential complications or sequelae of a suspected genetic anomaly.

Genetic testing is not covered to determine whether a member carries a hereditary predisposition to cancer or other diseases.

Genetic testing is also not covered for members diagnosed with cancer to determine whether their particular cancer is due to a hereditary genetic mutation known to increase the risks of developing that cancer.

11.25 Radiology Services

The Health Plan provides benefits for medically necessary radiology and medical imaging services for all eligible members when ordered by a primary care physician (PCP) or other practitioner for diagnosis, prevention, treatment, or assessment of medical conditions.

Radiology services must be provided by a participating radiology provider. Members may be responsible for copayments that correspond to the type of facility where services are rendered.

Complete the entire radiology order form when requesting radiology services, including all insurance information.

Participating providers with applicable radiology equipment can provide diagnostic radiology services in their office.

Section 12 - BEHAVIORAL HEALTH NETWORK PROVIDER SERVICE DELIVERY REQUIREMENTS

12.1 Eligibility Screening For AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program

Eligibility status is essential for knowing the types of services a person may be able to access. In Arizona's public behavioral health system, a person may:

- Be eligible for Title XIX/XXI (Medicaid) or Title XXI covered services;
- Not qualify for Title XIX/XXI services, but be eligible for services as a person determined to have a Serious Mental Illness (SMI);
- Be covered under another health insurance plan or "third party" (including Medicare and plans available via the Federal Health Insurance Marketplace); or
- Be without insurance or entitlement status and asked to pay a percentage of the cost of services.

Determining current eligibility and enrollment status is one of the first things to be completed upon receiving a request for services. For persons who are not Title XIX/XXI eligible, a financial screening and eligibility application must be completed to determine eligibility. Verification of an individual's identification and citizenship/lawful presence in the United States is completed through the AHCCCS Health-e-Arizona PLUS (HEAPlus) application process. See [AMPM Section 650](#) for additional information.

Medicare eligible Members, including persons who are dually eligible for Medicare (Title XVIII), Medicaid (Title XIX), and Children's Health Insurance Program (CHIP) (Title XXI) receive Medicare Part D prescription drug benefits. The benefit also provides for Part D *Extra Help* for eligible individuals whose income and resources are limited. Dual Eligible individuals are automatically eligible for the Part D *Extra Help* due to their Medicaid eligibility. See [AMPM Section 650](#) for additional information.

The following information will assist providers of covered services in:

- Accessing and interpreting eligibility and enrollment information;
- Conducting financial screenings and assisting persons with applying for Title XIX/XXI or other benefits; and
- Assessing potential eligibility for Medicare Part D Prescription Drug coverage and the Low Income Subsidy (LIS) program.

Providers must coordinate with AHCCCS acute care contractors, Primary Care Providers (PCP), Arizona Long Term Care System (ALTCs) contractors, service providers and eligible persons to share specific information to determine eligibility for Title XIX/XXI services and behavioral health coverage. In addition, providers must notify AHCCCS and The Health Plan of a Member's death, incarceration or relocation out-of-state that may affect a Member's eligibility status. Providers are required to have a policy and/or process in place for monitoring AHCCCS Eligibility and conducting timely screenings.

12.1.1 Title XIX/XXI Screening and Eligibility Procedures

Providers must screen persons requesting covered services for Medicaid and Medicare eligibility in conformance with **Section 12.1 - Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program.**

1. Verify the person's Title XIX/XXI eligibility for all persons referred for services and at least monthly thereafter;
2. For those persons who are not Title XIX/XXI eligible, screen for potential Title XIX/XXI or other eligibility; and
3. As indicated by the screening tool, assist persons with applications for a Title XIX/XXI or other eligibility determination.

12.1.2 Step #1 - Accessing Title XIX/XXI or Other Eligibility Information

Providers who need to verify the eligibility and enrollment of an AHCCCS Member can use one of the alternative verification processes 24 hours a day, 7 days a week. These processes include:

- **AHCCCS Web-based Verification (Customer Support 602-417-4451):** This web site allows the providers to verify eligibility and enrollment. To use the web site, providers must create an account before using the applications. To create an account, go to: <https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f> and follow the prompts. Once providers have an account they can view eligibility and claim information (claim information is limited to FFS). Batch transactions are also available. There is no charge to providers to create an account or view transactions. For technical web based issues, contact AHCCCS Customer Support at 602-417-4451 Monday – Friday from 7:00 a.m. to 5:00 p.m.

- **AHCCCS Subcontracted Medical Electronic Verification Service (MEVS):** The AHCCCS Member card can be “swiped” by providers to automatically access the AHCCCS Prepaid Medical Management System (PMMIS) for up to date eligibility and enrollment. For information on MEVS, contact the MEVS vendor: Emdeon at 1-800-444-4336.
- **Interactive Voice Response (IVR) System:** IVR allows unlimited verification information by entering the AHCCCS Member’s identification number on a touch-tone telephone. This allows providers access to AHCCCS’s PMMIS system for up to date eligibility and enrollment. There is no charge for this service. Providers may call IVR within Maricopa County at 602-417-7200 and all other counties at 1-800-331-5090.
- **Medifax:** Medifax allows providers to use a PC or terminal to access the AHCCCS PMMIS system for up to date eligibility and enrollment information. For information on EVS, contact Emdeon at 1-800-444-4336.
- **AHCCCS 270/271 Eligibility Look-up.**

If a person’s eligibility status still cannot be determined using one of the above methods, a provider must:

- Call The Health Plan Customer Service at 866-796-0542 for assistance during normal business hours (8:00 a.m. through 5:00 p.m. Monday-Friday); or
- Call the AHCCCS Verification Unit, which is open Monday through Friday, from 8:00 a.m. to 5:00 p.m. The Unit is closed Saturdays and Sundays and on state holidays. Callers from outside Maricopa County can call 1-800-962-6690, or 602-417-7000 in Maricopa County, and remain on the line for the next available representative. When calling the AHCCCS Verification Unit, the provider must be prepared to provide the verification unit operator the following information:
 - The provider’s identification number;
 - The Member’s name, date of birth, AHCCCS identification number; and social security number (if known); and
 - Dates of service(s).

12.1.3 Step #2 - Interpreting Eligibility Information

A provider accesses important pieces of information when using the eligibility verification methods described in Step #1 above: AHCCCS eligibility key codes and/or AHCCCS rate codes. The [AHCCCS Codes and Values \(CV\) 13 Reference System](#) includes a key code index that may be used by providers to interpret AHCCCS eligibility key codes and/or AHCCCS rate codes. The Health Plan will ensure that providers have access to and are familiar with the codes as they may help indicate provider responsibility for the delivery of Title XIX/XXI covered services.

If eligibility status and provider responsibility is confirmed, the provider must provide any needed covered services in accordance with The Health Plan Provider Manual, the AHCCCS Covered Behavioral Health Services Guide, and the [AHCCCS Medical Policy Manual](#).

There are some circumstances whereby a person may be Title XIX/XXI eligible but the State behavioral health system is not responsible for providing covered services. This includes persons

enrolled as elderly or physically disabled (EPD) under the Arizona Long Term Care System (ALTCS) Program and persons eligible for family planning services only through the Sixth Omnibus Reconciliation Act (SOBRA) Extension Program. Persons who are Title XIX/XXI eligible through ALTCS must be referred to their ALTCS case manager to arrange for provision of Title XIX/XXI services. However, ALTCS-EPD individuals who are determined to have a SMI may also receive Non-Title XIX/XXI SMI services from The Health Plan. ALTCS-Division of Developmental Disabilities (DDD) persons' services are provided through the AHCCCS behavioral health system.

If the person is not currently Title XIX/XXI eligible, proceed to Step #3 and conduct a screening for Title XIX/XXI or other eligibility.

12.1.4 **Step #3 - Screening for Title XIX/XXI eligibility: When and Who to Screen for Title XIX/XXI or Other Eligibility**

The Health Plan Providers are required to screen all Non-Title XIX/XXI persons using the [Health-e Arizona PLUS \(HEAPlus\) online application](#):

- Upon initial request for services;
- At least annually or during each Federal Health Insurance Marketplace open enrollment period thereafter, if still receiving services; and
- When significant changes occur in the person's financial status.

A screening is not required at the time an emergency service is delivered, but must be initiated within 5 days of the emergency service if the person seeks or is referred for ongoing services.

To conduct a screening for Title XIX/XXI or other eligibility, the provider meets with the person and completes AHCCCS eligibility screening through the [Health-e Arizona PLUS online application](#) for all Non-Title XIX/XXI persons. Documentation of AHCCCS eligibility screening must be included in a person's comprehensive clinical record upon completion after initial screening, annual screening and screening conducted when a significant change occurs in a person's financial status (see **Section 10.2 — Medical Record Standards**). The Health Plan will assist providers with contact information to obtain HEAPlus assistor modules and training from AHCCCS. Once completed, the screening tool will indicate:

- **That the person is potentially AHCCCS eligible.** Pending the outcome of the Title XIX/XXI or other eligibility determination, the person may be provided services in accordance with **Section 7.22 — Copayments**. Upon the final processing of an application, it is possible that a person may be determined ineligible for AHCCCS health insurance. If the person is determined ineligible for Title XIX/XXI or other benefits, the person may be provided services in accordance with **Section 8.11 — Copayments**.
- **That the person does not appear Title XIX/XXI or AHCCCS eligible.** If the screening tool indicates that the person does not appear to have Title XIX/XXI or any other AHCCCS eligibility, the person may be provided services in accordance with **Section 7.22 — Copayments**. However, the person may submit the application for review by DES and/or AHCCCS *regardless* of the initial screening result. Additional information requested and verified by DES/AHCCCS may result in the person receiving AHCCCS eligibility and services after all.

12.1.5 Reporting Requirements for Title XIX/XXI Eligibility Screening

The number of applicant screenings for Title XIX/XXI, SMI, and Federal Health Insurance Marketplace eligibility completed must be documented by providers and reported to The Health Plan on a monthly basis (RF-1011) as outlined in **Section 16 – Deliverable Requirements**.

Technical assistance is available by calling The Health Plan Contracts Department.

The reporting is required to include the following elements:

1. Number of applicants to be screened for AHCCCS eligibility;
2. Number of applicant screenings for AHCCCS eligibility completed;
3. Number of applicant screenings for AHCCCS eligibility to be completed;
4. Number of AHCCCS eligible applicants as a result of the screening;
5. Number of applicants to be screened for health coverage via the Federal Health Insurance Marketplace;
6. Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace completed;
7. Number of applicant screenings for health coverage via the Federal Health Insurance Marketplace to be completed; and
8. Number of applicants eligible for health coverage via the Federal Health Insurance Marketplace as a result of the screening.

12.1.6 Medicare Part D Prescription Drug Coverage and Low Income Subsidy (LIS) Eligibility

Persons must report to The Health Plan or the provider if they are eligible or become eligible for Medicare as it is considered third party insurance. See **Section 7.24 — Third Party Liability and Coordination of Benefits** regarding how to coordinate benefits for persons with other insurance including Medicare. If a Member is unsure of Medicare eligibility, The Health Plan or providers may verify Medicare eligibility by calling 1-800-MEDICARE (1-800-633-4227), with a Member's permission and needed personal information. Once a person is determined Medicare eligible, The Health Plan providers must offer and provide assistance with Part D enrollment and the LIS application upon a Member's request. The Health Plan providers shall track Part D enrollment and LIS application status of Members, and report tracking activities when required by AHCCCS.

12.1.6.1 Enrollment in Part D

All persons eligible for Medicare must be encouraged to and assisted in enrolling in a Medicare Part D plan to access Medicare Part D Prescription Drug coverage. Enrollment must be in a Prescription Drug Plan (PDP), which is fee-for-service Medicare plan or a Medicare Advantage Prescription Drug Plan (MA-PD), which is a managed care Medicare plan. Upon request, providers must assist Medicare eligible persons in selecting a Part D plan. The Centers for Medicare and Medicaid Services (CMS) developed web tools to assist with choosing a Part D plan that best meets the person's needs. The web tools can be accessed at www.medicare.gov. For additional information regarding Medicare Part D Prescription Drug coverage, call Medicare at 1-800-633-4227 or the Arizona State Division of Aging and Adult Services at 602-542-4446 or toll free at 1-800-432-4040.

12.1.6.2 ***Applying for the Low Income Subsidy (LIS)***

- The LIS is a program in which the federal government pays all or a portion of the cost sharing requirements of Medicare Part D on behalf of the person. If the provider determines that a person may be eligible for the LIS (see the Social Security Administration (SSA) website at www.ssa.gov for income and resource limits), the provider must offer to assist the person in completing an application.
- Applications can be obtained and submitted through the following means:
 - Online at <https://secure.ssa.gov/i1020/start>;
 - By calling 1-800-772-1213 or TTY 1-800-325-0078, Monday – Friday, 7 AM – 7 PM.
 - In person at a SSA local office; or
 - By mailing a paper application to the SSA.

12.1.6.3 ***Reporting Part D Enrollment and LIS Applications***

Providers must track Part D enrollment and LIS application status for Medicare eligible Members. AHCCCS has developed **Provider Manual Form 3.1.1, Tracking of Medicare Part D Enrollment** which can be used by The Health Plan or the provider to track persons eligible for Medicare. This will assist The Health Plan to ensure that Medicare eligible persons are enrolled in a Part D plan and apply for the LIS program, if applicable. Providers are directed to call the Provider Service Center to obtain a copy of this forms, if needed, at 1-866-796-0542.

12.1.6.4 ***Federal Health Insurance Marketplace***

Providers must educate and encourage Non-Title Members with SMI to apply for health coverage from a qualified health plan using the application process located at the Federal Health Insurance Marketplace and offer assistance for those choosing to enroll during open enrollment periods and qualified life events. Members enrolled in a qualified health plan through the Federal Health Insurance Marketplace may continue to be eligible for Non-Title XIX/XXI covered services that are not covered under the Federal Health Insurance Marketplace plan.

12.1.7 **Refusal to Participate With Screening and/or Application Process for Title XIX/XXI or Other AHCCCS Eligibility or Enrollment in a Part D Plan**

On occasion, a person may decline to participate in the AHCCCS eligibility screening and application process or refuse to enroll in a Medicare Part D plan. In these cases, the provider must actively encourage the person to participate in the process of screening and applying for AHCCCS health insurance coverage or enrolling in a Medicare Part D plan.

Arizona state law provides that persons who refuse to participate in the AHCCCS screening and eligibility application process or to enroll in a Medicare Part D plan are ineligible for state funded services (see [A.R.S. § 36-3408](http://legis.state.ar.us/doc.aspx?docid=363408)). As such, individuals who refuse to participate in the AHCCCS screening and eligibility application or enrollment in Medicare Part D, if eligible, will not be enrolled with The Health Plan during their initial request for services or will be dis-enrolled if the person refuses to participate during an annual screening. The following conditions do not constitute a refusal to participate:

- A person's inability to obtain documentation required for the eligibility determination;

- Persons incapable of participating as a result of their mental illness and does not have a legal guardian; and/or
- A person who is enrolled in a qualified health plan through the Federal Health Insurance Marketplace and refuses to take part in the AHCCCS screening and application process will not be eligible for Non-Title XIX/XXI SMI funded services.

If a person refuses to participate in the screening and/or application process for Title XIX/XXI or other eligibility, or to enroll in a Part D plan, the provider must ask the person to sign the [AHCCCS AMPM Chapter 600 Section 650, Attachment A, Decline to Participate in AHCCCS Screening or Referral Process](#). If individuals refuse to sign the form, the provider must document their refusal to sign in the comprehensive clinical record (See **Section 10.2 — Medical Records Standards**).

12.1.7.1 ***Special Considerations for Persons Determined to Have a Serious Mental Illness (SMI)***

If a person who is eligible for or requesting services as a person determined to have a SMI is unwilling to complete the eligibility screening or application process for Title XIX/XXI or to enroll in a Part D plan and does not meet the conditions above, the provider must request a clinical consultation by a Behavioral Health Medical Professional. If the person continues to refuse following a clinical consultation, the provider must request that the person sign the [AHCCCS AMPM Chapter 600 Section 650, Attachment A, Decline to Participate in AHCCCS Screening or Referral Process](#). Prior to the termination of services for persons with a SMI who have been receiving behavioral health services and subsequently decline to participate in the screening/referral process, The Health Plan must provide written notification of the intended termination using the **Provider Manual Form 15.3.1, Notice of Decision and Right to Appeal** (see **Section 8.5 — Notice and Appeal Requirements (SMI and GMH/SA Non-Title XIX/XXI)**). Providers are directed to call the Provider Service Center to obtain a copy of this form, if needed, at 1-866-796-0542.

12.1.7.2 ***Persons Who Refuse to Cooperate With the AHCCCS Eligibility and/or Application Process or Who Do Not Enroll in a Part D Plan***

The provider must inform the person who they can contact in the behavioral health system for an appointment if the person chooses to participate in the eligibility and/or application process in the future. Members may call the behavioral health provider, The Health Plan Customer Services at 866-796-0542 8:00 a.m. – 5:00 p.m., Monday – Friday, or the Crisis Call Center at 866-796-0542 for assistance.

12.2 **Appointment Standards and Timeliness of Service**

It is vital that the State behavioral health system be responsive and accessible to all the persons it serves. It is the expectation of the State that provider response to a person's identified behavioral health service need is timely and based on clinical need, resulting in the best possible behavioral health outcomes for that person.

Response time is always determined by the acuity of individuals assessed behavioral health condition at the moment they are in contact with the provider. The State has organized responses into two categories: urgent responses and routine responses.

Please note that at the time it is determined that an urgent response is needed, a person's eligibility and enrollment status may not be known. Providers must respond to all persons in urgent need until the situation is clarified that the provider is not financially responsible. Persons who are determined ineligible for covered services may be referred to applicable community resources.

Per AHCCCS Appointment Availability policy, providers will be monitored for appointment availability standards quarterly through telephonic surveys and reviews of provider schedules during face-to-face site visits. Results of the surveys are reviewed in the Quality Management Performance Improvement Committee Meeting to determine the need for performance improvement projects, corrective actions or closing of panels. Appointment Availability concerns will be addressed in subsequent technical assistance sessions with the assigned provider engagement staff. Appointment Availability performance issues may result in closed panels and overall network trends will be reported out in the monthly Essential Provider Calls.

Providers must develop and implement policies and procedures to monitor the availability and timeliness of appointments for Members and providers must disseminate information regarding appointment standards to Members, service providers, and Out-of-Network providers. Providers also must clearly post hours of operation in a location accessible to Members. For more information on appointment standards, see the AHCCCS [ACOM Policy 417](#) on Appointment Standards and Timeliness of Services.

12.2.1 Type of Response by a Behavioral Health Provider (Non- Hospitalized Persons)

For Behavioral Health Provider Appointments:

- a. Urgent need appointments as expeditiously as the member's health condition requires but no later than 24 hours from identification of need;
- b. Routine care appointments:
 - i. Initial assessment within seven calendar days of referral or request for service;
 - ii. The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but no later than 23 calendar days after the initial assessment; and
 - iii. 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.

For Psychotropic Medications:

- a. Assess the urgency of the need immediately; and
- b. Provide an appointment, if clinically indicated, with a Behavioral Health Medical Professional within a timeframe that ensures the member a) does not run out of needed

medications, or b) does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

For Behavioral Health Appointments for persons in legal custody of the Department of Child Safety (DCS) and adopted children in accordance with A.R.S. §8-512.01:

- a. 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;
- b. Initial appointment within timeframes indicated, by clinical need, but no later than 21 calendar days after the initial assessment; and
- c. 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.

Note: Standards for persons receiving services as part of SABG Grant funding are in Section 12.10 — Special Populations.

12.2.2 Health Home Appointment Availability and Scheduling

In accordance with the requirements in this Provider Manual, providers must maintain adequate urgent, and routine outpatient office and in-home appointments to meet the needs of Members in their areas. For more information regarding Appointment Availability Requirements see [ACOM Policy 417](#).

At all clinics open four or more days per week, Health Home providers must provide intake and clinical office services during evenings (until at least 7:00 PM and at least two (2) nights per week) and on Saturdays. Health Home providers providing routine outpatient services must verify that at least fifteen percent (15%) of a clinic's scheduled hours of operation are outside of regular business hours (8:00 AM – 5:00 PM, Monday through Friday) in each community served.

Health Home providers must maintain daily appointment slots for urgent treatment appointments in each community served. Health Home providers also must make available additional urgent psychiatric appointments each week of at least thirty (30) minute duration each and not fill the urgent appointment slots prior to two (2) business days before the date of the urgent appointment.

Health Home providers must collaborate with The Health Plan in maintaining a centralized after-hours scheduling system to facilitate after-hours urgent and appointment scheduling. The Health Home provider must review and monitor the online centralized schedule at least twice a day to facilitate effective coordination of care. In each community served, a Health Home provider must "block" one (1) hour per day of scheduling time in the late afternoon to allow The Health Plan and/or its crisis telephone vendor to schedule urgent and emergent psychiatric and intake appointments. If by 8:00 AM on a given day no appointment has been booked in the "blocked" time, the Health Home provider may release the "blocked" time for other appointments.

12.2.3 Wait Times

The State has established standards so that persons presenting for scheduled appointments do not have to wait unreasonable amounts of time. Unless a provider is unavailable due to an emergency, a person appearing for an established appointment must not wait for more than one hour. Providers are required to monitor wait times via a daily log to include the time the member arrived, the time of the scheduled appointment and the time the member was taken back to appointment. Providers offering open access or walk-in appointments must carefully monitor wait times and offer Members the opportunity to schedule an appointment if the waiting time is anticipated to exceed two hours.

Providers arranging for, or providing non-emergency transportation services for Members must adhere to the following standards:

- Members must not be transported to a facility sooner than one hour before their scheduled appointment; and
- Members must not have to wait for more than one hour after the conclusion of their appointment for transportation home or to another pre-arranged destination.
- Providers must develop and implement a quarterly performance auditing protocol to evaluate compliance with the standard for all subcontracted transportation vendors/brokers and require corrective action if standards are not met.

12.2.4 72-Hour Urgent Behavioral Health Response for Children Taken into Department of Economic Security/Department of Children's Safety (DES/DCS) Custody

An urgent response, known as "Rapid Response" (within 72 hours), is required for all children who are taken into the custody of ADES/DCS regardless of Title XIX/XXI eligibility status. The purpose for this rapid response service is to identify immediate safety needs and presenting problems of the child, to stabilize behavioral health crises, and to establish services that will lead to family reunification, when appropriate.

More specific details and requirements of the 72-Hour Rapid Response can be found in **Provider Manual Section 14.2.1, 72-Hour Rapid Response Requirements for Children Removed by DCS and the Provider Manual Form 6.1.1 Urgent Response Disposition** which can be obtained by calling the Provider Service Center at 1-866-796-0542.

12.2.5 Appointments for Psychotropic Medications

For persons who may need to be seen by a Behavioral Health Medical Practitioner (BHMP), it is required that the person's need for medication be assessed immediately and, if clinically indicated, that the person be scheduled for an appointment within a timeframe that ensures:

- The person does not run out of any needed psychotropic medications; or
- Individuals are evaluated for the need to start medications to verify that the person does not experience a decline in their behavioral health condition.

Response for 387, or Requests for Psychotropic Medications:

	WHEN	WHAT	WHO
Referral for psychotropic medications	Assess the urgency of the need immediately. If clinically indicated, provide an appointment with a BHMP within a timeframe indicated by clinical need, but no later than 30 calendar days from the referral/initial request for services.	Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.	<ul style="list-style-type: none"> • All Title XIX/XXI eligible persons; • All Non-Title XIX/XXI persons enrolled with The Health Plan • All persons determined to have a SMI; and • Any person in an emergency or crisis.
All initial assessments and treatment recommendations that indicate a need for psychotropic medications	The initial assessment and treatment recommendations must be reviewed by a BHMP within a timeframe based on clinical need.	Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.	<ul style="list-style-type: none"> • All Title XIX/XXI eligible persons; • All persons determined to have a SMI; and • Any person in an emergency or crisis.

12.2.6 Referrals for Hospitalized Persons

Providers must quickly respond to referrals pertaining to eligible persons not yet enrolled in The Health Plan or Title XIX/XXI eligible persons who have not been receiving services prior to being hospitalized for psychiatric reasons and persons previously determined to have a SMI. Upon receipt of such a referral, the following steps must be taken:

- For referrals of Title XIX/XXI eligible persons and persons previously determined to have a SMI, initial face-to-face contact, an assessment and disposition must occur within 24 hours of the referral/request for services.
- For referrals of Non-Title XIX/XXI eligible persons and persons referred for eligibility determination of SMI:
 - Initial face-to-face contact and an assessment must occur within 24 hours of the referral/request for services. Determination of SMI eligibility must be made within timeframes consistent with and in accordance with **Section 12.6 — SMI Eligibility Determination**; and
 - Upon the determination that the person is eligible for services and the person is in need of continued behavioral health services, the person must be enrolled and the effective date of enrollment must be no later than the date of first contact.

12.2.7 Other Requirements

All referrals from a person's primary care provider (PCP) requesting a psychiatric evaluation and/or psychotropic medications must be accepted and acted upon in a timely manner according to the needs of the person, and the response time must help ensure that the person

does not experience a lapse in necessary psychotropic medications, as described in **Section 12.2.5 — Appointments for Psychotropic Medications**.

Title XIX/XXI persons must never be placed on a “wait list” for any Title XIX/XXI covered behavioral health service. If The Health Plan network is unable to provide medically necessary covered services for Title XIX/XXI persons, The Health Plan must ensure timely and adequate coverage of needed services through an alternative provider until a network provider is subcontracted. In this circumstance, The Health Plan must ensure coordination with respect to authorization and payment issues. In the event that a covered behavioral health service is temporarily unavailable to a Title XIX/XXI eligible person, the provider must adhere to the following procedure:

1. Maintain the current level of services being provided to the person;
2. Identify and provide any supportive services needed by the person while securing the needed service;
3. Verify the creation of a service plan and a crisis plan for the Title XIX/XXI Member and verify that the person understands how to access crisis services during this time; and
4. Contact The Health Plan’s Utilization Management Department at 1-866-495-6738 to coordinate and track care while securing the service, and to discuss needs for any non-contracted services, including for persons who are in an inpatient or residential facility and are awaiting a referral for outpatient services.

12.2.8 Special Populations

The State receives some funding for services through the Federal Substance Abuse Block Grant (SABG). SABG funds are used to provide substance abuse services for Non-Title XIX/XXI eligible persons. As a condition of receiving this funding, certain populations are identified as priorities for the timely receipt of designated services. Any providers contracted with The Health Plan for SABG funds must follow the requirements found in this Section. For all other providers that do not currently receive these funds, the following expectations do not apply.

12.2.8.1 SABG Block Grant Populations

The following populations are prioritized and covered under the SABG Block Grant:

- **First:** Pregnant females who use drugs by injection;
- **Then:** Pregnant females who use substances;
- **Then:** Other injection drug users;
- **Then:** Substance-using females with dependent children, including those attempting to regain custody of their child(ren); and
- **Finally:** All other persons in need of substance abuse treatment.

Response Times for Designated Behavioral Health Services under the SABG Block Grant:

When	What	Who
<p>Behavioral health services provided within a timeframe indicated by clinical need, but no later than 48 hours from the referral/initial request for services.</p>	<p>Any needed covered behavioral health service, including admission to a residential program if clinically indicated;</p> <p>If a residential program is temporarily unavailable, an attempt shall be made to place the person within another provider agency facility, including those in other geographic service areas. If capacity still does not exist, the person shall be placed on an actively managed wait list and interim services must be provided until the individual is admitted. Interim services include: counseling/education about HIV and Tuberculosis (include the risks of transmission), the risks of needle sharing and referral for HIV and TB treatment services if necessary, counseling on the effects of alcohol/drug use on the fetus and referral for prenatal care.</p>	<p>Pregnant individuals/teenagers referred for substance abuse treatment (includes pregnant injection drug users and pregnant substance abusers) and substance-using females with dependent children, including those attempting to regain custody of their child(ren).</p>
<p>Behavioral health services provided within a timeframe indicated by clinical need but no later than 14 days following the initial request for services/referral.</p> <p>All subsequent services must be provided within timeframes according to the needs of the person.</p>	<p>Includes any needed covered behavioral health services;</p> <p>Admit to a clinically appropriate substance abuse treatment program (can be residential or outpatient based on the person's clinical needs); if unavailable, interim services must be offered to the person. Interim services shall minimally include education/interventions with regard to HIV and tuberculosis and the risks of needle sharing and must be offered within 48 hours of the request for treatment.</p>	<p>All other injection drug users</p>

When	What	Who
Behavioral health services provided within a timeframe indicated by clinical need but no later than 23 days following the initial assessment. All subsequent behavioral health services must be provided within timeframes according to the needs of the person.	Includes any needed covered behavioral health services.	All other persons in need of substance abuse treatment

12.3 Referral and Intake Process

The referral process serves as the principal pathway by which persons are able to gain prompt access to publicly supported services. The intake process serves to collect basic member information from persons in order to enroll them in the AHCCCS system, screen for Title XIX/XXI AHCCCS eligibility and determine the need for any copayments (See **Section 7.22 — Copayments**). It is critical that both the referral process and intake process are culturally sensitive, efficient, engaging, and welcoming to the person and/or family member seeking services, and leads to the provision of timely and appropriate services based on the urgency of the situation.

A “referral” is any oral, written, faxed or electronic request for services made by the Member or Member’s legal guardian, family member, an AHCCCS Acute Contractor, PCP, hospital, court, Tribe, IHS, school, or other state or community agency.

Providers must not arbitrarily or prematurely reject or eject a Member from services/referrals without prior authorization of The Health Plan. Providers must resolve referral disputes promptly. The Health Plan will promptly intervene and resolve any dispute between a provider and a referring source when those parties cannot informally resolve disputes regarding the need for emergency, urgent, or routine appointments.

The Health Plan providers are responsible for managing referrals and wait lists for Non-Title XIX/XXI persons in accordance with the SABG Block Grant for identified priority populations when services are temporarily unavailable. If The Health Plan network is unable to provide medically necessary services to Title XIX/XXI persons, The Health Plan will verify timely and adequate coverage of needed services through an out-of-network provider until a network provider is contracted (See **Section 12.2 — Appointment Standards and Timeliness of Service**).

12.3.1 Objectives

To facilitate a Member's access to services in a timely manner, providers will maintain an effective process for the referral and intake for services that includes:

- Communicating to potential referral sources the process for making referrals (e.g., centralized intake, identification of providers accepting referrals);
- Collecting enough basic information about the person to determine the urgency of the situation and subsequently scheduling the initial assessment within the required timeframes and with an appropriate provider (See **Section 12.2 — Appointment Standards and Timeliness of Service**);
- Adopting a welcoming, trauma informed, and engaging manner with the person and/or person's legal guardian/family member;
- Ensuring that intake interviews are culturally appropriate and delivered by providers that are respectful and responsive to the Member's cultural needs (see **Section 12.14 — Cultural Competence**);
- 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, the referral source about the final disposition of the referral; and
- Conducting intake interviews that ensure the accurate collection of all the required information necessary and ensure Members who have difficulty communicating because of a disability or who require language assistance are afforded appropriate accommodations to assist them in fully expressing their needs.

12.3.2 Where to Send Referrals

The Health Plan maintains a provider directory on its website that is available to AHCCCS Health Plans and Department of Economic Security /Division of Developmental Disabilities District Program Administrators (DES/DDD). A printed copy can be made available upon request. The directory indicates which providers are accepting referrals and conducting initial assessments. It is important for providers to promptly notify The Health Plan of any changes that would impact the accuracy of the provider directory (e.g., change in telephone or fax number, no longer accepting referrals).

Individuals may access services by directly contacting a Health Home. Contracted Health Homes are identified on The Health Plan website (www.azcompletehealth.com) and in The Health Plan Member Handbook. Individuals may also call The Health Plan Customer Service at 1-866-796-0542, 24 hours a day/7 days a week, and receive a referral to a contracted Health Home. During normal business hours, The Health Plan will transfer callers to an intake provider. After-hour referrals are provided to Health Home providers who are expected to follow up on the referral. The Crisis Call Center staff tracks referrals to verify the caller is appropriately connected with a Health Home. In addition, the Crisis Call Center has access to emergent and urgent psychiatric appointments at intake provider sites and can schedule these appointments on the Member's behalf.

Providers are required to notify The Health Plan of any changes that would alter or change information provided through the directory. A 30-day notice is required for changes in telephone number, fax number, email address, service changes, staff changes, service capacity changes or ability to accept new referrals as outlined in **Section 16 — Deliverable Requirements.**)

12.3.3 Choice of Providers

The Health Plan offers Members a choice in selecting providers, and providers are required to provide each Member a choice in selecting a provider of services, provider agency, and direct care staff. Providers are required to allow Members to exercise their right to services from an alternative In-Network provider, and offer each Member access to the most convenient In-Network service location for the service requested by the Member. In addition, providers must make available all Covered Services to all Title XIX/XXI eligible American Indians, whether they live on or off reservation. Eligible American Indian Members may choose to receive services through a RBHA/MCO/Health Plan, Tribal and Regional Behavioral Health Authorities, or through an IHS or 638 tribal provider.

12.3.4 Referral to a Provider for a Second Opinion

Title XIX/XXI Members are entitled to a second opinion and providers are required to provide proof that each Member is informed of the right to a second opinion.

Upon a Title XIX/XXI eligible Member's request or at the request of the provider's treating physician, the provider must—at no cost to the Member—make available a second opinion from a qualified health care professional either within the network, or arrange for the Member to obtain a second opinion from a qualified health care professional outside the network (42 CFR 438.206(b)(3)). For purposes of this section, a "qualified health care professional" is (a) an AHCCCS registered provider of covered health services (b) who is a physician, a physician assistant, a nurse practitioner, a psychologist, or an independent Master's level therapist.

A behavioral health provider can arrange for a second opinion in-network or can contact the Health Plan Customer Service at 1-866-796-0542, 8:00 a.m. – 5:00 p.m. Monday – Friday, for assistance. Out-of-Network requests should be submitted to The Health Plan Medical Management department for review and processing. A provider must maintain a record identifying both (1) the date of service for the second opinion and (2) the name of the provider who provided the second opinion. There must be documentation in the clinical chart of the following:

- Rationale for the use of two medications from the same pharmacological class;
- Rationale for the use of more than three different psychotropic medications in adults; and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population.

12.3.5 Referrals Initiated by Department of Economic Security/ Department of Child Safety (DES/DCS) Pending the Removal of a Child

Upon notification from DES/ Department of Child Safety (DCS) that a child has been, or is at risk of being taken into the custody of DES/Department of Child Safety (DCS), providers are expected to respond in an urgent manner (for additional information, see **Section 12.2 — Appointment**

Standards and Timeliness of Service and AHCCCS Practice Protocol, Unique Needs of Children, Youth and Families Involved with Child Protective Services).

12.3.6 Accepting Referrals

Providers must establish written procedures for accepting and acting upon referrals, including emergency referrals. Providers must accept referrals for services as identified in the provider's contract with the Health Plan, unless The Health Plan grants a written waiver or suspension of this requirement. Providers must not arbitrarily or prematurely reject or eject a Member from services/referrals without prior authorization of the Health Plan. Providers must accept referrals, regardless of diagnosis, level of functioning, age, Member's status in family, or level of service needs. (See 42 CFR 438.210 (a)(3)(iii))

Providers must accept and respond to emergency referrals of Title XIX/XXI eligible Members and Non-Title XIX/XXI Members with SMI twenty-four (24) hours a day, seven (7) days a week. Emergency referrals do not require prior authorization. Emergency referrals include those initiated for Title XIX/XXI eligible and Non-Title XIX/XXI with SMI Members admitted to a hospital or treated in the emergency room. Providers must respond within twenty-four (24) hours upon receipt of an emergency referral.

The following information shall be collected from referral sources:

- Date and time of referral;
- Information about the referral source including name, telephone number, fax number, affiliated agency, and relationship to the person being referred;
- Name of person being referred, address, telephone number, gender, age, date of birth and, when applicable, name and telephone number of parent or legal guardian;
- Whether or not the person, parent, or legal guardian is aware of the referral;
- Transportation and other special needs for assistance due to impaired mobility, blindness/low vision or being deaf or hard of hearing, or developmental or cognitive impairment;
- Accommodations due to cultural uniqueness and/or the need for interpreter services;
- Information regarding payment source (i.e., AHCCCS, private insurance, Medicare or self-pay) including the name of the AHCCCS health plan or insurance company;
- Name, telephone number, and fax number of AHCCCS primary care provider (PCP) or other PCP as applicable;
- Reason for referral including identification of any potential risk factors such as recent hospitalization, evidence of suicidal or homicidal thoughts, pregnancy, and current supply of prescribed psychotropic medications;
- Medications prescribed by the Member's PCP or other medical professional including the reason why the medication is being prescribed; and
- The names and telephone numbers of individuals the Member, parent, or guardian may wish to invite to the initial appointment with the referred Member.

Providers should act on a referral regardless of how much information they obtained. While the information listed above will facilitate evaluating the urgency and type of practitioner the Member may need to see, timely triage and processing of referrals must not be delayed because of missing or incomplete information.

When psychotropic medications are a part of an enrolled person's treatment or have been identified as a need by the referral source, providers must respond as outlined in **Section 12 — Appointment Standards and Timeliness of Service**.

When individuals seek services or their family member, legal guardian, or significant other contacts a provider directly about accessing services, provider shall ensure that the protocol used to obtain the necessary information about the person seeking services is engaging and welcoming.

When a SMI eligibility determination is being requested as part of the referral or by the person directly, providers must conduct an eligibility determination for SMI in accordance with **Section 12.6 — SMI Eligibility Determination**. The SMI assessment and pending determination will not delay behavioral health service delivery to the Member.

12.3.7 Responding to Referrals

Follow-Up: When a request for services is initiated but the Member does not appear for the initial appointment, the provider must attempt to contact the Member and implement engagement activities consistent with **Section 12.4 — Outreach, Engagement, Re-engagement and Closure**. The provider must also attempt to notify the entity that made the referral.

Final Dispositions: Within 30 days of receiving the initial assessment, or if the person declines services, within 30 days of the initial request for services, the provider must notify the following referral sources of the final disposition:

- AHCCCS health plans;
- AHCCCS PCPs;
- Arizona Department of Economic Security;
- Arizona Department of Child Safety;
- Arizona Department of Economic Security/Division of Developmental Disabilities;
- Arizona Department of Corrections;
- Arizona Department of Juvenile Corrections;
- County Adult and Juvenile Detention Centers;
- Administrative Offices of the Court;
- Arizona Department of Economic Security/Rehabilitation Services Administration; and
- Arizona Department of Education and affiliated school districts.

The final disposition must include 1) the date the Member was seen for the initial assessment; and 2) the name and contact information of the provider who will assume primary responsibility for the Member's behavioral health care, or 3) if no services will be provided, the reason why. When required, authorization to release information will be obtained prior to communicating

the final disposition to the referral sources referenced above. (See **Section 10.2.8 — Disclosure of Records**).

12.3.8 Documenting and Tracking Referrals

The Health Plan provider shall document and track all referrals for services including, at a minimum, the following information:

- Person's name and, if available, AHCCCS identification number;
- Name and affiliation of referral source;
- Date of birth;
- Type of referral (immediate, urgent, routine) as defined in **Section 12.2 — Appointment Standards and Timeliness of Service**;
- Date and time the referral was received;
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment; and
- Final disposition of the referral.

12.3.9 Eligibility Screening and Supporting Documentation

Persons who are not already AHCCCS eligible must be asked to bring supporting documentation to the screening interview to assist the provider in identifying if the person could be AHCCCS eligible (See **Section 12.1 — Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program**). Explain to the person that the supporting documentation will only be used for the purpose of assisting the person in applying for AHCCCS health care benefits. Let the person know that AHCCCS health care benefits may help pay for services, and ask the person to bring the following supporting documentation to the screening interview:

- Verification of gross family income for the last month and current month (e.g., pay check stubs, social security award letter, retirement pension letter);
- Social security numbers for all family members (social security cards if available);
- For those who have other health insurance, bring the corresponding health insurance card (e.g., Medicare card);
- For all applicants, documentation to prove United States citizenship or immigration status and identity,);
- For those who pay for dependent care (e.g., adult or child daycare), proof of the amount paid for the dependent care; and
- Verification of out-of pocket medical expenses.

12.3.10 Intake Interviews

Providers must conduct intake interviews in an efficient and effective manner that is both "person friendly," trauma informed, and verifies the accurate collection of all required information necessary for enrollment into the system or for collection of information for AHCCCS eligible individuals who are already enrolled. The intake process must:

- Be flexible in terms of when and how the intake occurs. For example, in order to best meet the needs of the person seeking services, the intake might be conducted

over the telephone prior to the visit, at the initial appointment prior to the assessment and/or as part of the assessment; and

- Make use of readily available information (e.g., referral form, AHCCCS eligibility screens) in order to minimize any duplication in the information solicited from the person and family members.

During the intake, the provider will collect, review, and disseminate certain information to persons seeking services. Examples can include:

- The collection of contact information, insurance information, the reason why the person is seeking services and information on any accommodations the person may require to effectively participate in treatment services (i.e., need for oral interpretation or sign language assistance, consent forms in large font, etc.).
- The collection of required member information and completion of client member information sheet, including the Member's primary/preferred language (see **Section 6.1 - Enrollment, Disenrollment and other Data Submission**);
- The completion of any applicable authorizations for the release of information to other parties (see **Section 10.2.8 — Disclosure of Records**);
- Advising the member that The Health Plan Member Handbook is available to them (see **Section 3 — The Health Plan Member Handbook**);
- The review and completion of a general consent to treatment (see **Section 12.7 — General and Informed Consent to Treatment**);
- The collection of financial information, including the identification of third party payers and information necessary to screen and apply for AHCCCS health insurance, when necessary (see **Section 12.1 — Eligibility Screening for AHCCCS Health Insurance, Medicare Part D Prescription Drug Coverage, and the Limited Income Subsidy Program** and **7.24 — Third Party Liability and Coordination of Benefits**);
- Advising Non-Title XIX/XXI persons determined to have a SMI that they may be assessed a copayment (see **Section 7.22 — Copayments**);
- The review and dissemination of The Health Plan Notice of Privacy Practices and the AHCCCS HIPAA Notice of Privacy Practices in compliance with [45 CFR 164.520 \(c\)\(1\)\(B\)](#); and
- The review of the person's rights and responsibilities as a Member of services, including an explanation of the appeal process.

The person and/or family members may complete some of the paperwork associated with the intake, if acceptable to the person and/or family members.

Providers conducting intakes must be appropriately trained, approach the person and family in an engaging manner, and possess a clear understanding of the information that needs to be collected.

12.3.11 Specialty Behavioral Health Agency Referrals

All Health Plan contracted providers are responsible for ensuring timely and appropriate service delivery as requested by the member and/or as determined necessary to meet the member's

needs. Specialty Behavioral Health Agencies are responsible for determining medical necessity for specialty services and regularly reporting progress to Health Homes and PCPs as appropriate.

12.3.12 Referrals for Screening and/or Diagnosis of Autism Spectrum Disorders

The Health Plan covers medically necessary behavioral health services for all AHCCCS-eligible children and adults, including the diagnosis and treatment for individuals who may have an Autism Spectrum Disorder (ASD).

AHCCCS-eligible families who are engaged in services within the Health Plan, and who believe an adult or child may have ASD, should schedule an appointment with their psychiatrist or primary care provider.

Children and adults not currently engaged with a behavioral health provider in the Health Plan should first see their primary care provider, who can then refer the child and family to a specialized ASD diagnosing provider

Completion of an intake at a Health Home is not required for families seeking a one-time consultation for the diagnosis or to rule out Autism Spectrum Disorder.

12.4 Outreach, Engagement, Re-Engagement, and Closure

The activities described within this section are an essential element of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening clinical environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

This section addresses five critical activities that providers must incorporate when delivering services within Arizona's public behavioral health system:

1. Expectations for outreach activities directed to persons who are at risk for the development or emergence of behavioral health disorders;
2. Establish expectations for the engagement of persons seeking or receiving services behavioral health services.
3. Determine procedures to re-engage persons who have withdrawn from participation in the treatment process,
4. Describe conditions necessary to end re-engagement activities for a person in the behavioral health system; and
5. Establish expectations for serving persons who are attempting to re-enter the behavioral health system.

12.4.1 Outreach Activities

Health Home providers must provide outreach activities to inform the public of the benefits and availability of services and how to access them. The Health Plan disseminates and requires providers to disseminate information to the general public, other human service providers,

school administrators and teachers, and other interested parties regarding the services that are available to eligible persons.

Outreach activities conducted by The Health Plan and providers may include, but are not limited to:

- Participation in community events, local health fairs, or health promotion activities;
- Involvement with local schools;
- Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition events,
- Development of outreach programs and activities for first responders (i.e. police, fire, EMT),
- Routine contact with AHCCCS Health Plan behavioral health coordinators and/or primary care providers;
- Development of homeless outreach programs;
- Development of outreach programs to persons who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues, or are underserved;
- Publication and distribution of informational materials;
- Liaison activities with local, county and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety DCS offices and programs,
- Routine interaction with agencies that have contact with substance abusing pregnant women/teenagers;
- Conduct home visits;
- Development and implementation of outreach programs that identify persons with co-morbid medical and behavioral health disorders and those who have been determined to have a SMI within The Health Plans geographic service area, including persons who reside in jails, homeless shelters, county detention facilities, or other settings;
- Provision of information to behavioral health advocacy organizations; and
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

In addition to the above outreach activities, the Crisis Call Center telephonically conducts outreach to new AHCCCS enrollees to educate them about the availability of behavioral health services and how to access services, and to assist in removing stigma associated with obtaining services.

12.4.2 Engagement

Providers must provide services in a culturally competent manner in accordance with The Health Plan Cultural Competency Plan (see **Section 9.2 — Cultural Competence**).

Providers are required to:

- Provide a courteous, welcoming environment that provides persons with the opportunity to explore, identify, and achieve their personal goals;
- Engage persons in an empathic, hopeful, and welcoming manner during all contacts;
- Provide culturally relevant care that addresses and respects language, customs, and values and is responsive to the person's unique family, culture, traditions, strengths, and age, ; to meet the needs of members with diverse cultural and ethnic backgrounds, including those with limited English Proficiency, disabilities, and regardless of gender, sexual orientation or gender identity (see Section 3.15 — Cultural Competence)
- Provide an environment that in which consumers from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options;
- Provide care by communicating to Members in their preferred language and verifying that they understand all clinical and administrative information (see **Section 9.2 — Cultural Competence**);
- Be aware of and seek to gain an understanding of persons with varying disabilities and characteristics;
- Display sensitivity to, and respect for, various cultural influences and backgrounds (e.g. ethnic, racial, gender identity, sexual orientation, and socio-economic class);
- Establish an empathic service relationship in which the person experiences the hope of recovery and is considered to have the potential to achieve recovery while developing hopeful and realistic expectations;
- Demonstrate the ability to welcome the person, and/or the person's legal guardian, the person's family members, others involved in the person's treatment and other service providers as collaborators in the treatment planning and implementation process;
- Demonstrate the desire and ability to include the person's and/or legal guardian's viewpoint and to regularly validate the daily courage needed to recover from persistent and relapsing disorders;
- Assist in establishing and maintaining the person's motivation for recovery; and
- Provide information on available services and assist the person and/or the person's legal guardian, the person's family, and the entire clinical team in identifying services that help meet the person's goals.

12.4.3 Re-Engagement

Providers must attempt to re-engage persons in treatment who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to re-engage persons who have withdrawn from treatment, refused services, or failed to appear for a scheduled service must be documented in the comprehensive clinical record. The provider must attempt to re-engage the person by:

- Communicating in the person's preferred language;
- Contacting the person or the person's legal guardian by telephone, at times when the person may reasonably be expected to be available (e.g., after work or school);

- Whenever possible, contacting the person or the person's legal guardian face-to-face, if telephone contact is insufficient to locate the person or determine acuity and risk;
- Sending a letter to the current or most recent address requesting contact, if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record; and
- For persons determined to have a Serious Mental Illness who are receiving Special Assistance (see [AMPM section 320-R](#))

If the above activities are unsuccessful, the provider must make further attempts to re-engage persons determined to have a SMI, persons under court ordered treatment, children (including children in foster care), pregnant substance abusing women/teenagers, or any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts may include contacting the person or person's legal guardian, face-to-face visits, or contacting natural supports who the Member has given permission to the provider to contact. If the person appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled, the provider must make attempts as appropriate to engage the person to voluntarily seek inpatient care. If this is not a viable option for the person and the clinical standard is met, the provider must initiate the pre-petition screening or petition for treatment process described in [AMPM Section 320-U](#), <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/320-U.pdf> — **Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment.**

All attempts to re-engage persons determined to have a SMI, children, pregnant substance abusing women/teenagers, or any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others must be clearly documented in the comprehensive clinical record. Providers are required to have a clearly defined outreach and engagement policy.

Re-Engagement for Members on Court Ordered Treatment:

“For members who are on Court Ordered Treatment, it is the expectation that providers will re-engage within 24 hours of a missed appointment and continue frequent re-engagement efforts until such a time as the member is re-engaged and adherent with treatment, the court order is amended/revoked with the person placed in a psychiatric facility, or it has been confirmed that the member is now living in a different Regional Behavioral Health Authority/Managed Care Organization/Health Plan area or that the member has permanently moved out of state”.

- If a member misses a Behavioral Health Medical Provider (BHMP) appointment, whether it is because the member canceled, no-showed, or the provider canceled the appointment, Re-engagement attempts should immediately be started to reschedule the missed BHMP appointment. The appointment should be rescheduled so that the requirement of a monthly appointment is met.
- BHMP emergency appointment slots should be utilized to accommodate this appointment.

- Missed appointments and non-adherence to the treatment plan should prompt the treatment team to re-evaluate the treatment plan to ensure that it is meeting the member's needs and goals. A member's input into the plan, with attention to achieving *their* goals as much as possible, will help with engagement. Any barriers to attending appointments should be assertively and creatively addressed, for example a member's difficulties with communication, transportation, competing commitments, childcare, managing schedules, etc. The treatment plan should be as flexible and personalized as possible to facilitate each member's adherence.
- If maximal effort to re-engage a member into outpatient treatment fails, the treatment team should file a revocation so that the member may be assessed in a crisis setting. This is especially important if the member has missed an injection as a result of missing their outpatient appointment. Whether or not the member is hospitalized as a result of the revocation, revocations are another opportunity to re-engage the member and amend the treatment plan with the member's input.
- If a provider does not reschedule the missed appointment within two business days, the provider should not revoke the member for this reason alone. Instead, the provider must make arrangements to reschedule the member as soon as possible. Providers should not revoke a member due to a provider administrative or coordination issue.

12.4.3.1 *Follow-Up After Missed Appointments*

Providers are required to contact all persons who miss scheduled appointments without rescheduling. Providers must contact the person following a missed appointment or as soon as possible but no later than two work days after the missed appointment. Documentation of all attempts to reach the person shall be documented in the person's medical record. At least three attempts shall be made to reschedule a missed appointment and shall include contacts made by certified mail and telephone. Face-to-face outreach shall be required for all persons receiving medication services, all individuals identified to be at risk, or to persons who have reported danger to self/danger to others thoughts in the last year. All outreach attempts shall be completed within thirty days of a missed appointment.

12.4.3.2 *Follow-Up After Significant and/or Critical Events*

Providers must also document activities in the clinical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days of the person's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization,
- Involved in a behavioral health crisis within timeframes based upon the person's clinical needs, but no later than seven days, and
- Refusing prescribed psychotropic medications within timeframes based upon the person's clinical needs and individual history; and
- Released from local and county jails and detention facilities based on the needs of the member but no later than 7 days.

Additionally, for persons released from jail or hospital settings, outpatient providers must help establish priority prescribing clinician appointments based on the needs of the member but no

later than 7 days of the person's release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.

12.4.3.3 *Provider Requirements to Notify the Crisis Call Center of At-Risk Situations*

Providers are required to notify the Crisis Call Center by telephone call within 2 hours of any enrolled persons determined to be a danger to self or others and supply an updated crisis plan ([AHCCCS Crisis Plan reference](#)). Providers are also required to notify the Crisis Call Center by telephone call and report a Member who has withdrawn from treatment and presents a potential risk to self, others, or the community; including, all persons with a SMI, all children at risk, all pregnant substance abusing women/teenagers, and any person determined to be at risk of relapse. The Crisis Call Center will assist with telephonic engagement activities, assist providers in developing appropriate intervention strategies, and coordinate with The Health Plan to bring additional resources to assist effective engagement in treatment.

12.4.4 *Ending Treatment for a Person in the Behavioral Health System*

Providers may not end a member's treatment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior. Providers must not arbitrarily or prematurely reject or eject a Member from services without prior authorization of The Health Plan. However, under certain circumstances, it may be appropriate or necessary to close a person's chart for administrative reasons, or after re-engagement efforts described above have been expended.

12.4.4.1 *Children Held at County Detention Facilities*

Providers must check the AHCCCS Pre-paid Medical Management Information System (PMMIS) to determine eligibility for treatment services prior to the delivery of each behavioral health service to a child who is held in a county detention facility.

Contact The Health Plan for assistance when a child loses their Title XIX/XXI eligibility while in detention. Children who lose their eligibility or have their eligibility suspended while temporarily in detention may be eligible for Mental Health Block Grant (MHBG) funded services, depending on availability of funds. Health Homes are required to maintain contact with children in detention and during the 30-day period prior to release to facilitate appropriate release planning. These coordination of care services are funded through state funds and block grant funds.

12.4.4.2 *Inmates of Public Institutions*

AHCCCS has implemented an electronic inmate of public institution notification system developed by the AHCCCS Division of Member Services (DMS). If a Member is eligible for AHCCCS covered services during the service delivery period. The Health Plan is obligated to cover the services regardless of the perception of the Members' legal status.

In order for AHCCCS to monitor any change in a Members' legal status, and to determine eligibility, The Health Plan providers are required to notify The Health Plan and AHCCCS via e-mail, and if they become aware that an AHCCCS eligible Member is incarcerated. AHCCCS has established an email addresses for this purpose as well. Please note that there are two separate AHCCCS e-mail addresses based on the Members' age. For children less than 18 years of age,

please use DMSJUVENILEincarceration@azahcccs.gov. For adults age 18 years and older, please use DMSADULTincarceration@azahcccs.gov. Notifications must include the following Member information:

- AHCCCS ID;
- Name;
- Date of Birth;
- Incarceration date; and
- Name of public institution where incarcerated.

Please note that providers do **not** need to report Members incarcerated with the Arizona Department of Corrections.

Health Homes are required to maintain contact with persons in detention and during the 30-day period prior to release to facilitate appropriate release planning. These coordination of care services are funded through state funds and block grant funds.

12.5 Assessment and Service Planning

AHCCCS supports a model for assessment, service planning, and service delivery that is strength-based, person-centered, family friendly, culturally and linguistically appropriate, and clinically sound and supervised. The model is based on four equally important components:

- Input from the person regarding individual needs, strengths, and preferences;
- Input from other persons involved in the person's care who have integral relationships with the person;
- Development of a therapeutic alliance between the person and provider that fosters an ongoing partnership built on mutual respect and equality; and
- Clinical expertise.

The model incorporates the concept of a "team," established for each person receiving services in accordance with the Arizona Vision and 12 Principles and the 9 Guiding Principles for recovery oriented adult behavioral health services. For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the CFT and ART include:

- Ongoing engagement of the person, family, and others who are significant in meeting the behavioral health needs of the person, including their active participation in the decision-making process and involvement in treatment;
- An assessment process is conducted to:
 - Elicit information on the strengths, needs, and goals of the individual person and family members/guardians;
 - Identify the need for further or specialty evaluations; and
 - Support the development and updating of a service plan which effectively meets the person's/family's needs and results in improved health outcomes.

- Continuous evaluation of the effectiveness of treatment through the CFT and ART process, the ongoing assessment of the person, and input from the person and their team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided consistent with the Arizona Vision and Principles, and for adults, services which are provided consistent with the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems;
- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g., primary care providers, school, child welfare, juvenile or adult probation, other involved service providers);
- Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist persons who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCs) Contractor); and
- Development and implementation of transition plans prior to discontinuation or modification of services.

12.5.1 Assessments

All persons being served in the public behavioral health system must have a behavioral health assessment upon an initial request for services. For persons who continue to receive services, updates to the assessment must occur at least annually. Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual.

AHCCCS does not mandate that a specific assessment tool or format be used but requires certain minimum elements. Providers must collect and submit all required member information in accordance with the criteria outlined in the AHCCCS Demographic and Outcome Data Set User Guide (DUG).

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral health technician (BHT) under the clinical oversight of a BHP, who are trained on the minimum elements of a behavioral health assessment and meets requirements in **Section 5 — Credentialing and Re-credentialing** and **Section 15— Training Requirements**.

12.5.1.1 *Minimum elements of the behavioral health assessment*

AHCCCS has established the following minimum elements that must be included in a comprehensive behavioral health assessment and documented in the comprehensive clinical record, in accordance with AHCCCS [AMPM Section 320-O, Behavioral Health Assessment and Treatment Service Planning](#). Providers are required to have policies in place to monitor accuracy and completion of the behavioral health assessment.

For persons referred for or identified as needing ongoing psychotropic medications for a behavioral health condition, the assessor must establish an appointment with a licensed medical practitioner with prescribing privileges, in accordance with **Section 12.2 — Appointment Standards and Timeliness of Service**. If the assessor is unsure regarding a person’s need for psychotropic medications, then the assessor must review the initial assessment and treatment recommendations with their clinical supervisor or a licensed medical practitioner with prescribing privileges.

12.5.1.2 *Social Determinants of Health*

AHCCCS and The Health Plan collect and track member outcomes related to Social Determinants of Health. The use of specific International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) diagnostic codes representing Social Determinants of Health are a valuable source of information that relates to member health.

The Social Determinants of Health codes identify the conditions in which people are born, grow, live, work, and age. They are often responsible, in part, to health inequities. They include factors like:

- Education
- Employment
- Physical environment
- Socioeconomic status
- Social support networks

As appropriate and within a scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Any identified social determinant diagnosis codes should be provided on all claims for AHCCCS members in order to comply with state and federal coding requirements.

The following ICD-10-CM diagnosis codes are defined as Social Determinants of Health codes under ICD-10-CM. Please note that Social Determinants of Health codes may be added or updated on a quarterly basis. Providers should remain current in their thorough utilization of these codes.

ICD Code	Description
Z55.0	Illiteracy and low-level literacy
Z55.1	Schooling unavailable and unattainable
Z55.2	Failed school examinations
Z55.3	Underachievement in school
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.8	Other problems related to education and literacy
Z55.9	Problems related to education and literacy, unspecified
Z56.0	Unemployment, unspecified
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work schedule

Z56.4	Discord with boss and workmates
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.4	Lack of adequate food and safe drinking water
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance and welfare support
Z59.8	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified
Z60.0	Problems of adjustment to life-cycle transitions
Z60.2	Problems related to living alone
Z60.3	Acculturation difficulty
Z60.4	Social exclusion and rejection
Z60.5	Target of (perceived) adverse discrimination and persecution
Z60.8	Other problems related to social environment
Z60.9	Problem related to social environment, unspecified
Z62.0	Inadequate parental supervision and control
Z62.1	Parental overprotection
Z62.21	Child in welfare custody
Z62.22	Institutional upbringing
Z62.29	Other upbringing away from parents
Z62.3	Hostility towards and scapegoating of child
Z62.6	Inappropriate (excessive) parental pressure
Z62.810	Personal history of physical and sexual abuse in childhood
Z62.811	Personal history of psychological abuse in childhood
Z62.812	Personal history of neglect in childhood
Z62.819	Personal history of unspecified abuse in childhood

Z6.2820	Parent-biological child conflict
Z62.821	Parent-adopted child conflict
Z62822	Parent-foster child conflict
Z62.890	Parent-child estrangement NEC
Z62.891	Sibling rivalry
Z62.898	Other specified problems related to upbringing
Z62.9	Problem related to upbringing, unspecified
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with in-laws
Z63.31	Absence of family member due to military deployment
Z63.32	Other absence of family member
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.71	Stress on family due to return of family member from military deployment
Z63.72	Alcoholism and drug addiction in family
Z63.79	Other stressful life events affecting family and household
Z63.8	Other specified problems related to primary support group
Z63.9	Problem related to primary support group, unspecified
Z64.0	Problems related to unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.4	Discord with counselors
Z65.0	Conviction in civil and criminal proceedings without imprisonment
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.3	Problems related to other legal circumstances
Z65.4	Victim of crime and terrorism
Z65.5	Exposure to disaster, war and other hostilities
Z65.8	Other specified problems related to psychosocial circumstances
Z65.9	Problem related to unspecified psychosocial circumstances
Z71.41	Alcohol abuse counseling and surveillance of alcoholic
Z71.42	Counseling for family member of alcoholic
Z71.51	Drug abuse counseling and surveillance of drug abuser
Z71.52	Counseling for family member of drug abuser
Z72.810	Child and adolescent antisocial behavior
Z72.811	Adult antisocial behavior
Z72.89	Other problems related to lifestyle
Z72.9	Problem related to lifestyle, unspecified
Z73.0	Burn-out
Z73.1	Type A behavior pattern
Z73.2	Lack of relaxation and leisure
Z73.3	Stress, not elsewhere classified
Z73.4	Inadequate social skills, not elsewhere classified
Z73.89	Other problems related to life management difficulty
Z73.9	Problem related to life management difficulty, unspecified

12.5.2 Service Planning

All persons being served in the public behavioral health system must have a written plan for services upon an initial request for services and periodic updates to the plan to meet the changing behavioral health needs for persons who continue to receive behavioral health services. AHCCCS does not mandate a specific service planning tool or format. Service plans must be utilized to document services and supports that will be provided to the individual, based on behavioral health service needs identified through the person's behavioral health assessment. **Provider Manual Attachment 3.5.1 Service Plan Rights Acknowledgment Template** is available to use. Providers are directed to call the Provider Services Call Center at 866-796-0542 to obtain a copy of this attachment, if needed.

If a person is in immediate or urgent need of services (see **Section 12.2 — Appointment Standards and Timeliness of Service**), an interim service plan may need to be developed to document services until a complete service plan is developed. A complete service plan, however, must be completed no later than 90 days after the initial appointment.

At a minimum, the Member, guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives, and other involved parties, as applicable, may be invited to participate in the development of the service plan. Providers must coordinate with the person's health plan, PCP, or others involved in the care or treatment of the individual, as applicable, regarding service planning recommendations (see **Section 4.3 — Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers**).

12.5.2.1 *Minimum Elements of the Service Plan for Title XIX/XXI Members*

Service plans must be completed AHCCCS [AMPM Section 320](#), **Behavioral Health Assessment and Treatment Service Planning** and the **AHCCCS BQI Specifications Manual** found on the AHCCCS Resources website. Providers must have policies in place to monitor the timely completion of service plans.

Members must be provided with a copy of their Plan. Questions regarding service plans or Member rights should be directed to The Health Plan customer service line at 1-866-796-0542.

12.5.2.2 *Optional element that can be included in the Service Plan*

A Functional Behavioral Assessment (FBA) can be requested by any member of the treatment team and included in the member's Individualized Service Plan. The purpose of an FBA is to ascertain the purpose or reason behind problem behaviors that a family, care giver or team may be unable to identify. An FBA allows teams to determine the why, how, where, when and what a members behavior means. It uses a variety of techniques to understand what is behind the behavior and how to find ways to change the behavior. An FBA can be completed for the member at any time with updates being made as needed after completion of the assessment. **Provider Manual Attachment 3.5.8 Functional Behavioral Assessment Guidance Document** is included in the attachments. Providers are directed to call the Provider Services Call Center at 866-796-0542 to obtain a copy of this attachment, if needed.

12.5.2.3 ***Minimum Elements of the Service Plan for Non-Title XIX/XXI Persons Determined to Have a SMI That Do Not Have an Assigned Health Care Coordinator***

Service plans for Non-Title XIX/XXI persons determined to have a SMI who do not have an assigned Health Care Coordinator can be incorporated into the psychiatric progress notes completed by the Behavioral Health Professional as long as the treatment goals reflect the needs identified on the assessment, are clearly documented, and summarize the progress made. The BHP must document when a clinical goal has been achieved and when a new goal has been added.

Non-Title XIX/XXI persons determined to have a SMI, who do not have an assigned Health Care Coordinator shall have the option of accessing peer support services to assist them in developing a Peer-Driven, Self-Developed Proposed Service Plans (PDSDPSPs) to be shared with their BHMP for approval, adoption, and implementation. PDSDPSPs are not required to contain all minimum elements as outlined above for those that have assigned Health Care Coordinators; however, they should consider the Member-specific needs for and expected benefits from community-based support services including, but not limited to supported employment, peer support, family support, permanent supportive housing, living skills training, health promotion, personal assistance, and respite care. PDSDPSPs should also address natural supports that can be leveraged and strengthened as well as outline crisis prevention approaches (e.g. warm line availability) and how the emergence of a potential crisis will be addressed. These services should be incorporated into the PDSDPSPs as appropriate.

It is recommended that a standardized process be used to develop Peer-Driven, Self-Developed Proposed Service Plans (PDSDPSPs). Providers serving Non-Title XIX/XXI Adults with SMI must ensure all services outlined on PDSDPSPs are reviewed and Member wishes identified on the PDSDPSPs are included on individualized service plans.

Additionally, the PDSDPSPs must be reviewed with and approved by the behavioral health medical practitioner and maintained in the medical record. Progress and outcomes related to the approved PDSDPSPs must be tracked and documented by the behavioral health medical practitioner.

12.5.2.4 ***Appeals or Service Plan Disagreements***

Every effort should be taken to ensure that the service planning process is collaborative, solicits and considers input from each team member, and results in consensus regarding the type, mix, and intensity of services to be offered. In the event that a person and/or legal or designated representative disagree with any aspect of the service plan, including the inclusion or omission of services, the team should take reasonable attempts to resolve the differences and actively address the person's and/or legal or designated representative's concerns.

Despite a behavioral health provider's best effort, it may not be possible to achieve consensus when developing the service plan. In cases that the person and/or legal or designated representative disagree with some or all of the Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative **must** be given the opportunity to obtain a second-opinion from an in-network provider or, if necessary, an out-of-network provider at no cost.

In cases that a person determined to have a SMI and/or legal or designated representative disagree with some or all of the Non-Title XIX/XXI covered services included in the service plan, the person and/or legal or designated representative **must** be given a **Provider Manual Form 15.3.1 Notice of Decision and Right to Appeal (For Individuals with a Serious Mental Illness)**, by the behavioral health representative on the team. This form can be obtained by calling the Provider Services Call Center at 866-796-0542.

In either case, the person and/or legal or designated representative may file an appeal within 60 days of the action.

12.5.2.5 ***Updates to the Assessment and Service Plan***

Providers must complete an annual assessment update with input from the Member and family, if applicable, that records a historical description of the significant events in the person's life and how the person/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the Member and their family. Providers must have a policy in place to monitor timely updates of both assessments and services plans.

12.6 SMI Eligibility Determination

A critical component of the service delivery system is the effective and efficient identification of persons who have special behavioral health needs due to the severity of their behavioral health disorder. One such group is persons with Serious Mental Illness (SMI). Without receipt of the appropriate care, these persons are at high risk for further deterioration of their physical and mental condition, increased hospitalizations, and potential homelessness and incarceration. For this reason, The Health Plan contracted Health Homes are required to provide a SMI screening/assessment to any person requesting a SMI determination at no cost to the requesting person.

In order to ensure that persons with a SMI are promptly identified and enrolled for services, AHCCCS has developed a standardized process for the referral, evaluation, and determination for SMI eligibility. The requirements associated with the referral for a SMI evaluation and SMI eligibility determination are set forth in [AHCCCS AMPM Policy 320-P, SMI Eligibility Determination](#). Additionally, the [SMI Determination Form](#) can be located on the Crisis Response Network website.

12.6.1 Criteria for SMI Eligibility

The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis (see [AMPM, 320-P2](#) for a list of qualifying diagnostic categories).

12.6.1.1 *Functional Criteria for SMI Eligibility*

To meet the functional criteria for SMI status, a person must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four domains, as described below, for most of the past twelve (12) months or for most of the past six (6) months with an expected continued duration of at least six (6) months:

- ***Inability to live in an independent or family setting without supervision:*** Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food, and clothing must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder.
- ***A risk of serious harm to self or others:*** Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the person's care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the person's education, livelihood, career, or personal relationships.
- ***Dysfunction in role performance:*** Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/ developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities; or
- ***Risk of Deterioration:*** A qualifying diagnosis with probable chronic, relapsing and remitting course. Co-morbidities (like cognitive difficulties, substance dependence, personality disorders, etc.). Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (life-threatening or debilitating medical illnesses, victimization, etc.). Other (past psychiatric history; gains in functioning have not solidified or are a result of current compliance only; court-committed; care is complicated and requires multiple providers; etc.).

The following reasons shall not be sufficient in and of themselves for denial of SMI eligibility:

- An inability to obtain existing records or information; or
- Lack of a face-to-face psychiatric or psychological evaluation.

12.6.1.2 *Considerations for Person with Co-occurring Substance Abuse*

For persons who have a qualifying SMI diagnosis and co-occurring substance use, for purposes of SMI determination, presumption of functional impairment is as follows:

For psychotic diagnoses (bipolar I disorder with psychotic features, delusional disorder, major depression, recurrent, severe, with psychotic features, schizophrenia, schizoaffective disorder and psychotic disorder not due to a substance or known psychological condition) functional impairment is presumed to be due to the qualifying psychiatric diagnosis.

For other major mental disorders (bipolar disorders, major depression, and obsessive-compulsive disorder), functional impairment is presumed to be due to the psychiatric diagnosis, unless:

- i. The severity, frequency, duration or characteristics of symptoms contributing to the functional impairment cannot be attributed to the qualifying mental health diagnosis, or
- ii. The assessor can demonstrate, based on a historical or prospective period of treatment, that the functional impairment is present only when the person is abusing substances or experiencing symptoms of withdrawal from substances.

For all other mental disorders not covered above, functional impairment is presumed to be due to the co-occurring substance use unless:

- i. The symptoms contributing to the functional impairment cannot be attributed to the substance use disorder, or
- ii. The functional impairment is present during a period of cessation of the co-occurring substance use of at least 30 days, or
- iii. The functional impairment is present during a period of at least 90 days of reduced use and is unlikely to cause the symptoms or level of dysfunction.

12.6.2 Completion Process of Final SMI Determination

A licensed psychiatrist, psychologist, or psychiatric nurse practitioner designated by the AHCCCS contracted SMI Evaluation Agency must make a final determination as to whether the person meets the eligibility requirements for SMI status based on:

- A face-to-face assessment or reviewing a face-to-face assessment by a qualified assessor; and
- A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

The following must occur if the designated reviewing psychiatrist, psychologist, or psychiatric nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the qualified assessor and/or the treating Behavioral Health Professional that cannot be resolved by oral or written communication:

- **Disagreement Regarding Diagnosis:** Determination that the person does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The resolution of (specific reasons for) the disagreement shall be documented in the person's comprehensive clinical record.
- **Disagreement Regarding Functional Impairment:** Determination that the person does not meet eligibility requirements must be based upon a face-to-face functional evaluation conducted by a designated psychiatrist, psychologist, or nurse practitioner. The psychiatrist, psychologist, or nurse practitioner shall document the

specific reason(s) for the disagreement in the person's comprehensive clinical record.

If there is sufficient information to determine SMI eligibility, the person shall be provided written notice of the SMI eligibility determination within three (3) business days of the initial meeting with the qualified assessor in accordance with the next section of this policy.

12.6.3 Issues preventing timely completion of SMI eligibility determination

The time to initiate or complete the SMI eligibility determination may be extended no more than 20 days if the person agrees to the extension and:

- There is substantial difficulty in scheduling a meeting at which all necessary participants can attend;
- The person fails to keep an appointment for assessment, evaluation, or any other necessary meeting (see **Section 12.4 — Outreach, Engagement, Re-Engagement, and Closure**);
- The person is capable of but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
- The person or the person's guardian and/or designated representative requests an extension of time;
- Additional documentation has been requested, but has not yet been received; or
- There is insufficient functional or diagnostic information² to determine SMI eligibility within the required time periods.

The AHCCCS contracted SMI Evaluation Agency (Crisis Response Network (CRN)) must:

- Document the reasons for the delay in the person's eligibility determination record when there is an administrative or other emergency that will delay the determination of SMI status; and
- Not use the delay as a waiting period before determining SMI status or as a reason for determining that the person does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

In situations in which the extension is due to insufficient information:

- The AHCCCS contracted SMI Evaluation Agency (CRN) shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;

² Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

- The designated reviewing psychiatrist, psychologist, or nurse practitioner must communicate with the person's current treating clinician, if any, prior to the determination of SMI, if there is insufficient information to determine the person's level of functioning; and
- SMI eligibility must be determined within three (3) days of obtaining sufficient information, but no later than the end date of the extension.

If the person refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, applicants shall be notified of their appeal rights and the option to reapply (see the next section of this policy).

If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the person shall be notified that the determination may, with the agreement of the person, be extended for up to 90 (calendar) days.³

12.6.4 Notification of SMI Eligibility Determination

If the eligibility determination results in approval of SMI status, the SMI status must be reported to the person in writing, including notice of the right to appeal the decision (see **Section 8.4 — Notice Requirements and Appeal Process (SMI and Non-SMI/Non-Title XIX)**).

If the eligibility determination results in a denial of SMI status, the AHCCCS contracted SMI Evaluation Agency (CRN) shall include in the notice above:

- The reason for denial of SMI eligibility (see **AHCCCS AMPM 320-P SMI Determination**);
- The right to appeal (see **Section 8.4 — Notice Requirements and Appeal Process for Title XIX and Title XXI Eligible Persons** and **Section 8.5 — Notice Requirements and Appeal Process (SMI and Non-SMI/Non-Title XIX)**); and
- The statement that Title XIX/XXI eligible persons will continue to receive needed Title XIX/XXI covered services.

12.6.5 Review of SMI Eligibility

A review of SMI eligibility made by The Health Plan for individuals currently enrolled as a person with a SMI may be initiated by The Health Plan or our contracted behavioral health providers:

- As part of an instituted, periodic review of all persons determined to have a SMI;
- When there has been a clinical assessment that supports that the person no longer meets the functional and/or diagnostic criteria; or

³ This extension may be considered a technical re-application to verify compliance with the intent of Rule. However, the person does not need to actually reapply. Alternatively, the determination process may be suspended and a new application initiated upon receipt of necessary information.

- As requested by an individual currently enrolled as a person with a SMI, or their legally authorized representative.

A review of the determination may not be requested by The Health or their contracted behavioral health providers within six (6) months from the date an individual has been determined SMI eligible.

If, as a result of a review, the person is determined to no longer meet the diagnosis and functional requirements for SMI status, The Health Plan must ensure that:

- Services are continued depending on eligibility, The Health Plan service priorities and any other requirements as described in **Section 2 — Covered Services and Related Program Requirements** and **Section 13.2 — Inter-RBHA/MCO Coordination of Care** and **Section 12.10 — Special Populations**.
- Written notice of the determination made on review with the right to appeal is provided to the affected person with an effective date of thirty (30) days after the date the written notice is issued.

12.6.6 SMI Decertification

There are two established methods for removing a SMI designation, one clinical and the other an administrative option, as follows:

A member who has a SMI designation or an individual from the member's clinical team may request a SMI Clinical Decertification. A SMI Clinical Decertification is a determination that a member who has a SMI designation no longer meets SMI criteria. If, as a result of a review, the person is determined to no longer meet the diagnostic and/or functional requirements for SMI status:

- The Determining Entity (CRN) shall ensure that written notice of the determination and the right to appeal is provided to the affected person with an effective date of 30 days after the date the written notice is issued,
- Services are continued in the event an appeal is timely filed, and services are appropriately transitioned as part of the discharge planning process.

A member who has a SMI designation may request a SMI Administrative Decertification if the member has not received behavioral health services for a period of two or more years.

- Upon receipt of a request for Administrative Decertification, the Contractor shall direct the member shall be directed to contact AHCCCS Division of Health Care Management (DHCM) Customer Service,
- AHCCCS will evaluate the member's request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member's SMI designation. Based upon review, the following will occur:
 - In the event the member has not received a behavioral health service within the previous two years, the member will be provided with AHCCCS [AMPM Exhibit 320-P-3](#). This form must be completed by the member and returned to AHCCCS,

- ii. In the event the review finds that the member has received behavioral health services within the prior two year period, the member will be notified that they may seek decertification of their SMI status through the Clinical Decertification process.

Providers are highly encouraged to use SMI forms located on the CRN website <http://www.crisisnetwork.org/smi/provider/#forms>

12.7 General and Informed Consent to Treatment

Each Member has the right to participate in decisions regarding behavioral health care, including the right to refuse treatment (42 CFR 438.100(b)(2)(iv)). It is important for persons seeking services to agree to those services and be made aware of the service options and alternatives available to them as well as specific risks and benefits associated with these services.

AHCCCS recognizes two primary types of consent: general consent and informed consent.

General consent is a one-time agreement to receive services that is usually obtained from a person during the intake process at the initial appointment and is always obtained prior to the provision of any services. General consent must be verified by a Member's or legal guardian's signature.

Informed consent must be obtained before the provision of a specific treatment that has associated risks and benefits. Informed consent is required prior to the provision of the following services and procedures:

- Complementary and Alternative Medicine (CAM);
- Psychotropic medications;
- Electro-convulsive therapy (ECT);
- Use of telemedicine;
- Application for a voluntary evaluation;
- Research;
- Admission for medical detoxification, an inpatient facility or a residential program (for persons with a SMI); and
- Procedures or services with known substantial risks or side effects.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in R9-21-206.01(c), must present the facts necessary for a person to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given and that the person agrees or does not agree to the specific treatment must be included in the comprehensive clinical record, as well as the person's/guardian's signature when required.

Active Parent Consent

In addition to general and informed consent for treatment, state statute (A.R.S. § 15-104) requires written consent from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

Completion of Substance Abuse Prevention Program and Evaluation Consent applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself

The intent of this section is to describe the requirements for reviewing and obtaining general and informed consent, for persons receiving services within the public behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

12.7.1 General Requirements

Any person, aged 18 years and older, in need of services must give voluntary general consent to treatment, demonstrated by the person's or legal guardian's signature on a general consent form, before receiving services.

For persons under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency must give general consent to treatment, demonstrated by the parent, legal guardian, or lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of services.

Any person aged 18 years and older or the person's legal guardian, or in the case of persons under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive services.

Any person aged 18 years and older or the person's legal guardian, or in the case of persons under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

Providers treating persons in an emergency situation are not required to obtain general consent prior to the provision of emergency services. Providers treating persons pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.

All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per **Section 10.2 — Medical Record Standards**.

In initiating general care for The Health Plan Members, providers are required to use informed consent forms that include all the elements identified in the **Provider Manual Form 3.7.1, Consent for Treatment**. The form can be obtained by calling the Provider Services Call Center at 866-796-0542.

Providers prescribing medications for The Health Plan Members are required to use informed consent forms that include all the elements identified in [AHCCCS AMPM Section 310-V, Attachment A](#).

12.7.2 General Consent

Administrative functions associated with a Member's enrollment do not require consent, but before any services are provided, general consent must be obtained. General consent is usually obtained during the intake process and represents a person's, or if under the age of 18, the person's parent, legal guardian or lawfully authorized custodial agency representative's, written agreement to participate in and to receive non-specified (general) services. Providers are required to use **Provider Manual Form 3.7.1, Consent for Treatment** which can be obtained by calling the Provider Services Call Center at 866-796-0542, and to have a policy in place to monitor completion of general consents.

12.7.3 Informed Consent

12.7.3.1 *What Information Must Be Provided to Obtain Informed Consent?*

In all cases where informed consent is required by this section, informed consent must include, at a minimum, the following:

- Member's right to participate in decisions regarding health care, including the right to refuse treatment, and to express preferences about future treatment decisions;
- Information about the person's diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;
- The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding;
- The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects;
- That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs the provider must document the person's choice in the medical record;
- The potential consequences of revoking the informed consent to treatment; and
- A description of any clinical indications that might require suspension or termination of the proposed treatment.

12.7.3.2 *Who Can Give Informed Consent, and How Is It Documented?*

Persons, or if applicable the client's parent, guardian or custodian shall give informed consent for treatment by signing and dating an acknowledgment that they have received the information and gives informed consent to the proposed treatment.

When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the person, must be established. If the informed consent is for psychotropic medication or telemedicine and the person or the person's guardian (if applicable) refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the person's record that the information was given, the

client refused to sign an acknowledgment, and that the client gives informed consent to use psychotropic medication or telemedicine.

12.7.3.3 *Who Can Provide Informed Consent and How Is It Communicated?*

When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

- Presented in a manner that is understandable and culturally appropriate to the person, parent, legal guardian or an appropriate court; and
- Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In a specific situation in which that is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

12.7.3.4 *Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine*

Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the person, parent, or legal guardian, it must be documented in written fashion. Informed consent is required in the following circumstances:

- Prior to the initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see **Section 12.8 — Psychotropic Medication: Prescribing and Monitoring**). The use of **Provider Manual Form 3.7.1, Consent for Treatment** is recommended as a tool to review and document informed consent for psychotropic medications which can be obtained by calling the Provider Services Call Center at 866-796-0542; and
- Prior to the delivery of services through telemedicine.

12.7.3.5 *Electro-Convulsive Therapy (ECT), Research Activities, Voluntary Evaluation and Procedures or Services with Known Substantial Risks or Side Effects*

Written informed consent must be obtained from the person, parent, or legal guardian, unless treatments and procedures are under court order, in the following circumstances:

- Before the provision of (ECT);
- Prior to the involvement of the person in research activities;
- Prior to the provision of a voluntary evaluation for a person. The use of **AHCCCS Policy Form 107.2, MH-103** is required for persons with SMI and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations; and
- Prior to the delivery of any other procedure or service with known substantial risks or side effects.

12.7.3.6 ***Additional Provisions***

Written informed consent must be obtained from the person, legal guardian, or an appropriate court prior to the person's admission to any medical detoxification, inpatient facility, or residential program operated by a behavioral health provider.

12.7.3.7 ***Revocation of Informed Consent***

If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the person. In such cases, treatment may be phased out to avoid any harmful effects.

12.7.4 **Special Requirements for Children Related to Consents**

In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

12.7.4.1 ***Non-Emergency Situations***

In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child's legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian;
- Foster parent, group home staff, or other person with whom the Department of Economic Security/Department of Child Safety (DES/DCS) has placed the child; or
- Government agency authorized by the court.

If someone other than the child's parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child's comprehensive clinical record:

Individual/Entity	Documentation
Legal guardian	Copy of court order assigning custody
Relatives	Copy of power of attorney document
Other person/agency	Copy of court order assigning custody

<p>DES/DCS Placements (for children removed from the home by DES/DCS), such as:</p> <ul style="list-style-type: none"> • Foster parents • Group home staff • Foster home staff • Relatives • Other person/agency in whose care DES/DCS has placed the child 	<p>None required⁴</p>
--	----------------------------------

For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative, or other person or agency in whose care the child is currently placed may give consent for the following services:

- Evaluation and treatment for emergency conditions that are not life threatening; and
- Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).

Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, emancipated youth, or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

12.7.4.2 ***Emergency Situations***

In emergency situations involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

⁴ If providers doubt whether the individual bringing the child in for services is a person/agency representative in whose care DES/DCS has placed the child, the provider may ask to review verification, such as documentation given to the individual by DES indicating that the individual is an authorized DES/DCS placement. If the individual does not have this documentation, then the provider may also contact the child's DES/DCS caseworker to verify the individual's identity.

12.7.5 Informed Consent During Involuntary Treatment

At times, involuntary treatment can be necessary to protect safety and meet needs when a person, due to mental disorder, is unwilling or unable to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as an individual may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Individuals should be assessed for capacity to give informed consent for specific treatment and such consent obtained if the individual is willing and able, even though the individual remains under court order.

12.7.6 Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

Written consent must be obtained from a child's parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by The Health Plan Provider.

[AHCCCS AMPM Section 320-Q-2 Substance Abuse Prevention Program Evaluation Form](#) must be used to gain parental consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of AHCCCS. The consent must satisfy all of the following requirements:

- Contain language that clearly explains the nature of the screening program and when and where the screening will take place;
- Be signed by the child's parent or legal guardian; and
- Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.

Completion of [AHCCCS AMPM Section 320-Q-2 Substance Abuse Prevention Program Evaluation Form](#) applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.

12.8 Psychotropic Medication: Prescribing and Monitoring

AHCCCS has developed guidelines and minimum requirements designed to guide the Health Plans in developing appropriate psychotropic medication use policies and procedures to:

- Promote the safety of persons taking psychotropic medications;
- Reduce or prevent the occurrence of adverse side effects;
- Promote positive clinical outcomes for behavioral health recipients who are taking psychotropic medications;
- Monitor the use of psychotropic medications to foster safe and effective use; and
- To clarify that medication will not be used for the convenience of the staff, in a punitive manner or as a substitute for other services and shall be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which otherwise would interfere with aspects of treatment, as stated in R9-21-207(C).

See **Provider Manual Attachment 3.8.5 – Minimum Laboratory Monitoring for Psychotropic Medications**. Providers are directed to call the Provider Services Call Center at 866-796-0542 to obtain a copy of this attachment, if needed.

12.8.1 Basic Requirements

Medications may only be prescribed by The Health Plan credentialed and licensed physicians, licensed physician assistants, or licensed nurse practitioners. See **Section 5 – Credentialing and Re-Credentialing Requirements** for more information regarding credentialing requirements.

Psychotropic medication will be prescribed by a licensed psychiatrist, psychiatric nurse practitioner, physician assistant, or other physician trained or experienced in the use of psychotropic medication. The prescribing clinician must have seen the Member and is familiar with the Member's medical history or, in an emergency, the prescribing clinician is at least familiar with the Member's medical history.

When a Member on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the Member's record (see **Section 10.2 – Medical Record Standards**).

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the Member's record (see **Section 10.2 – Medical Record Standards**).

12.8.2 Assessments

Reasonable clinical judgment, supported by available assessment information, must guide the prescribing of psychotropic medications. To the extent possible, candidates for psychotropic medication use must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the person's comprehensive clinical record per **Section 10.2 – Medical Record Standards** and must be scheduled in a timely manner consistent with **Section 12.2 – Appointment Standards and Timeliness of Service**. Behavioral Health Professionals (BHPs) can use assessment information that has already been collected by other sources and are not required to document existing assessment information that is part of the person's comprehensive clinical record. At a minimum, assessments for psychotropic medications must include:

- An adequately detailed medical and behavioral health history;
- A mental status examination;
- A diagnosis;
- Target symptoms;
- A review of possible medication allergies;
- A review of previously and currently prescribed psychotropic or other medications including any reported side effects and/or potential drug-drug interactions and all medications (including medications prescribed by the PCP and medical specialists,

OTC medications, and supplements) currently being taken for the appropriateness of the combination of the medications;

- For sexually active females of childbearing age, a review of reproductive status (pregnancy);
- For post-partum females, a review of breastfeeding status; and
- A review of the recipients profile in the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database when initiating a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis or for short term addition of agents when the client is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber.

Reassessments require the prescribing clinician of psychotropic medication notes in the Member's record the following (see **Section 10.2 — Medical Record Standards**):

- The reason for and the effectiveness of the medication;
- The clinical appropriateness of the current dosage;
- All medication (including medications prescribed by the PCP and medical specialists, over the counter medications, and supplements) being taken and the appropriateness of the combination of the medications;
- Any side effects such as weight gain and/or abnormal/involuntary movements if treated with an anti-psychotic medication; and
- Minimum requirements as per **Section 12.8 — Psychotropic Medication: Prescribing and Monitoring**;
- Rationale for the use of two medications from the same pharmacological class and
- Rationale for the use of more than three different psychotropic medications in adults, and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population.

12.8.3 Informed Consent

Informed consent must be obtained from the person and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the BMHP must communicate in a manner that the person and/or legal guardian can easily understand. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or a registered nurse.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see **Section 10.2 — Medical Record Standards**). Essential elements for obtaining informed consent for medication are contained within [AHCCCS AMPM Section 310-V, Attachment A: Informed Consent for Psychotropic Medication Treatment](#). [AHCCCS AMPM Section 310-V, Attachment A](#) is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person's individual

comprehensive clinical record in an alternative fashion (see **Section 10.2 — Medical Record Standards**).

For more information regarding informed consent, see **Section 12.7 — General and Informed Consent to Treatment**.

12.8.4 Youth and Psychotropic Medications

- Youth under the age of 18 are to be educated on options, allowed to provide input, and encouraged to assent to medication(s) being prescribed. Information is discussed with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth.
- The information to be shared should be consistent with the information shared in obtaining informed consent from adults.
- Discussion of the youth's ability to give consent for medications at the age of 18 years old is begun no later than age 17 ½ years old, especially for youth who are not in the custody of their parents.
- There should be special attention to the effect of medications on the reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements and other health parameters.
- Evidence of the youth's consent to continue medications after reaching age 18 may be documented through use of AHCCCS Policy Form 108.1, Informed Consent/Assent for Psychotropic Medication Treatment, a recommended tool to review and document informed consent for psychotropic medications.

12.8.5 Psychotropic Medication Monitoring

Per national guidelines and to address the monitoring of psychotropic medications and metabolic parameters, the provider must establish policies and procedures for monitoring of lithium, valproic acid, carbamazepine, renal function, liver function, thyroid function, glucose metabolism, as well as screening for metabolic syndrome and movement disorders. See **Provider Manual Attachment 3.8.5 Minimum Laboratory Monitoring for Psychotropic Medication**. Providers are directed to call the Provider Services Call Center at 866-796-0542 to obtain a copy of this attachment, if needed.

Medications prescribed for Youth (members less than 18 years old) must be monitored for efficacy, side effects and adverse events at each visit with a registered nurse, physician assistant, psychiatric nurse practitioner, or physician.

12.8.6 Reporting Requirements

The Health Plan has established the AHCCCS system requirements for monitoring the following:

- Adverse drug reactions;
- Adverse drug event; and
- Medication errors.

The above referenced events must be identified, reported, tracked, reviewed and analyzed by The Health Plan.

An incident report must be completed for any medication error, adverse drug event and/or adverse drug reaction that results in harm and/or emergency medical intervention (See **Section 10.10 — Reporting of Incidents, Accidents and Deaths** for more information).

12.8.7 Complementary and Alternative Medicine (CAM)

Complementary and alternative medicine (CAM) is not AHCCCS reimbursable.

When a Behavioral Health Professional uses Complementary and Alternative Medicine (CAM), (See [Arizona Medical Board's Guidelines For Physicians Who Incorporate Or Use Complementary Or Alternative Medicine In Their Practice](#)) informed consent must be obtained from the person or guardian, when applicable, for each CAM prescribed (See **Section 4.13.9 — The Health Plan's Drug Lists**). When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the person and/or legal guardian can easily understand. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (see **Section 10.2 — Medical Record Standards**).

Essential elements for obtaining informed consent for medication are contained within [AHCCCS AMPM Section 310-V, Attachment A, Informed Consent for Psychotropic Medication Treatment](#).

If [AHCCCS AMPM Section 310-V, Attachment A](#) is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person's individual comprehensive clinical record in an alternative fashion (see **Section 10.2 — Medical Record Standards**).

12.9 Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment

At times, it may be necessary to initiate civil commitment proceedings to ensure the safety of a person, or the safety of other persons, due to a person's mental disorder when that person is unable or unwilling to participate in treatment. In Arizona, State law permits any responsible person to submit an application for pre-petition screening when another person may be, as a result of a mental disorder:

- A danger to self (DTS);
- A danger to others (DTO);
- Persistently or acutely disabled (PAD); or
- Gravely disabled (GD).

If the person who is the subject of a court ordered commitment proceeding is subject to the jurisdiction of an Indian Tribe rather than the State, the laws of that Tribe, rather than State law, will govern the commitment process. Information about the tribal court process and the procedures under State law for recognizing and enforcing a tribal court order are found in **Section 12.9.10 — Court-Ordered Treatment for American Indian Tribal Members in Arizona**.

Pre-petition screening includes an examination of the person's mental status and/or other relevant circumstances by a designated screening agency. Upon review of the application, examination of the person and review of other pertinent information, a licensed screening agency's medical director or designee will determine if the person meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. Based on the immediate safety of the person or others, an emergency admission for evaluation may be necessary. Otherwise, an evaluation will be arranged for the person by a designated evaluation agency within timeframes specified by State law.

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment on behalf of the person. A hearing, with the person and legal representative and the physician(s) treating the person, will be conducted to determine whether the person will be released and/or whether the agency will petition the court for court-ordered treatment. For the court to order ongoing treatment, the person must be determined, as a result of the evaluation, to be DTS, DTO, PAD, or GD. Court-ordered treatment may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the person's designation as DTS, DTO, PAD, or GD. Persons identified as:

- DTS may be ordered up to 90 inpatient days per year;
- DTO and PAD may be ordered up to 180 inpatient days per year; and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency may be identified by the court to supervise the person's outpatient treatment. In some cases, the mental health agency may be a Regional Behavioral Health Authority/Managed Care Organization /Health Plan; however, before the court can order a mental health agency to supervise the person's outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process, a person will be provided an opportunity to change status to voluntary. Under voluntary status, the person is no longer considered to be at risk for DTS/DTO and agrees in writing to receive a voluntary evaluation.

County agencies and Regional Behavioral Health Authority/ /Health Plan subcontracted agencies responsible for pre-petition screening and court-ordered evaluations must use the following forms prescribed in AAC R9-21, Article 5 for persons determined to have a Serious Mental Illness:

- **Application for Involuntary Evaluation** ([AHCCCS AMPM Chapter 300, Section 320-U-1](#))
- **Application for Emergency Admission for Evaluation** ([AHCCCS AMPM Chapter 300, Section 320-U-2](#))

- **Petition for Court-Ordered Evaluation** ([AHCCCS AMPM Chapter 300, Section 320-U3](#))
- **Petition for Court-Ordered Treatment Gravely Disabled Person** ([AHCCCS AMPM Chapter 300, Section 320-U-4](#))
- **Affidavit** ([AHCCCS AMPM Chapter 300, Section 320-U-5](#))

*For the Pima County: forms referenced in this section, Health Home Title 36 Liaisons should reach out to the Pima County Attorney to obtain copies. For other forms referenced, the Health Home Title 36 Liaison may contact AzCHTitle36@AZCompleteHealth.com

Agencies may also use these forms for all other populations. In addition to court-ordered treatment as a result of civil action, an individual may be ordered by a court for evaluation and/or treatment upon: 1) conviction of a domestic violence offense; or 2) upon being charged with a crime when it is determined that the individual is court-ordered to treatment, or programs, as a result of being charged with a crime and appears to be an individual with a possible substance abuse disorder. The responsibilities of The Health Plan and its providers for the provision and coverage of those services is described in **Section 12.9.7 — Court-Ordered Treatment for Persons Charged with or Convicted of a Crime.**

The intent of this section is to provide a broad overview of the pre-petition screening, court-ordered evaluation, and court-ordered treatment process. Depending on a provider's designation as a screening, evaluation, or court-ordered treatment agency, the extent of involvement with persons receiving pre-petition screening, court-ordered evaluation, and court-ordered treatment services will vary.

12.9.1 Licensing Requirements

Providers who are licensed by the Arizona Department of Health Services/Division of Licensing Services as a court-ordered evaluation or court-ordered treatment agency must adhere to ADHS Licensing requirements.

12.9.2 Pre-Petition Screening

Arizona counties are responsible for managing, providing, and paying for pre-petition screening and court-ordered evaluations and are required to coordinate provision of services with the State system. Some counties contract with Regional Behavioral Health Authority/Managed Care Organization/Health Plans to process pre-petition screenings and petitions for court-ordered evaluations.

All applicants calling The Health Plan for court-ordered evaluations are referred to the Crisis Call Center at 866-495-6735 to assist callers in identifying the correct pre-petition screening agency and answering any questions they may have about the process.

When a county does not contract with The Health Plan for pre-petition screening services, the Crisis Call Center will answer any questions the caller may have about the process and warm-line the caller to the appropriate county-contracted prepetition screening agency.

When a county contracts with The Health Plan for pre-petition screening and petitioning for court-ordered evaluation, the Crisis Call Center will dispatch a designated pre-petition screening agency.

The pre-petition screening agency must conduct the following procedures:

- Provide pre-petition screening within forty-eight hours of the request excluding weekends and holidays;
- Prepare a report of the clinical assessment, professional opinions and conclusions. If pre-petition screening was not possible, the screening agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the pre-petition screening;
- Request the screening agency's medical director or designee review the report if it indicates that there is no reasonable cause to believe the allegations of the applicant for the court-ordered evaluation;
- Prepare a petition for court-ordered evaluation and file the petition if the screening agency's Medical Director determines that the person, due to a mental disorder, including a primary diagnosis of dementia and other cognitive disorders, is a Danger to Self (DTS), Danger to Others (DTO), Persistently or Acutely Disabled (PAD), or Gravely Disabled (GD). Refer to the **Petition for Court-Ordered Evaluation** form for pertinent information for court-ordered evaluation;
- If the screening agency determines that there is reasonable cause to believe that the person, without immediate hospitalization, is likely to harm themselves or others, the screening agency will verify completion of the **Application for Emergency Admission for Evaluation form**, and take all reasonable steps to procure hospitalization on an emergency basis; and
- Contact the county attorney prior to filing a petition if it alleges that a person is a Danger to Others.

12.9.3 Court-Ordered Evaluation

If the pre-petition screening indicates that the person may be DTS, DTO, PAD, or GD, the screening agency will file an application for a court-ordered evaluation. The procedures for court-ordered evaluations are outlined below.

If a county should subcontract with The Health Plan to provide court-ordered evaluations, The Health Plan or its provider must follow these procedures:

- A person being evaluated on an inpatient basis must be released within seventy-two hours if further evaluation is not appropriate, unless the person makes application for further care and treatment on a voluntary basis;
- A person who is determined to be DTO, DTS, PAD, or GD as a result of a mental disorder must have a petition for court-ordered treatment prepared, signed, and filed by the RBHA/MCO/Health Plan medical director or designee; and
- Title XIX/XXI funds must not be used to reimburse court-ordered evaluation services.

Regional Behavioral Health Authority/ /Health Plans are not responsible for the costs associated with court-ordered evaluation outside of the limited “medication only” benefit package available for Non-Title XIX/XXI persons determined to have a SMI, unless other prior payment arrangements have been made with another entity (e.g. county, hospital, provider).

12.9.4 Voluntary Evaluation

Any The Health Plan provider that receives an application for voluntary evaluation must immediately refer the person to the facility responsible for voluntary evaluations. Providers are to contact the Crisis Call Center at 1-866-495-6735 for assistance.

The Health Plan providers must follow these procedures:

- The evaluation agency must obtain the individual’s informed consent prior to the evaluation (see **AHCCCS Section 320-U-7, Application for Voluntary Evaluation**) and provide evaluation at a scheduled time and place within five days of the notice that the person will voluntarily receive an evaluation; and
- For inpatient evaluations, the evaluation agency must complete evaluations in less than seventy-two hours of receiving notice that the person will voluntarily receive an evaluation.

If a provider conducts a voluntary evaluation service as described in this section, the comprehensive clinical record (see **Section 10.2 — Medical Record Standards**) must include:

- A copy of the application for voluntary evaluation, use [AHCCCS AMPM Section 320-U-7 Application for Voluntary Evaluation](#);
- A completed informed consent form (see **Section 12.7 — General and Informed Consent to Treatment**); and
- A written statement of the person’s present medical condition.

12.9.5 Court-Ordered Treatment Following Civil Proceedings Under A.R.S. Title 36

Based on the court-ordered evaluation, the evaluating agency may petition for court-ordered treatment. The provider must follow these procedures:

- Upon determination that an individual is DTS, DTO, GD, or PAD, and if no alternatives to court-ordered treatment exist, the medical director of the agency that provided the court-ordered evaluation must file a petition for court-ordered treatment (see **Petition for Court-Ordered Treatment Gravely Disabled Person form**);
- Any provider filing a petition for court-ordered treatment must do so in consultation with the person’s clinical team prior to filing the petition;
- The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (see [Affidavit form](#));
- A copy of the petition, in cases of grave disability, must be mailed to the public fiduciary in the county of the patient’s residence, or the county in which the patient

was found before evaluation, and to any person nominated as guardian or conservator; and

- A copy of all petitions must be mailed to the superintendent of the Arizona State Hospital.

Background

Per Arizona Revised Statutes 36-545.06-County Services: “Each County shall provide directly, or by contract the services of a screening Provider and an evaluation Provider.”

Each County must have a process in place for:

- Involuntary mental health treatment requests and evaluations
- Court proceedings to satisfy the statutory requirements under Title 36 for individuals under court-ordered evaluation and court-ordered treatment

Every County in Arizona manages this responsibility differently based on their interpretation of the state statutes and the resources in that County. The Court Ordered Treatment/Court Ordered Evaluation (COT/COE) Coordinator and Liaison are required to work with the County Attorney’s Office to ensure proper execution of its procedures.

The Regional Behavioral Health Authority/Managed Care Organization/Health Plan is responsible for treatment of an eligible person* once placed under a Title 36 civil commitment or court-ordered treatment (COT). Per Arizona Administrative Code (R9-21-504) the RBHA/MCO/Health Plan “shall provide, either directly or by contract all treatment required by A.R.S. Title 36, Chapter 5, Article 5.”

* Populations eligible for RBHA/MCO/Health Plan services per The Health Plan Provider Manual Section 2.1.1-2:

- Title XIX/XXI enrolled individuals;
- Persons determined to have a Serious Mental Illness;
- Special populations, including individuals receiving services through the Substance Abuse Block Grant(SABG)

Overview

Each Health Home per The Health Plan contract scope of service is required to designate a staff person to serve as COT/COE Coordinator and Liaison for Title 36 and Court-Ordered services.

A Provider coordinates the provision of clinically appropriate covered services to individuals requiring court ordered treatment and serves as the Supervising Provider for court-ordered outpatient treatment plans.

In all cases, the Provider Medical Director** or physician designee has primary responsibility for oversight of an individual’s court-ordered treatment and is responsible for reviewing and signing all documents filed with Court, including the initial court-ordered treatment plan.

*** Per ARS 36-501 (24) Definitions - Medical Director of a mental health treatment Provider" means a psychiatrist, or other licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the Provider as the person in charge of the medical services of the Provider for the purposes of this chapter and includes the chief medical officer of the state hospital."*

Individuals on court ordered treatment (COT) are one of the most at-risk populations served and per The Health Plan screening tool, will always qualify to be served by a High Needs Recovery Center.

- Individuals on COT must be seen at least monthly by the Medical Director or designee (must be a Prescriber)
- Outreach and engagement with these individuals should be assertive and follow the re-engagement processes within The Health Plan Provider Manual (Section 3.4). The goal is to avoid re-hospitalization and improve the quality of life for the individual.
- A solid crisis plan must be developed that includes what works and does not work for this individual, supports that can help, and types of outreach that should be attempted if the individual has an increase in symptoms or disengages from treatment.
- The Health Plan has developed crisis protocols for every County served that include detailed descriptions about the way the crisis system works in each respective County. There are extensive sections on involuntary treatment that should be referenced for details on how each County facilitates the COT process. The protocols are located on The Health Plan website at www.azcompletehealth.com
- Providers must closely monitor COT expiration dates. Pursuant to A.R.S 36-540 (D), a court order cannot exceed 365 days, but some counties may order fewer days. Providers must ensure they understand the County's interpretation of the COT expiration date. Providers must monitor expiration dates to schedule annual reviews to determine if the individual's COT should continue for another year. Additionally, it gives Providers enough time to file a Petition for Continued Treatment with Court for individuals who were found Persistently or Acutely Disable or Gravely Disabled.
- The Health Plan will monitor and audit COT requirements and will issue Corrective Action Letters and/or Sanctions for failure to follow the requirements.

Requirements

Each Provider is responsible for maintaining a current list of individuals who are receiving court-ordered treatment.

PIMA COUNTY: Providers are responsible for establishing a group generic email box to receive minute entries from the Court. An example is MinuteEntries@[provider name].com. Pima County providers are required to contract with The Health Plan approved Pima County law firm to properly manage COT paperwork that will be submitted to Court. The Health Plan identifies a law firm to provide legal representation in filing post-hearing documents and coordinating with the Pima County Superior Court on behalf of Providers serving as Supervising Providers.

Urgent Engagement, SMI Evaluations and AHCCCS Screening for Member in COE/COT Process

Urgent Engagement is a no wrong door approach and therefore, all persons are eligible, regardless of benefit or assigned health plan and that “for persons who are not yet enrolled in Medicaid, Block Grant programs, or the Marketplace, Health Homes are required to continue to pursue coverage for the person for us to 45 days.”. (See Section 6.1.1 Health Home UE Responsibility)

For individuals going through Court Ordered Evaluation to be Court Ordered for Treatment, we must ensure that all avenues are explored to determine eligibility for services offered by The Health Plan. Therefore, when an agency in any county is activated for an Urgent Engagement for an individual who is NT19 and GMH and being evaluated for Court Ordered Treatment, an SMI evaluation/assessment should be completed. In general the SMI determination should be expedited by checking the 3-day turnaround time frame. The Health Home should also conduct financial screenings and assist the individual in applying for Title 19 benefits.

Should the member refuse services during the Court Ordered Evaluation process; the Health Home activated due to an urgent engagement shall retain the member until the member is Court Ordered for Treatment and then proceed to engage the member for 45 days so that eligibility with AHCCCS and an SMI determination can be completed. Please contact the Title 36 Coordinator at The Health Plan for additional Technical Assistance.

Health Homes are required to enroll and engage Title XIX members who refuse services during the COE process upon the member being Court Ordered.

Provider Participation in Hearings

The Individual's assigned Health Care Coordinator must attend all COT hearings, including the original hearing for court-ordered treatment, judicial reviews, and Petitions for Continued Treatment of Gravely Disabled (GD) or Persistently or Acutely Disabled (PAD). It is expected the Health Care Coordinator follows courtroom rules of decorum. The Health Care Coordinator should be prepared to provide information/clarification to Court regarding facts relevant to the hearing and the proposed outpatient treatment plan. The Health Care Coordinator must be present to receive orders set forth by the Judge/Commissioner and specific orders regarding the submitted outpatient treatment plan. In Pinal and Yuma Counties, this also includes the dates COT status reports are to be submitted to the Court.

Treatment Plan Development and Filing

Prior to the date of the hearing, the Health Care Coordinator is responsible for coordinating an Adult Recovery Team (ART) meeting for enrolled individual to develop discharge plans and ensure that those plans are included in the individual's Individual Service Plan (ISP). The ISP must be discussed/reviewed with the Provider Medical Director or physician designee. The individual's inpatient team must be involved in and agree to discharge decisions.

The COT outpatient treatment plan must be signed by Provider staff that reviewed the plan with the individual and the outpatient team. The individual is not required to sign the COT outpatient treatment plan and individual signature is optional. If the individual does not sign the plan, the individual signature line is to be left blank. Information regarding why the individual did not sign the plan is not to be written on the plan.

The COT outpatient treatment plan must have the individual's correct address/zip code and phone number and the type of residence (home, family, friend, BHRF, jail, etc.). If the individual is to reside with family, friends, etc., Provider staff must confirm this arrangement with family, friends, etc.

If a COT outpatient treatment plan has not been completed, the Health Care Coordinator is to inform Court why the plan has not been completed and the projected date of completion.

PIMA COUNTY: For individuals who are TXIX/TXXI eligible, the Health Care Coordinator develops a COT outpatient treatment plan using **PIMA County-COT Plan Ind. Receiving AHCCCS Benefits or the PIMA County-COT Plan Ind. NOT Receiving AHCCCS Benefits form**. In the event Persons who are Non-Title XIX/XXI eligible but are determined to have a Serious Mental Illness (SMI), the Health Care Coordinator develops a COT outpatient treatment plan using **PIMA County-COT Plan Ind. Receiving AHCCCS Benefits form or the PIMA County-COT Plan Ind. NOT Receiving AHCCCS Benefits**. The Health Care Coordinator is to submit to Court the original COT outpatient treatment plan to the Judge/Commissioner for signature, with 5 copies 1) County Attorney, 2) Defense Attorney, 3) Hospital T-36 Liaison, 4) Individual, 5) The Health Plan, totaling six treatment plans.

Amendments/Revocations (see the County Crisis Protocols or County specific sections of this guide for a detailed description of the process) *Refer to ARS 36-540 depending on the County process.*

Overview

The provider can amend/revoke an individual's court order and place the individual in an inpatient setting if the individual is not following the terms of the court order. It is important to note that only the Medical Director or physician designee can request an amendment/revocation of the outpatient treatment plan. *Note: Medical Directors are required to be available after hours if needed in order to facilitate the revocation/amendment of a court order.*

- It is important the provider track the numbers of days a member has spent in an inpatient setting, because there are a limited amount of inpatient days the court may order pursuant to A.R.S. 36-540:
 - DTS up to 90 days
 - DTO & PAD up to 180 days
 - GD up to 365 days
- If there are no more inpatient days available, the Medical Director must determine if the individual requires continued court-ordered treatment. If the individual is DTO/DTS the provider can follow the process for an Emergency Application for Evaluation for Admission. If the individual is PAD/GD the provider can initiate the Annual Review process or follow the Pre-Petition Screening process.
- Amended outpatient treatment orders do not increase the total period of commitment originally ordered by Court.

Emergent Amendment/Revocation A.R.S. 36-540 (E)(5)

If the individual is presenting with DTO/DTS behaviors and requires immediate hospitalization, the provider can verbally amend the outpatient treatment plan without an order from Court. The Medical Director or physician designee must contact an inpatient psychiatrist, discuss and agree that the individual requires immediate inpatient treatment. The Medical Director or

physician designee may authorize a peace officer to transport the individual to the inpatient treatment facility.

The Medical Director of the outpatient treatment facility must file a motion for an amended court order requesting inpatient treatment no later than the next working day following the individual being taken to the inpatient facility. If this paperwork is not filed in this timeframe, the individual may be detained and treated for no more than 48 hours, excluding weekends and holidays.

When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546.

PIMA COUNTY: Use the PIMA County-Emergent Amendment form

PIMA COUNTY: Verbal Revocation Process

When a member is in crisis at their placement, the following steps shall be taken: 1) The Out of Home (OOH) Placement shall assess if the Health Home is able to become involved. 2) If the Health Home can respond, they will follow their process for determining what steps need to be taken next. 3) If the Health Home cannot be involved, the OOH placement shall call NurseWise, who shall triage the situation and dispatch the Crisis Mobile Team.

If Crisis Mobile Team is dispatched, the Crisis Mobile Team shall assess if the member can be stabilized at the OOH placement. If member cannot be stabilized at the placement, the CMT shall consult on revocation recommendations with the Health Home doc on call. If the Health Home doctor does not recommend revocation, the Crisis Mobile Team shall determine next steps needed.

If the Health Home doctor does recommend revocation, the Crisis Mobile Team shall call the Crisis Response Center Intake Coordinator and staff member's care. The Crisis Response Center shall complete their internal paperwork to document the verbal revocation. The Crisis Response Center shall contact law enforcement to request Verbal Revocation Transport. Law Enforcement shall verify name, date of birth, and authorizing doctor and Health Home with the Crisis Mobile Team. Law Enforcement shall transport the member to the Crisis Response Network.

The Health Home shall be responsible the next business day for completing and filing with the courts the amendment in order to complete the verbal revocation process.

Non-Emergent Amendment/Revocation A.R.S. 36-540 (E)(4)

If the provider determines that the individual is not complying with the terms of the order or that the outpatient treatment plan is no longer appropriate, the Medical Director or physician designee can petition the court to amend/revoke the outpatient treatment plan to inpatient treatment. Court, without a hearing and based on the court record, the patient's medical record, the affidavits and recommendations of the Medical Director (must be notarized) , and the advice of staff and physicians or the psychiatric and mental health nurse practitioner familiar with the treatment of the patient, may enter an order amending its original order.

If the individual refuses to comply with an amended order for inpatient treatment, the court may authorize and direct a peace officer, on the request of the Medical Director, to take the individual into protective custody and transport the individual for inpatient treatment. When an individual is hospitalized pursuant to an amended order, the provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546.

PIMA COUNTY: For non-emergent amendments use the **PIMA County-Non-Emergent Amendment** form. The request for amendment to outpatient treatment plan must be signed by the outpatient psychiatrist and notarized. The provider submits the notarized form to The Health Plan approved law firm. Court requires specific information/facts regarding the individual's lack of compliance with the outpatient treatment plan. The preparer of the amended request should avoid using conclusions such as "delusional," "non-compliant," "AWOL (Absence without Leave)," "disruptive," "inappropriate," etc. The request should contain information regarding outreach attempts, attempts to engage the individual in treatment, or to offer hospitalization on a voluntary basis.

PIMA COUNTY: If Provider staff obtains updated information as to the individual's location after the amendment to the outpatient treatment plan has been filed with Court, the Provider should contact Pima County Mental Health Support Team (MHST) to provide updated information. When providing updated location information, staff should inform the MHST officer that an amendment to the outpatient treatment plan has been filed with Court. The MHST officer may request a copy of the amendment, which is permissible.

Quash a Court's Order for Law Enforcement to Transport for a Non-emergent Amendment

If Court has entered an order for law enforcement to transport the individual to an inpatient treatment facility and the provider believes this level of care is no longer required, the Provider can motion the court to quash the order to transport by law enforcement. This ensures the individual is not unnecessarily transported to an inpatient facility.

PIMA COUNTY: If 90 days has expired since the last amendment, the Provider is required to submit a written statement to The Health Plan approved law firm requesting to quash the previous amended and transport order. At this time the Provider may file a new amendment with the court for another 90 days. If an individual becomes incarcerated at Pima County Adult Detention Center (PCADC) during the timeframe of the amended outpatient treatment plan, a court order to quash the transport is not required if the current amendment does not indicate the address of PCADC. The Provider is responsible for notifying Pima County's MHST of the change in location of the individual. The Provider must email the amended pleading to MHST and PCADC records.

Tolling a Court Ordered Treatment

Per Statute 36.544; a member's Court Ordered Treatment is tolled during the unauthorized absence of the patient and resumes running only on the patient's voluntary or involuntary return to the treatment agency.

As defined by the Statute, an unauthorized absence is the following:

- if a member is no longer living in a placement or residence specified by the treatment plan without authorization OR
- leaving or failing to return to the county or state without authorization
- Absent from an inpatient treatment facility without authorization

The Statute indicates within five (5) days after a patient's unauthorized absence, the Health Homes shall file a motion with the Court to request a Toll of the Court Ordered Treatment. Health Home Title 36 Liaisons will be responsible for Filing Toll requests with the Courts, monitoring the number of days of the Toll and ensuring Status Reports for re-engagement efforts are filed every 60 days up to 180-Tolled Days. Tolled Orders will be reported to the The Health Plan Title 36 Coordinators.

Should the member not be re-engaged voluntarily or involuntarily, the Health Home has the option to ask the Court to terminate the Court Ordered Treatment after 180 days on Toll. Tolling a Court Order will move forward the expiration date of the current Order based upon the number of days the member was absent.

Judicial Reviews A.R.S. 36-546

Providers must inform the individual of the right to Judicial Review every 60 days and must document this in the clinical record. Judicial Reviews are to be calendared and offered every 60 days from the date of the original court order. The days from the court order are as follows: 60, 120, 180, 240, 300, and 360. It is the responsibility of the Provider to track the Judicial Review dates and ensure a Judicial Review is offered to an individual under Court-Ordered Treatment (COT) every 60 days. If an individual is hospitalized pursuant to an amendment to the outpatient treatment plan the Provider must inform the individual of the right to judicial review and the right to consult with counsel pursuant to A.R.S. 36-546. This Judicial Review does not change the count of the 60 days set from the date of the court order. It is considered an exception per statute and is permitted before the 60 days.

If the individual requests Judicial Review, the Health Care Coordinator completes the **Judicial Review-right to Speak to Legal Counsel** form. The form includes the following information:

- a. The individual being treated and the treating Provider.
- b. The individual to whom the request for release was made.
- c. The individual making the request for release, indicating whether the individual is the individual being treated or someone acting on the individual's behalf.

The individual reports current address and signs the form. The Health Care Coordinator must schedule an appointment for the individual to be evaluated by the Provider's Behavioral Health Medical Provider. The appointment cannot be scheduled with a Nurse Practitioner or Physician's Assistant. The completed PM form and psychiatric report must be completed and submitted to the County Attorney within 72 hours of the request and by the filing deadline.

For PIMA County, the completed form and psychiatric report is submitted to the law firm within 72 hours of the request and by the filing deadline.

For Greenlee, Graham, LaPaz, Santa Cruz and Yuma Counties; “The Treatment Team Recommendation for Judicial Review for COT” form, should be completed and submitted along with the following documents:

1. Letter from Medical Director;
2. The Right to Notification of Judicial Review form;
3. The last progress note from the Behavioral Health Medical Provider proving the Judicial review was discussed with Member and reporting recommendations.

For PINAL County, the following documents should be completed and submitted:

1. The Right to Notification of Judicial Review form;
2. The last 30-day Behavioral Health Medical Provider appointment that provides a psychiatric exam of the member. This is counted as the current “psychiatric exam”.

As a reminder, the Court could request additional documentation.

For Cochise County; the form “The Psychiatric Reports RE: Request for Judicial Review” must be completed and filed with the clerk of court along with the following documents:

1. The Psychiatric Report RE: Request for Judicial Review (The medical director’s letter)
2. The Right to Notification and Legal Counsel of Judicial Review form
3. The last psychiatric evaluation that was completed

The Behavioral Health Medical Provider appointment should be scheduled no later than 48 hours from request, so the Judicial Review form is received by the County Attorney or law firm the next day, to meet the 72 hour timeframe.

If the individual declines a Judicial Review, the Health Care Coordinator completes the same **form - Judicial Review**-right to Speak to Legal Counsel, and the individual signs this form. The individual provides a current address and location. The Provider maintains this form in the clinical record. If the individual is unavailable at the time the Judicial Review is due, the Health Care Coordinator completes the same form- **Judicial Review**-right to speak to Legal Counsel. The Health Care Coordinator must provide reasons why the individual was not available for the Judicial Review and include outreach and re-engagement attempts made. The Provider maintains this form in the clinical record. It should match the progress notes regarding outreach.

Court requires the psychiatric report to contain sufficient clinical information to render a decision regarding whether the individual needs continued court-ordered treatment or not. This psychiatric report can be in the form of a progress note. At a minimum the Judicial Review must include information regarding the individual’s insight regarding mental illness and information regarding adherence to court-ordered treatment plan. If the individual does not attend the Judicial Review appointment, the Behavioral Health Medical Provider must complete a chart review to provide this information. If an individual is hospitalized pursuant to an amended outpatient treatment plan and requests a Judicial Review, merely stating the individual is involuntarily hospitalized is not enough factual information for Court to render a decision. The BHMP should attempt to contact the inpatient Behavioral Health Medical Provider to gather information for the Judicial Review. Failure to provide sufficient evidence of need for continued treatment could result in Court requesting a hearing on the matter. A hearing can be set by the Judge/Commissioner or if requested by the defense attorney.

Status Reports

At the original hearing for court order, the Judge/Commissioner may direct the provider to submit status reports to Court. The Judge/Commissioner will set the dates when the reports are to be submitted.

- Pinal County court requires status reports due to the court at 30, 90, 180, 270 days. If the Provider fails to complete the status report to the court, the judge can order the person to appear and provide an in person status report regarding the treatment and process of the consumer.
- As this time, the following counties do not require a status report: Cochise, Graham, Greenlee, Yuma, La Paz and Pima.

Annual Review A.R.S. 36-543

Within 90 days of the expiration of the court order, the provider must conduct an annual review of an individual who was court-ordered to treatment as Gravely Disabled or Persistently or Acutely Disabled (GD & PAD) to determine if continuation of COT is appropriate and assess the needs of the individual for guardianship or conservatorship or both. The annual review includes a review of the mental health treatment and clinical records contained in the individual's treatment file.

If the Medical Director believes that continuation of the court-ordered treatment is appropriate, the Medical Director appoints one or more psychiatrists (depending on the County) to carry out a psychiatric examination of the individual. Each psychiatrist participating in the psychiatric examination must submit a report to the Medical Director that includes the following:

- 1) The psychiatrist's opinions as to whether the individual continues to have a grave disability or persistent or acute disability as a result of a mental disorder and is in need of continued COT;
- 2) A statement as to whether suitable alternatives to COT are available;
- 3) A statement as to whether voluntary treatment would be appropriate;
- 4) Review of the individual's need for a guardian or conservator or both;
- 5) Whether the individual has a guardian with mental health powers that would not require continued COT;
- 6) The result of any physical examination that is relevant to the psychiatric condition of the individual.

To ensure this review has taken place the provider submits to The Health Plan via email the progress note indicating the Behavioral Health Medical Provider met with the individual 45-90 days prior to expiration of the court order. Progress notes for the annual review can be emailed as soon as the annual review has been completed, but no later than the 2nd business day of the following month the annual review must have been completed.

Additionally, the individual's clinical team shall hold a service planning meeting, not less than 45 days prior to the expiration of the court-ordered treatment to determine if the court order should continue. The following information must be indicated and written in the BHMP progress notes of the service planning meeting for the annual review that you submit:

- That this appointment is for the 45/90 day face to face annual review appointment

- That the recommendation is either to roll/continue the members COT or to allow the COT expire
- That the recommendation was discussed with the member

If the Medical Director believes after reviewing the annual review that continued COT is appropriate, the Medical Director files with Court, no later than forty-five days before the expiration of the court order for treatment, an application for continued court-ordered treatment and the psychiatric examination conducted as part of the annual review. If the individual is under guardianship, the Medical Director must mail a copy of the application to the individual's guardian.

The annual exam must have current contact information for the individual. This includes full address, zip code, and telephone number. If the individual's location and/or other contact information changes, provider staff must contact the individual's attorney with this new information

Annual Review Missing or Incarcerated Members:

For the Annual Review requirement, please ensure that the Psychiatrist/Behavioral Health Medical Provider does the following within the allotted time frame (45-90 days) of the Annual Review dates:

1. For Incarcerated members:

Write a note in the chart that consists of the following information:

- This is an annual review;
- Circumstances as to why the member was not present;
- Indicate the date the member was booked to jail and that the member is still incarcerated;
- Indicate whether their recommendation is to roll the order or to allow it to expire. If the recommendation is to roll based on the member's clinical record and you are not able to file a Petition for Continued Treatment with the Court, indicate that due to lack of coordination from the jail, this is not possible;
- Indicate the date when you attempted to reach out to the jail psychiatrist to discuss member's annual review;
- File in the Member's medical Record;
- Send a copy to the Title 36 Coordinator indicating this is an annual review for an incarcerated member.

2. For Missing in Action (MIA) members for whom you have not closed or the Court has not agreed to term the COT early:

Write a note in the chart that consists of the following information:

- This is an annual review;
- Circumstances as to why the member was not present;
- Date that a revocation was filed with the Court;
- Psychiatrist has not seen the member for XX months due to the member being MIA;

- e. Indicate whether their recommendation is to roll the order or to allow it to expire. If recommendation would be to roll, indicate that due to lack of contact with the member, this is not possible;
- f. Indicate that re-engagement protocols have been attempted to locate the member (A request for progress notes to review re-engagement attempts may be asked for);
- g. File in the Member's medical record;
- h. Send a copy to the Title 36 Coordinator indicating this is an annual review for a missing member.

If your agency uses a psychiatric annual review examination form, please use that document and include the above information.

NOTE: You should still enter these reviews as the annual review in the Provider Portal COT Span event.

A hearing is conducted if requested by the individual's attorney on behalf of the request of the individual or otherwise ordered by Court.

For individuals determined DTS and/or DTO the provider must initiate the pre-petition screening process pursuant to Arizona Administrative Code.

For individuals whose Court Order is currently being tolled, the annual review will not be required until the member is re-engaged into services.

PIMA COUNTY: For continued treatment examinations for individuals found to be GD, utilize **PIMA County Psych Exam for Annual Review for GD Persons form**. For continued treatment examinations for individuals found to be PAD, utilize **the PIMA County Psych Exam for Annual Review for PAD Persons**. The Health Plan law firm will forward to the provider the conformed copy of the petition and order. The provider is required to give the paperwork to the individual and obtain a signature using **the Confirmation of Receipt form**. This form provides evidence to Court and defense counsel the individual is aware of the petition and the right to speak to an attorney. This original signed form must submit The Health Plan law firm within five (5) business days of receipt. If set for hearing, the Provider's Behavioral Health Medical Provider who completed the Annual Exam must testify at the hearing. The COT/COE Liaison is responsible for coordinating the hearing with The Health Plan law firm, provider staff and the Behavioral Health Medical Provider. The Health Care Coordinator must inform the individual of the hearing and arrange for transportation to the hearing. The Health Care Coordinator may be called as a witness.

Termination/Release from Court Ordered Treatment A.R.S. 36-541.01

Upon written request of the individual's Behavioral Health Medical Provider, a Court may order an individual to be released from court-ordered treatment prior to the expiration of the court-ordered period.

Specifically, the Title 36 Statute states "A patient who is ordered to undergo treatment pursuant to this article may be released from treatment before the expiration of the period ordered by the court if, in the opinion of the medical director of the mental health treatment agency, the patient no longer is, as a result of a mental disorder, a danger to others or a danger to self or no longer has a

persistent or acute disability or a grave disability. A person who is ordered to undergo treatment as a danger to others may not be released or discharged from treatment before the expiration of the period for treatment ordered by the court unless the medical director first gives notice of intention to do so as provided by this section.”

Termination from Reporting a member who is on Court Ordered Treatment

There are certain circumstances when a Health Home may no longer be required to report to The Health Plan a member who is on Court Ordered Treatment. These conditions would be as follows: 1) a member has been sentenced to the Department of Corrections, 2) a member has died, 3) the member has lost AHCCCS benefits and is NOT Severely Mentally Ill (SMI) and does not meet SMI criteria, 5) the member’s Court Order has been Tolloed for 180 days and the Court approves the Health Home’s request to terminate the Court Order, 6) the Order is dismissed during a Judicial Review hearing, and 7) the member has agreed to become voluntary.

Suspension of Outpatient Treatment Plan

In Pima County and occasionally in Maricopa County, if a member moves out of state and the Health Home can no longer provide services; the Health Home may petition the court to suspend the outpatient treatment section of the member’s court ordered treatment. This relieves the Health Home of the responsibility of services specifically for the court ordered treatment.

For Court Orders issued from Yuma, Pinal, Cochise, Santa Cruz, Graham and Greenlee Counties, no formal process has been established for suspending the outpatient treatment portion of the court order. Health Homes Title 36 Liaison are advised to contact The Health Plan Title 36 Coordinator for direction.

Termination of a Court Order that has been Tolloed

Per Revised ARS Title 36 Statute 36-544, if a member’s Court Order has been tolloed for 180 days, the Health Home may petition the court to terminate the member’s Court Ordered Treatment. The Court may or may not approve of the request.

Transfers

Provider to Provider

- Note: The following are general guidelines-each County has the right to request additional or different documentation. When the specific County process is known, it shall be included in this guide.
- Before a COT individual can be transferred from one treating Provider to another, the sending Provider must have verification that the Medical Director of the receiving Provider has accepted the member and accepted responsibility for overseeing treatment under the court order. This must happen before the transfer is completed.
- This is best accomplished by requesting a “Letter of Intent to Treat”. The Letter of Intent can be a letter from the Medical Director of the receiving HNRC that includes:
 - Name and DOB of the individual on COT
 - COT start and end date
 - The standard under which the person is court ordered (DTO; /DTS; PAD; GD)
 - Printed name and signature of the receiving Provider’s Medical Director
 - Effective transfer date (date of intake)

- The letter can read simply: *“This letter is to verify that Dr. X and Provider Y has agreed to provide court ordered treatment to member Z”*
- The HNRC must keep a copy of the letter in the clinical record.
- The Medical Director of the receiving Provider notifies Court in writing that there has been a change in oversight of the individuals COT. It is recommended that an official document from the court be requested that reflects the current treatment Provider/Medical Director as the responsible party overseeing the court ordered treatment.

Members Currently being Served by a Health Home.

A Provider serving as a Behavioral Health Home is required to provide all services including outpatient treatment plan services for members on Court Ordered Treatment. However, there are some Intake Agencies who cannot typically provide the services required by the Outpatient Treatment Plan for Court Ordered Treatment. If the member is currently receiving services from one of these providers, the member may need to be transferred/assigned to a Health Home who will assume responsibility for the members Court Ordered Outpatient Treatment Plan. A Health Home should be designated prior to the member being discharged from the hospital so that a court ordered treatment plan can be submitted to the Court. A transfer/assignment of the member should occur upon discharge from an inpatient stay. Should this occur, please contact The Health Plan Title 36 Coordinator for additional Technical Assistance”

Also see Section 4.1.4 - Transition of Persons Receiving Court Ordered Services for additional details for Transfers

Transfers for Members on Court Ordered Treatment.

For Members who are on court ordered treatment:

- The Health Home shall inform AzCHMemberTransfers that must include all court ordered treatment documents along with transfer packet;
- The Receiving Agency shall schedule an Intake appointment and inform AzCHMemberTransfers and the Sending Agency the date of the appointment;
- The Receiving Agency must inform AzCHMemberTransfers and the Sending Agency that intake appointment has been completed ;
- The Receiving Agency must send the Letter of Intent to AzCHMemberTransfers and the Sending Agency;
- Member Transfers and the Sending Agency must acknowledge receipt of the Letter of Intent;
- The Sending Agency shall file the court document to transfer the Court Ordered Treatment from their County to the new County.

Please reference Section 4.2.4.3 *Behavioral Health Provider’s Responsibilities During an Inter-RBHA/MCO Transfers*

Arizona State Hospital (AzSH)

AzSH PSRB GEI-If a person is being released from AzSH after serving a sentence under the guilty except insane (GEI) standard, the release of this person is generally reviewed by the Psychiatric Security Review Board. (PSRB) The PSRB will make recommendations for the individuals release into the community. This will often include a referral to the Regional Behavioral Health

Authority/Managed Care Organization /Health Plan where the individual plans to reside upon release and often consideration for court ordered treatment. In these situations, the local County Attorney's office is notified by AzSH to initiate the court ordered evaluation process.

PIMA COUNTY: A transfer hearing must be set if a COT individual objects to the transfer to ASH.

Change of Venue – Counties other than Pima

When a client transfers from one County to another, the receiving provider must agree to accept the individual on COT through an LOI and, once transferred, must request the change of venue from the County in which the COT originated. Although, Change of Venue is a Court jurisdiction process, the receiving provider must follow-up with Court to ensure the change of venue is completed to ensure there is an accurate record of COT individuals by provider.

Change of venue from Pima County to another County

Change of venue should be requested by the outpatient provider at the time of the initial Court Ordered Treatment hearing. The provider should appear in court with an outpatient treatment plan and request the judge to change the venue to the receiving County. If a change of venue needs to occur after the initial Court Ordered Treatment hearing, the outpatient provider must submit: 1) Motion for approval of court-ordered outpatient treatment plan, accompanied by a Court Ordered Treatment Plan, 2) Motion to Change Venue, Order to Change Venue, accompanied by a Letter of Intent. **The documents must be mailed to The Health Plan approved law firm to file with the Court.**

Reporting

Per AHCCCS, monthly reporting is required for all persons on court ordered treatment. All providers must identify and track treatment engagement of Court Ordered Treatment (COT) individuals.

The Health Plan has developed a portal-based submission for monthly reports for all COT individuals:

- Provider can complete/submit updates at any time during the reporting month, but all updates (updates include portal data entry and required documentation) must be completed and submitted no later than the 2nd business day of the next month.
- Provider must submit initial or continuing COTs as soon as they are received from Court
- It is highly recommended that each Provider designate a backup designee for the COT/COE Coordinator and Liaison to manage report submission and any questions from The Health Plan T-36 Coordinator if the Provider's COT/COE Coordinator and Liaison not be available.
- It is recommended that the COT/COE Coordinator and Liaison and their backup designee be responsible to submit the data via the Provider Portal
- There can be multiple updates per member per month depending on the number of events occurring in the reporting month
- The EC-302 COT Title 36 Reporting Monthly Deliverable due on the 2nd business day of the next month, as outlined in **Section 16 – Deliverable Requirements** is to ensure that updates and documents are entered/submitted no later than this date.

12.9.6 Persons Who Are Title XIX/XXI Eligible or Non-Title XIX/XXI and/or Determined to Have a Serious Mental Illness (SMI).

When a person referred for court-ordered treatment is Title XIX/XXI or non-Title XIX/XXI eligible and/or determined or suspected to have SMI, the provider must:

- Conduct an evaluation to determine if the person has a Serious Mental Illness in accordance with **Section 12.6 — SMI Eligibility Determination**, and conduct a behavioral health assessment to identify the person's service needs in conjunction with the person's clinical team, as described in **Section 12.5 — Assessment and Service Planning**;
- Provide necessary court-ordered treatment and other covered services in accordance with the person's needs, as determined by the person's clinical team, the Member, family Members, and other involved parties (see **Section 12.5 — Assessment and Service Planning**); and
- Perform, either directly or by contract, all treatment required by ARS Title 36, Chapter 5, Article 5 and 9 AAC 21, Article 5.

12.9.7 Court-Ordered Treatment For Persons Charged with or Convicted of a Crime

The Health Plan or providers may be responsible for providing evaluation and/or treatment services when an individual has been ordered by a court due to: conviction of a domestic violence offense; or upon being charged with a crime when it is determined that the individual is court ordered to treatment, or programs, as a result of being charged with a crime and appears to be an "alcoholic."

12.9.8 Domestic Violence Offender Treatment

Domestic violence offender treatment may be ordered by a court when an individual is convicted of a misdemeanor domestic violence offense. Although the order may indicate that the domestic violence (DV) offender treatment is the financial responsibility of the offender under A.R.S. § 13-3601.01 The Health Plan will cover Domestic Violence services with Title XIX/XXI funds when the person is Title XIX/XXI eligible, the service is medically necessary, required prior authorization is obtained if necessary, and the service is provided by an in-network provider. For Non-TXIX/XXI eligible person's court ordered for DV treatment, the individual can be billed for the DV services.

12.9.9 Court-Ordered DUI Services

Substance abuse evaluation and/or treatment (i.e., DUI services) ordered by a court under A.R.S. § 36-2027 is the financial responsibility of the county, city, town, or charter city whose court issued the order for evaluation and/or treatment. Accordingly, if AHCCCS or The Health Plan receives a claim for such services, the claim will be denied with instructions to the provider to bill the responsible county, city, or town.

12.9.10 Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona Tribes are sovereign nations, and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to State court-ordered evaluation or treatment ordered because of a behavioral health crisis occurring off reservation.

Although some Arizona Tribes have adopted procedures in their tribal codes that are similar to Arizona law for court-ordered evaluation and treatment, each Tribe has its own laws which must be followed for the tribal court process. Tribal court ordered treatment for American Indian tribal members in Arizona is initiated by tribal behavioral health staff, the tribal prosecutor, or other person authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a mental health disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether court ordered treatment is necessary. Tribal court orders specify the type of treatment needed.

Additional information on the history of the tribal court process, legal documents, and forms as well as contact information for the tribes The Health Plan liaisons, and tribal court representatives can be found on the AHCCCS web page titled, Tribal Court Procedures for Involuntary Commitment - Information Center.

Since many Tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure court ordered treatment off reservation, the court order must be “recognized” or transferred to the jurisdiction of the State.

The process for establishing a tribal court order for treatment under the jurisdiction of the State is a process of recognition, or “domestication” of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the State recognized tribal court order is enforceable off reservation. The State recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities, including the Arizona State Hospital, must provide treatment, as identified by the tribe and recognized by the ([A.R.S. § 12-136 Recognition and Enforcement of Tribal Court Involuntary Co0mmitment Orders in the Arizona Superior Courts](#))

The Health Plan providers must comply with State recognized tribal court orders for Title XIX/XXI and Non-Title XIX/XXI SMI persons. When tribal providers are also involved in the care and treatment of court-ordered tribal members, The Health Plan and providers must involve tribal providers to verify the coordination and continuity of care of the Members for the duration of court ordered treatment and when Members are transitioned to services on the reservation, as applicable.

This process must run concurrently with the tribal staff’s initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the appropriate RBHA/MCO/Health Plan. This clinical communication and coordination with the RBHA/MCO/Health Plan is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon State/county court recognition of the

tribal court order. The Arizona State Hospital should be the last placement alternative considered and used in this process

A.R.S. § 36-540(B) states, “The Court shall consider all available and appropriate alternatives for the treatment and care of the patient. The Court shall order the least restrictive treatment alternative available.” RBHA/MCO/Health Plans are expected to partner with American Indian Tribes and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of services.

Due to the options American Indians have regarding their health care, including services, payment of services for AHCCCS eligible American Indians may be covered through a TRBHA, RBHA/MCO/Health Plan or Indian Health Services/638 provider (see Behavioral Health Services Payment Responsibilities on the AHCCCS Tribal Court Procedures for Involuntary Commitment web page for a diagram of these different payment structures).

12.10 Special Populations

The State receives Federal grants and State appropriations to deliver services to special populations in addition to Federal Medicaid (Title XIX) and the State Children’s Health Insurance Program (Title XXI) funding. The grants are awarded by a Federal agency and made available to the State. The State then disburses the funding throughout Arizona for the delivery of covered services in accordance with the requirements of the fund source.

This section is intended to present an overview of the major Federal grants that provide the State and the public behavioral health system with funding to deliver services to persons who may otherwise not be eligible for covered services: the Substance Abuse Block Grant (SABG), the Community Mental Health Services Block Grant (MHBG), and the Projects for Assistance in Transition from Homelessness (PATH) Program. These are all annual formula grants authorized by the United States Congress. The Substance Abuse and Mental Health Services Administration (SAMHSA) facilitates these grant awards to states in support of a national system of mental health and substance abuse prevention and treatment services. All entities receiving SABG and MHBG funds must obtain and maintain an Inventory of Behavioral Health Services (I-BHS) number through SAMHSA.

It is important for providers to be aware of the following:

- Who is eligible to receive services through these funding sources;
- How the funds are prioritized; and
- What services are available through each funding source.

12.10.1 Substance Abuse Block Grant (SABG)

The SABG supports primary prevention services and treatment services for persons with substance use disorders. It is used to plan, implement, and evaluate activities to prevent and treat substance abuse. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance abusers.

12.10.1.1 **Coverage and Prioritization**

Substance use treatment services shall be available to all Members based upon medical necessity and the availability of funds. SABG funds are used to ensure access to treatment and long-term recovery support services for (in order of priority):

- Pregnant women/teenagers who use drugs by injection;
- Pregnant women/teenagers who use substances;
- Other persons who use drugs by injection;
- Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children; and
- All other clients with a substance abuse disorder, regardless of gender or route of use (as funding is available).

Persons must indicate active substance use within the previous 12-month period to be eligible for SABG funded services.

Families involved with ADES/DCS who are in need of substance use disorder treatment and are not Title XXI/SSI eligible, can receive services paid for with SABG funds.

12.10.1.2 **Choice of Substance Abuse Providers**

Persons receiving substance abuse treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object. Providers providing substance abuse services under the SABG must notify persons of this right in writing. Providers must document that the person has received notice in the person's comprehensive clinical record (see AHCCCS [AMPM Policy 320-T Exhibit 320-T9](#)).

If a person receiving services under the SABG objects to the religious character of a provider, the provider must refer the person to an alternate provider within 7 days, or earlier when clinically indicated, after the date of the objection. Upon making such a referral, providers must notify The Health Plan of the referral and confirm that the person makes contact with the alternative provider.

Intake Providers must utilize the Health Plan web-based Member transfer system to facilitate all transfers between provider agencies, including transfers associated with religious considerations (see **Section 13.1 — Transition of Persons**).

12.10.1.3 **Program and Financial Management Policies**

Providers must establish program and financial management policies and procedures for services funded by the SABG to meet all requirements in the provider agreement, the Provider Manual and the requirements of The Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public Health Service Act (42 USC 300 et seq.) and 45 CFR Part 96 as amended. The policies and procedures should include, but are not limited to, a listing of prohibited expenditures, references to the SABG FAQs, monitoring and reporting of funds by priority populations and funding category.

All providers who receive SABG funding are required to submit their SABG Policy and Procedure to AzCH annually, each November. Procedures must include reporting and monitoring requirements to track encountering of SABG funds and to verify that treatment services are delivered at a level commensurate with funding under the SABG. Providers must submit SABG related program reports. These reports must be submitted in a format prescribed by The Health Plan.

The Health Plan must submit an annual plan regarding outreach activities and coordination efforts with local substance abuse coalitions. The Health Plan may ask providers receiving SABG funds for information for this report.

12.10.1.4 *SABG Reporting Requirements:*

Providers must promptly submit information for Priority Population Members (Pregnant Women, Women with Dependent Child(ren) and Intravenous Drug Users) who are waiting for placement in a Behavioral Health Inpatient Facility to the State SABG Waitlist System, or in a different format upon written approval by the State.

- Title XIX/XXI persons may not be added to the wait list;
- Priority Population Members must be added to the wait list if The Health or its providers are not able to place the person in a Behavioral Health Residential facility within the timeframes prescribed in **Section 12.2 — Appointment Standards and Timeliness of Service**; and
- Non-Title XIX/XXI persons may be added to the wait list and must be provided interim services if there are no available services.

12.10.1.5 *Considerations When Delivering Services to SABG Populations*

SABG treatment services must be designed to support the long-term recovery needs of eligible persons and meet the requirements set forth in The Health Plan Provider Manual Section. Specific requirements apply regarding preferential access to services and the timeliness of responding to a person's identified needs (see **Section 12.2 — Appointment Standards and Timeliness of Service**). Providers must also submit specific data elements to identify special populations and record limited clinical information (see **Section 6.1 — Enrollment, Disenrollment and Other Data Submission** for requirements).

12.10.1.6 *Services Available to SABG Special Populations*

Treatment programs must include the following minimum core components: outreach, screening, referral, early intervention, case management, relapse prevention, child care services and continuity of addiction treatment. These are critical components for treatment programs targeting substance-using individuals. In addition, medical providers must be included in the treatment planning process from the initial contact for services to verify continuity and coordination of care.

Providers must refer persons with substance use disorders for tuberculosis screening. In addition, provider must deliver services to persons with HIV in accordance to this Provider Manual.

The overall goal in a continuum of comprehensive addiction treatment is improved life functioning and wellbeing, as measured by reductions in the medical, psychosocial, spiritual, social, and family consequences of addiction.

12.10.1.7 *Interim Services for Pregnant Women/Injection Drug Users (Non-Title XIX/XXI only)*

The purpose of interim services is to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. Interim services are available for Non-Title XIX/XXI priority populations who are maintained on an actively managed wait list. Title XIX/XXI eligible persons who also meet a priority population type may not be placed on a wait list (see **Section 12.2 — Appointment Standards and Timeliness of Service**). Provision of interim services must be documented in the Member's chart as well as reported to the State through the online waitlist. The minimum required interim services include education that covers the following:

- Prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C, and other sexually transmitted diseases;
- Effects of substance use on fetal development;
- Risk assessment/screening;
- Referrals for HIV, Hepatitis C, and tuberculosis screening and services; and
- Referrals for primary and prenatal medical care.

12.10.1.8 *Program Requirements for Pregnant Women and Women with Dependent Children*

Providers must comply with Program Requirements for Pregnant Women and Women with Dependent Children in accordance with this Provider Manual as follows:

- Engage, retain, and treat pregnant women and women with dependent children who request and are in need of substance use disorder treatment.
- Deliver outreach, specialized evidence-based treatment, and recovery support services for pregnant women, women with dependent children or women attempting to regain custody of children.
- Deliver services to the family as a unit and for residential treatment programs, admit both women and their children into treatment.
- Deliver medically necessary covered services to each pregnant woman who requests and is in need of substance use disorder treatment within forty-eight (48) hours of the request.
- Deliver medically necessary covered services for women with dependent children within five (5) days.
- Publicize the availability and accessibility of SABG-funded substance abuse services to the community and referral sources including, at a minimum, schools, substance abuse coalitions, and medical providers. Publicize the availability of gender-based substance use disorder treatment services for pregnant women or women who have dependent children. Publication must include, at minimum, the posting of fliers at each SABG service delivery site notifying pregnant women or women with

dependent children of the availability and right to receive substance use disorder treatment services at no cost.

- Deliver the following services as needed: referral for primary medical care for women and primary pediatric care for children; gender-specific substance use treatment; therapeutic interventions for children; and case management and medically-necessary transportation to access medical and pediatric care.
- Eliminate barriers to access treatment through incorporation of child care, case management and medically-necessary transportation to medical and pediatric care and treatment services.
- Prioritize services available for substance use disorder treatment services for pregnant women pursuant to A.R.S. § 36-141.

Providers are required to ensure the following issues do not pose barriers to access to obtaining substance abuse treatment:

- Child care;
- Case management; and
- Transportation.

Specific goals of women-focused treatment include reducing fetal exposure to alcohol/drugs, verifying a healthy birth outcome as an immediate priority, and addressing issues relevant to women; such as, domestic abuse and violence, demands of child-rearing, vocational and employment skills.

12.10.1.9 *Program Requirements for Persons Involved with Injection Drug Use*

Providers must engage in evidence-based best practice outreach activities to encourage individuals in need of services to undergo treatment and deliver medically necessary covered services to persons involved with injection drug use who request and are in need of substance use disorder treatment within fourteen (14) calendar days. Providers must notify The Health when an intravenous drug use program has reached ninety percent (90%) of its capacity. Providers are prohibited from using SABG funds to supply individuals with hypodermic needles or syringes to use illegal drugs.

12.10.1.10 *Human Immunodeficiency Virus (HIV) Early Intervention Services*

Because persons with substance abuse disorders are considered at high risk for contracting HIV-related illness, the SABG requires HIV intervention services to reduce the risk of transmission of this disease. HIV Early Intervention services are available to Members receiving substance use disorder treatment, although HIV services may not be provided to incarcerated populations.

- Accessing HIV Early Intervention Services

Provider agencies must provide locations and specified times for Members to access HIV Early Intervention services. Providers shall inform Members of the opportunity to receive HIV education, screenings and early intervention services and facilitate Members' access to the services. Substance use treatment providers must make their facilities available for HIV Early

Intervention providers contracted with The Health Plan and verify Members have access to HIV Early intervention services.

Requirements for Providers Offering HIV Early Intervention Services

- HIV Testing Services

HIV early intervention service providers who accept funding under the SABG must provide HIV testing services. Providers must administer HIV testing services in accordance with the Clinical Laboratory Improvement Amendments (CLIA) requirements, which requires that any agency that performs HIV testing must register with Centers for Medicare and Medicaid (CMS) to obtain CLIA certification. However agencies may apply for a CLIA Certificate of Waiver, which exempts them from regulatory oversight if they meet certain federal statutory requirements.

Many of the Rapid HIV tests are waived. For a complete list of waived Rapid HIV tests please see (<http://www.fda.gov/cdrh/cli/cliawaived.html>). Waived rapid HIV tests can be used at many clinical and non-clinical testing sites, including community and outreach settings. Any agency that is performing waived rapid HIV tests is considered a clinical laboratory. Any provider planning to perform waived rapid HIV tests must develop a quality assurance plan, designed to verify any HIV testing will be performed accurately. (See Centers for Disease Control Quality Assurance Guidelines).

HIV early intervention service providers cannot provide HIV testing until they receive a written HIV test order from a licensed medical doctor, in accordance with A.R.S. § 36-470. HIV rapid testing kits must be obtained from the ADHS Office of HIV.

The Health Plan is expected to administer a minimum of one test per \$600 in HIV funding.

- HIV Education and Pre/Post-Test Counseling

The HIV Prevention Counseling training provided through Arizona Department of Human Services must be completed by all The Health Plan HIV Coordinators, provider staff and provider supervisors whose duties are relevant to HIV services. Staff must successfully complete the training with a passing grade prior to performing HIV testing. HIV education and pre/post-test counseling. The Health Plan HIV Coordinators and provider staff delivering HIV Early Intervention Services for the SABG also must attend an HIV Early Intervention Services Webinar issued by the State on an annual basis, or as indicated by the State. The Webinar will be recorded and made available by the State. New staff assigned to duties pertaining to HIV services must view the Webinar as part of their required training prior to delivering any HIV Early Intervention Services reimbursed by the SABG.

Community Involvement

HIV early intervention service providers must actively participate in regional community planning groups to verify coordination of HIV services.

- Reporting Requirements for HIV Early Intervention Services

For every occurrence in which an oral swab rapid test provides a reactive result, a confirmatory blood test must be conducted and the blood sample sent to the Arizona State Lab for

confirmatory testing. Therefore, each provider who conducts rapid testing must have capacity to collect blood for confirmatory testing whenever rapid testing is conducted.

The number of the confirmatory lab slip will be retained and recorded by the provider. This same number will be used for reporting in the Luther data base. The HIV Early Intervention service provider must establish a Memorandum of Understanding (MOU) with their local County Health Department to define how data and information will be shared. Providers must use the Luther database to submit HIV testing data after each test administered.

- **Monitoring Requirements for HIV Early Intervention Services**

Provider is required to submit monthly progress reports to The Health Plan. The Health Plan will conduct bi-annual site visits to providers offering HIV Early Intervention Services. The State HIV Coordinator, The Health Plan HIV Coordinator, provider staff, and supervisors relevant to HIV services must be in attendance during site visits. As part of the site visit, provider must make available a budget review and a description/justification for use of the SABG funding.

12.10.1.11 *Other Populations*

Providers must deliver evidence-based services to other populations requiring substance use interventions and supports, including homeless individuals, individuals with sight limitations, who are deaf or hard of hearing, persons with criminal justice involvement and persons with co-occurring mental health disorders, subject to the availability of SABG funds.

12.10.1.12 *Restrictions on the Use of SABG Grant Funds*

Providers may not expend SABG funds on the following activities:

- Inpatient hospital services;
- Acute Care or physical health care services including payment of copays;
- Make cash payments to intended recipients of health services;
- Purchase or improve land; purchase, construct, or permanently improve any building or facility except for minor remodeling with written approval from AHCCCS;
- Purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of Federal funds;
- Provide financial assistance to any entity other than a public or non-profit private entity;
- Provide individuals with hypodermic needles or syringes for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
- Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year; see <http://grants.nih.gov/grants/policy/salcapsummary.htm>;

- Purchase treatment services in penal or correctional institutions in the State of Arizona;
- Sponsorship for events and conferences; and Flex funds purchases.

Room and Board (H0046 SE) services funded by the SABG are limited to children/adolescents with a Substance Use Disorder (SUD), and adult priority population Members (pregnant females, females with dependent child(ren), and intravenous drug users with a Substance Use Disorder) to the extent in which funding is available.

12.10.2 **Community Mental Health Services Block Grant (MHBG)**

The MHBG Block Grant provides funds to establish or expand an organized community-based system of care for providing Non-Title XIX/XXI mental health services to children with serious emotional disturbances (SED) and adults with a Serious Mental Illness (SMI). The MHBG Block Grant funds are used to: (1) carry out the State plan contained in the application; (2) evaluate programs and services; and (3) conduct planning, administration, and educational activities related to the provision of services. The MHBG Block Grant requires the State to maintain a statewide planning council with representation by Members, family members, State employees and providers.

12.10.2.1 ***Populations Covered and Prioritized***

In serving children with SED and adults with SMI, MHBG funds must be used for the following:

- To ensure access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental , and health services, as well as mental health services and supports;
- To promote participation by Member/survivors and their families in planning and implementing services and programs, as well as in evaluating State mental health systems;
- To verify access for underserved populations, including people who are homeless, residents of rural areas, and older adults;
- To promote recovery and community integration for adults with a SMI and children with SED;
- To provide for a system of integrated services to include:
 - Social services;
 - Educational services;
 - Juvenile justice services;
 - Substance abuse services; and
 - Health and services.
- To provide for training of providers of emergency health services regarding behavioral health.

12.10.2.2 ***Restrictions on the Use of MHBG Block Grant Funds***

Providers must ensure that MHBG Block Grant funds are not expended on the following activities:

- Inpatient hospital services;
 - Acute Care or physical health care services including payment of copays;
 - Make cash payments to intended recipients of health services;
 - Purchase or improve land; purchase, construct, or permanently improve any building or facility except for minor remodeling with written approval from AHCCCS;
 - Purchase major medical equipment;
 - To satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of Federal funds;
 - Provide financial assistance to any entity other than a public or non-profit private entity;
 - Provide individuals with hypodermic needles or syringes for illegal drug use, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug use and the risk that the public will become infected with the etiologic agent for AIDS;
 - Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year; see <http://grants.nih.gov/grants/policy/salcapsummary.htm>;
 - Purchase treatment services in penal or correctional institutions in the State of Arizona,
 - Sponsorship for events and conferences; and
 - Flex funds purchases.
- Room and Board services funded by the MHBG are limited to children with SED.

12.10.2.3 ***Provider Management of MHBG Funds***

Providers must comply with all terms, conditions, and requirements of the MHBG including the Children's Health Act of 2000, P.L. 106-310 Part B of Title XIX of the Public Health Service Act (42 U.S.C. 300 et seq.) and 45 CFR Part 96 as amended. Providers must retain documentation of compliance with Federal requirements, and produce upon The Health Plan request, financial, performance, and program data that is subject to audit. These services will be available based upon medical necessity and the availability of funds.

Providers must report MHBG and SABG funds and services separately and report or produce information related to block grant expenditures to The Health Plan upon request. Providers must manage the MHBG funds during each fiscal year to make funds available for obligation and expenditure until the end of the fiscal year for which the funds were paid.

Providers must have internal MHBG policies and procedures that should include, but are not limited to, a listing of prohibited expenditures, references to the MHBG FAQs, monitoring and reporting of funds by priority populations and funding category. All providers who receive

MHBG funding are required to submit their MHBG Policy and Procedure to AzCH annually, each November. Copayments, or any other fee, are prohibited for the provision of services funded by MHBG Block Grants.

12.10.3 Projects for Assistance in Transition from Homelessness (PATH) Grant

The PATH Grant provides outreach services designed to assist individuals who are homeless or at imminent risk of becoming homeless who are suspected to have or have been determined to have a Serious Mental Illness (SMI) or co-occurring SMI and substance use disorder. The services are to be provided in locations where persons who are homeless gather, such as food banks, parks, vacant buildings and the streets.

PATH grant funds are allocated by the State based on a competitive request for proposals (RFP) process and direct provider contract. The Health Plan does not currently receive this funding therefore there are no PATH providers in our service areas.

12.11 Special Assistance for Members Determined to Have a Serious Mental Illness

Health Homes and contracted BH Inpatient Facilities must identify and report to the AHCCCS Office of Human Rights (OHR) on members determined to have a Serious Mental Illness (SMI) who meet the criteria for Special Assistance. If the person's Special Assistance needs appear to be met by an involved family member, friend, designated representative or guardian providers must still submit a notification to the OHR. Health Homes, contracted BH Inpatient Facilities and the Behavioral Health Office of Grievances and Appeals (BHOGA) must ensure that the person designated to provide Special Assistance is involved at key stages.

Health Homes and contracted BH Inpatient Facilities are expected to follow the policies and procedures outlined in [AMPM Policy 320-R](#), all other applicable AHCCCS policies and state policies outlined in Arizona Revised Statutes and Arizona Administrative Code.

12.11.1 General Requirements

Criteria to deem a member to be in need of Special Assistance:

A member determined to have a Serious Mental Illness (SMI) is in need of Special Assistance if the member is unable to do any of the following:

- Communicate preferences for services;
- Participate effectively in Individual Service Planning (ISP) or Inpatient Treatment Discharge Planning (ITDP);
- Participate effectively in the appeal, grievance or investigation processes.

The member's limitations described above must also be due to any of the following:

- Cognitive ability/intellectual capacity (i.e. cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity);
- Language barrier (an inability to communicate, other than a need for an interpreter/translator); and/or

- Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

A member who is subject to general guardianship has been found to be incapacitated under A.R.S. § 14-5304, and therefore automatically satisfies the criteria for Special Assistance.

For a member determined to have a SMI, the existence of any of the following circumstances may warrant the Health Home to more closely review whether the member is in need of Special Assistance:

- Developmental disability involving cognitive ability;
- Residence in a 24 hour setting;
- Limited guardianship, or The Health Plan or the Health Home is recommending the establishment of a limited guardianship; or
- Existence of a serious medical condition, that affects intellectual and/or cognitive functioning (such as, dementia or traumatic brain injury).

12.11.2 Persons Qualified to Make a Special Assistance Determination

Specific staff and agencies are qualified to screen for Special Assistance and determine whether a member qualifies for Special Assistance (See [AMPM Policy 320-R](#) for specific requirements).

12.11.3 Screening for Special Assistance

Health Homes and contracted Behavioral Health (BH) Inpatient Facilities perform screenings to assess whether members determined to have a SMI are in need of Special Assistance, in accordance with the criteria set out in [AMPM Policy 320-R](#). **Provider Manual Attachment 3.11.1 Special Assistance Guidance Document** is available to assist Health Homes and contracted BH Inpatient Facilities screen for Special Assistance by calling the Provider Services Call Center at 866-796-0542 to obtain a copy of this attachment, if needed.

Health Homes and contracted BH Inpatient Facilities that receive 3 or more DNMC (Does Not Meet Criteria) Part B responses within a quarter will be subject to additional Special Assistance training. Required agency staff to be trained is specified by The Health Plan following review of processes leading to excessive DNMC. All Health Home staff identified for training are required to complete within 2 months of notification by The Health Plan.

12.11.4 Documentation

Special Assistance documentation and record keeping policies and procedures are referenced in AMPM Policy 320 Special Assistance for Members Determined to Have a Serious Mental Illness.

If a member is currently identified as a member in need of Special Assistance, a notation of “Special Assistance” and a completed AHCCCS [AMPM 320-R, Attachment A, Notification of Member in Need of Special Assistance](#) should already exist in the clinical record. However, if it is unclear, Health Homes and contracted Behavioral Health Inpatient Facilities can contact The Health Plan Human Rights Committee Liaison to inquire about current status. The Health Plan maintains a database on members in need of Special Assistance and shares data with Health Homes and contracted Behavioral Health Inpatient Facilities on a regular basis (at a minimum quarterly).

12.11.5 Notification Requirements to the Office of Human Rights

Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures for notifying the Office of Human Rights as outlined in [AMPM Policy 320-R](#).

Health Homes and contracted Behavioral Health inpatient Facilities must use the current Special Assistance Notification Form (AHCCCS [AMPM 320-R Attachment A, Notification of Member in Need of Special Assistance](#)).

12.11.6 Members No Longer in Need of Special Assistance

Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures for notifying the Office of Human Rights when a member no longer meets Special Assistance criteria, as outlined in [AMPM Policy 320-R](#).

12.11.7 Requirement to Help Ensure the Provision of Special Assistance

Health Homes and contracted BH Inpatient Facilities collaborate with and involve the member (guardian, family member, friend, Office of Human Rights advocate, etc.) meeting Special Assistance needs in all relevant Behavioral Health planning and processes. Health Homes and contracted Behavioral Health Inpatient Facilities are expected to follow the policies and procedures within [AMPM Policy 320-R](#).

12.11.8 Health Home Reporting Requirements

Health Homes and contracted BH Inpatient Facilities are expected to follow all reporting requirements listed within the [AMPM Policy 320-R](#).

To support The Health Plan and OHR in maintaining accurate and up-to-date information on members in need of Special Assistance, Health Homes are required to submit monthly updates on members in need of Special Assistance as outlined in **Provider Manual Section 12.11**.

Health Homes with repetitive occurrences of not meeting /succeeding the Special Assistance MPS of 85% will be required to attend a live Special Assistance training facilitated by The Health Plan. Identified Health Home staff are required to attend the live training within 2 months of the notification.

12.11.9 Confidentiality Requirements

Health Homes shall grant access to clinical records of members in need of Special Assistance to the Office of Human Rights in accordance with federal and state confidentiality laws ([AMPM Policy 550](#)).

Human Rights Committees receive confidential information related to Special Assistance members and are expected to safeguard the information in accordance with the requirements set out in [ACOM, Policy 447](#).

12.11.10 Other Procedures

Health Homes and contracted Behavioral Health Inpatient Facilities must follow the training requirements related to Special Assistance, as outlined in [AMPM, Policy 320-R](#) and [AMPM Policy 1060](#).

Health Homes and contracted Behavioral Health Inpatient Facilities must assign one staff member to act as the Special Assistance Single Point of Contact. The Single Point of Contact must be proficient in all Special Assistance policies and procedures as outlined in [AMPM, Policy 320-R](#) and all other applicable Special Assistance policy.

The Single Point of Contact verifies AHCCCS Office of Human Rights requests for further information and/or ensures timely submission of documents. The Single Point of Contact is responsible to review all information provided on AHCCCS [AMPM 320-R Attachment A, Notification of Member in Need of Special Assistance](#), prior to submission to AHCCCS Office of Human Rights to ensure member meets criteria.

Health Home Single Point of Contact staff are required to attend the Special Assistance Single Point of Contact Monthly Conference Call. Health Homes should notify The Health Plan Human Rights Committee Liaison of any changes in Single Point of Contact staff.

12.11.11 Transfer of a Special Assistance Member

Notice of a request to transfer, for all Special Assistance members, must be shared with The Health Plan Human Rights Committee Liaison (AzCHdeliverables@azcompletehealth.com) prior to initiating the transfer through the Provider Portal and submitting the transfer packet. All changes and updates to a Special Assistance member's services, including transfers, requires collaboration with the member assigned to meet Special Assistance needs.

12.12 Arizona State Hospital

AzSH is a Level I facility currently licensed under applicable State and local law, is accredited by The Joint Commission and certified by the Centers for Medicare and Medicaid Services (CMS). AzSH is a long-term inpatient psychiatric hospital that provides the most restrictive setting for care in the state. Coordination between AzSH and The Health Plan must occur in a manner that ensures persons being admitted meet medical necessity criteria. Pursuant to A.R.S. § 36-201 through 36-217, AzSH provides inpatient care and treatment to patients with mental disorders, personality disorders or emotional conditions. The level of care provided at AzSH must be the most appropriate and least restrictive treatment option for the person (A.R.S. § 36-501(21)). The provision of appropriate, medically necessary covered behavioral health services must be consistent with treatment goals outlined on the admission application and individual needs identified in the course of treatment of individuals admitted to AzSH.

The goal of all hospitalizations of persons at AzSH is to provide comprehensive evaluation, treatment, and rehabilitation services to assist each behavioral health recipient in their own recovery, and to achieve successful placement into a less restrictive community-based treatment option.

12.12.1 Admissions

To ensure that individuals are treated in the least restrictive and most appropriate environment that can address their individual treatment and support their needs, the criteria for clinically appropriate admissions to AzSH are as follows:

- The Member must not require acute medical care beyond the scope of medical care available at AzSH.
- The referral source must make reasonable good-faith efforts to address the individual's target symptoms and behaviors in an inpatient setting(s).
- For Members who are also enrolled with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), the DES/DDD Director or designee agrees with the recommendation for admission.
- The referral source must complete Utilization Review of the potential admission referral and it recommend admission to the AzSH as necessary and appropriate, and as the least restrictive option available for the person based on clinical status.
- When a community provider agency or other referral source believes that a civilly committed or voluntarily admitted adult is a candidate to be transferred from another inpatient facility for treatment at AzSH, the agency will contact The Health Plan to discuss the recommendation for admission to AzSH. The Health Plan must be in agreement with the referral source that a referral for admission to AzSH is necessary and appropriate. If the candidate is not Health Plan enrolled, the Member will be referred for SMI determination and the enrollment process prior to application or at the latest within twenty-four (24) hours of admission pursuant to **Section 12.2 — Appointment Standards and Timeliness of Service** to AzSH. The enrollment date is effective the first date of contact by a The Health Plan contracted Health Home. The Health Plan Health Home is required to also complete a Title XIX/XXI application once enrollment is completed. For all non-T/RBHA enrolled Tribal behavioral health recipients, upon admission to AzSH, the hospital will enroll the person, if eligible in the AHCCCS Indian Health Program.
- For T/RBHA (Tribal RBHA only) enrolled Members, AHCCCS must also be in agreement with the referring agency that admission to AzSH is necessary and appropriate, and AHCCCS must prior authorize the person's admission (see **Section 4.1 — Securing Services and Prior Authorization/Retrospective Authorization**).
- The Health Plan and/or other referral sources must contact the AzSH Admissions Office and forward a completed packet of information regarding the referral to the Admissions Office, and if determined to be SMI and previously assessed as requiring Special Assistance, then the existing Special Assistance form should be included in the package. If the form has not been completed, please refer to **Section 12.11 — Special Assistance for Persons Determined to have a Serious Mental Illness** for further instructions.
- The Admissions Office confirms receipt of the complete packet and notifies the referral source of missing or inadequate documentation within two business days of receipt. AzSH cannot accept any person for admission without copies of the necessary legal documents.
- For TXIX enrolled persons, the **Certification of Need (CON)** (see **AHCCCS Prior Authorization Forms: Certification of Need at**

<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html>) should be included in the application for admission. The Health Plan needs to generate a Letter of Authorization (LOA) or issue a denial. The LOA should be provided to the AzSH Admissions Department with the application for admission to AzSH.

- The Health Plan is responsible for notifying AzSH's Admissions Office of any previous court ordered treatment days utilized by the Member. Members referred for admission must have a minimum of forty-five (45) inpatient court-ordered treatment days remaining to qualify for admission. The Member's AHCCCS eligibility will be submitted by The Health Plan to the AzSH Admissions Office with the admission application and verified during the admission review by the AzSH Admissions Office. The AzSH Admissions Office will notify (AHCCCS) Member Services of the behavioral health recipient's admission to AzSH and any change in health plan selection, or if any other information is needed.
- The Chief Medical Officer or Acting Designee will review the information within 14 calendar days after receipt of the completed packet and determine whether the information supports admission and whether AzSH can meet the Member's treatment and care needs.
- If the AzSH Chief Medical Officer or Acting Designee determines that the Member does not meet criteria for admission, the Chief Medical Officer or Acting Designee will provide a denial letter.
- If the admission is approved, the Admissions Office will send the acceptance statement from the Chief Medical Officer or Acting Designee to the referral source.
- A Court Order for transfer is not required by AzSH when the proposed Member is already under a Court Order for treatment with forty-five (45) remaining inpatient days. However, in those jurisdictions in which the court requires a court order for transfer be issued, the referring agency will obtain a court order for transfer to AzSH.
- If a Court Order for transfer is not required, the AzSH Admissions Office will set a date and time for admission. It is the responsibility of the referring agency to make the appropriate arrangements for transportation to AzSH.
- When AzSH is unable to admit the accepted behavioral health recipient immediately, AzSH shall establish a pending list for admission. If the behavioral health recipient's admission is pending for more than 15 days, the referral agency must provide AzSH a clinical update in writing, including if any alternative placements have been explored while pending, and if the need for placement at AzSH is still necessary.

12.12.2 Adult Members Under Civil Commitment

The Member must have a primary diagnosis of Mental Disorder (other than Cognitive Disability, Substance Abuse, Paraphilia-Related Disorder, or Antisocial Personality Disorder) as defined in A.R.S. § 36-501, which correlates with the symptoms and behaviors precipitating the request for admission, and be determined to meet DTO, DTS, GD, or PAD criteria as the result of the mental disorder.

The Member is expected to benefit from proposed treatment at AzSH (A.R.S. § 36-202). The Member must have completed 25 days of mandatory treatment in a local mental health treatment agency under T-36 COT, unless waived by the court as per A.R.S. § 36-541 or, if PAD, waived by the Chief Medical Officer of AzSH.

AzSH must be the least restrictive alternative available for treatment of the person (A.R.S. § 36-501) and the less restrictive long-term level of care available elsewhere in the State of Arizona to meet the identified behavioral health needs of the Member.

The Member must not suffer more serious harm from proposed care and treatment at AzSH. ([AAC R9-21-507\(B\)\(1\)](#)).

Hospitalization at AzSH must be the most appropriate level of care to meet the person's treatment needs, and the person must be accepted by the Chief Medical Officer for transfer and admission ([AAC R9-21-507\(B\)\(2\)](#)).

12.12.3 Treatment and Community Placement Planning

AzSH will begin treatment and community placement planning immediately upon admission, utilizing the Adult Clinical Team model. All treatment is patient-centered and is provided in accordance with AHCCCS-established five principles of person-centered treatment for adult Members determined to have SMI.

Members shall remain assigned to their original clinic/outpatient treatment team throughout their admission, unless the Member initiates a request to transfer to a new clinic site or treatment team.

- Consideration of comprehensive information regarding previous treatment approaches, outcomes and recommendations/input from The Health Plan and other outpatient community treatment providers is vital.
- Representative(s) from the outpatient treatment team are expected to participate in treatment planning throughout the admission in order to facilitate enhanced coordination of care and successful discharge planning.
- Treatment goals and recommended assessment/treatment interventions must be carefully developed and coordinated with the outpatient providers (including The Health Plan, ALTCS Health Plan, Department of Developmental Disabilities, other providers), the Member's legal guardian, family members, significant others as authorized by the Member and advocate/designated representative whenever possible.
- The first Inpatient Treatment and Discharge Plan (ITDP) meeting, which is held within 10 days of the Member's admission, should address specifically what symptoms or skill deficits are preventing the Member from participating in treatment in the community and the specific goals/objectives of treatment at AzSH. This information should be used to establish the treatment plan.
- The first ITDP meeting should also address the discharge plan for reintegration into the community. The Member's specific needs for treatment and placement in the community, including potential barriers to community placement and successful return to the community, should be identified and discussed.

- All required medical services for enrolled members residing at AzSH that are not provided by AzSH will be provided by Maricopa Integrated Health Systems (MIHS) Clinics and/or Medical Center. The Health Plan will provide payment to MIHS for all medically necessary services provided to enrolled T19/21 persons with a Serious Mental Illness (SMI) as described in the [AHCCCS ACOM – Policy 432](#)- Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services, Section III –B, titled Specific Circumstances Regarding Payment for Behavioral Health Services.

AzSH will provide all treatment plans to the responsible agency. The responsible agency should indicate review of an agreement/disagreement with the treatment plan on the document. Any disagreements should be discussed as soon as possible and resolved as outlined in [AAC 9R-21](#).

Treatment plans are reviewed and revised collaboratively with the Adult Clinical Team at least monthly.

Any noted difficulties in collaboration with the outpatient provider treatment teams will be brought to the attention of The Health Plan to be addressed. The Health Plan Hospital Liaison will monitor the participation of the outpatient team and assist when necessary.

Through the Adult Clinical Team, AzSH will actively address the identified symptoms and behaviors which led to the admission, and link them to the community rehabilitation and recovery goals whenever possible. AzSH will actively seek to engage the Member and all involved parties to establish understandable, realistic, achievable and practical treatment, discharge goals and interventions.

While in AzSH and depending upon the Member's individualized treatment needs, a comprehensive array of evaluation and treatment services are available and will be utilized as appropriate and as directed by the Member's treatment plan and as ordered by the Member's treating psychiatrist.

12.12.4 Recertification of Need (RON)

The AzSH Utilization Manager is responsible for the recertification process, when recertification is required, for all Title XIX/XXI eligible persons and is the contact for AzSH for all The Health Plan continued stay reviews.

The AzSH Utilization Manager will work directly with the Member's attending physician to complete the **Provider Manual Form 10.1.2, Recertification of Need (RON)** which can be obtained by calling the Provider Services Call Center at 866-796-0542. For members 65 and over, the RONs cover up to a 60 day span, for members under 21 the RONs cover a 30 day span and are submitted accordingly. The RON will be sent to The Health within five (5) days of expiration of the current CON/ RON. If required by The Health Plan, the AzSH Utilization Manager will send to The Health Plan Utilization Review staff additional information/documentation needed for review to determine continued stay. The Health Plan pays the first 30 days following admission to the AzSH for T19 members; following this period, a 1-day authorization is created for all members regardless of age, and then denies.

All Health Plan decisions with regard to the approval or denial for continued stay will be rendered prior to the expiration date of the previous authorization and upon receipt of the RON for those Members. The Health Plan authorization decisions are based on review of chart documentation supporting the stay and application of the AHCCCS Level Continued Stay criteria. If continued stay is approved, The Health Plan sends a Letter of Approval (LOA) to the AzSH Utilization Management Department with the completed RON and updated standard nomenclature diagnosis codes (if applicable). Denials will be issued upon completion of the denial process described in **Section 4.1 — Securing Services and Prior Authorization**.

12.12.5 Transition to Community Placement Setting

The Member is considered to be ready for community placement and is placed on the Discharge Pending List when the following criteria are met:

- The agreed upon discharge goals set at the time of admission with The Health Plan have been met by the Member.
- The Member presents no imminent danger to self or others due to psychiatric disorder. Some Members, however, may continue to exhibit occasional problematic behaviors. These behaviors must be considered on a case-by-case basis and do not necessarily prohibit the person from being placed on the Discharge Pending List. If the Member is psychiatrically stable and has met all treatment goals but continues to have medical needs, the Member remains eligible for discharge/community placement.
- All legal requirements have been met.

Once a Member is placed on the Discharge Pending List, The Health Plan must immediately take steps necessary to transition the Member into community-based treatment as soon as possible. The Health Plan up to thirty (30) days to transition the Member out of AzSH. The Health Plan outpatient treatment team should identify and plan for community services and supports with the Member's inpatient clinical team 60 – 90 days out from the Member's discharge date. This will allow sufficient time to identify appropriate community covered behavioral health services.

When the Member has not been placed in a community placement setting within 30 days, a quality of care concern will be initiated by the Health Plan or AHCCCS, if an agreement has not been made between AzSH and the outpatient treatment team that the discharge will take place after 30 days.

For T19/21 persons with a Serious Mental Illness and insulin-dependent diabetes, Health Plan will provide at discharge the same brand and model glucose monitoring device as used competently at AzSH. Care must be coordinated with the AzSH prior to discharge to ensure that all supplies are authorized and available to the member upon discharge.

AzSH Conditional Release Requirements

- The Health Plan has processes in place to provide high touch care management and/or other behavioral health and related services to members on Conditional Release from the Arizona State Hospital (AzSH) that are consistent with the Conditional Release Plan (CRP) issued by the Psychiatric Security Review Board (PSRB) per AHCCCS [AMPM Policy 1020- I: Contractor Care Management](#). This includes but is not limited to assignment to a contractor

care manager, which may be the assigned AzSH liaison or another team care manager working in conjunction with the AzSH liaison. Care management functions may not delegate these functions to a subcontracted provider.

- The Health Plan Care Manager is responsible to provide, at a minimum, the following:
 - Discharge planning coordination with AzSH;
 - Participation in developing and implementing Conditional Release Plans;
 - Participation in the modification of an existing Individual Service Plan (ISP) or the modification of an existing ISP that complies with the Conditional Release Plan (CRP);
 - Member outreach and engagement to help the PSRB evaluate compliance with CRP;
 - Attendance in outpatient staffing at least once per month;
 - Coordination of care with member's treatment team, TRBHA, and physical and behavioral health providers to implement the ISP and CRP;
 - Routine delivery of comprehensive status reporting to the PSRB;
 - Attendance in a monthly conference call with AHCCCS Medical Management (MM)
 - In the event that a member violates any term of their CRP, the Health Plan shall immediately notify the PSRB and provide a copy of the notification to AHCCCS and AzSH;
 - The Health Plan agrees and understands that it will follow all obligations, including those stated above, applicable to it as set forth in A.R.S. §13-3994.
-

Any violation of the Conditional Release, psychiatric decompensation or the use of alcohol, illegal substances or prescription medications not prescribed to the member shall be reported to the PSRB and the AzSH immediately.

The Health Plan shall submit a monthly comprehensive status report for members on Conditional Release to the PSRB and AHCCCS Medical Management, as specified in Contract utilizing [AMPM Attachment 1020-1](#). The Health plan shall provide additional documentation at the request of AHCCCS Medical Management. In the event that a member's mental status renders them incapable or unwilling to manage their medical condition and the member has a skilled medical need, the Health Plan must arrange ongoing medically necessary nursing services in a timely manner.

12.13 Out-of-State Placements for Children and Young Adults

At times, it may be necessary to consider an out-of-state placement for a child or young adult to meet the person's unique circumstances or clinical needs, as outlined in the [AHCCCS AMPM Policy 450](#), *Out of State Placements for Children or Young Adults for Behavioral Health Treatment*.

12.13.1 Initial Notification to AHCCCS Office of Medical Management

All Provider Manual Forms and Attachments can be obtained by calling the Provider Services Call Center at 866-796-0524, if needed.

Providers are required to assist The Health Plan in gathering the required information to notify the AHCCCS Office of Medical Management prior to a referral for out-of-state placement using **Provider Manual Form 3.13.1, Out-of-State Placement, Initial Notice and 30 Day Update**. Prior authorization must be obtained prior to making a referral for out-of-state placement, in accordance with the Health Plan criteria (See **Section 4.1 — Securing Services and Prior Authorization**).

12.13.1.1 *Process for Providing Initial Notification to the State*

For providers subcontracted with The Health Plan, the provider notifies The Health Plan of the intent to make a referral for out-of-state placement on **Provider Manual Form 3.13.1, Out-of-State Placement, Initial Notice and 30-Day Update**.

Prior to placing the child or young adult the Health Home provider must complete **Provider Manual Form 3.13.1, Out-of-State Placement, Initial Notice and 30-Day Update** and submit it to the Health Plan. The Health Plan will review the documentation and forward it to AHCCCS Office of Medical Management for approval of the out-of-state placement request. The Health Plan will also submit an electronic copy to AHCCCS Office of Medical Management, via secure e-mail, for approval of planned out-of-state placements.

12.13.2 Periodic Updates to AHCCCS Office of Medical Management

In addition to providing initial notification, the provider is required to submit updates to the Health Plan for review. The updates will be forwarded to the AHCCCS Office of Medical Management regarding the person's progress in meeting the identified criteria for discharge from the out-of-state placement every 30 days. To adhere to this requirement, providers must use **Provider Manual Form 3.13.1, Out-of-State Placement, Initial Notice and 30-Day Update**.

Once completed, the Health Home must submit the form to The Health Plan Medical Management department every 30 days the person continues to remain in out-of-state placement. The 30 day update timelines will be based upon the date of approval by AHCCCS of the out-of-state placement. The Health Plan will review the form and forward it to the AHCCCS Office of Medical Management.

12.13.3 Required Reporting of an Out-of-State Provider

All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, and/or injuries from seclusion/restraint implementations

12.14 Cultural Competence for the Behavioral Health System Requirements

See Section 9.2 Cultural Competence System of Care Requirements

In addition, behavioral health providers report appropriately for Language Assistance - T1013, Interpretation.

- T1013 must be reported when providing language assistance delivered by certified bilingual staff or provided by a language vendor. This code is used

to track language assistance that is being provided (languages other than English, including ASL).

- Interpretation must be reported in conjunction with another service that cannot be delivered effectively without the availability of sign language or interpreter assistance, never a standalone code.

12.15 Business Continuity/ Recovery Plan and Emergency Response/ Pandemic Plan / Heat Plan Requirements

12.15.1 Business Continuity/Recovery Plans

In order to effectively manage unexpected events that may negatively and significantly impact the ability to deliver services to members, all of the following provider types must develop, maintain and annually test a Business Continuity/Disaster Recovery and Emergency Response Plan.

Provider Type (provider type licensing code number)

Level 1 Hospitals (02)

Level 1 Psych Hospitals (71)

Behavioral Health Outpatient Clinics (77)

Integrated Clinics (77)

Level 1 Residential Treatment Center Secure (non-IMD) (78)

Community Service Agency (A3)

Rural Substance Abuse Transitional Agency (A6)

Level 1 Residential Treatment Center Secure (IMD) (B1)

Level 1 Residential Treatment Center Non-Secure (non-IMD) (B2)

Level 1 Residential Treatment Center Non-Secure (IMD) (B3)

Level 1 Subacute Facility (IMD) (B6)

Crisis Service Provider (B7)

Federally Qualified Health Center (FQHC) (C2)

Community/Rural Health Center (RHC) (29)

12.15.2 Business Continuity and Emergency Response Plan Provisions

These provider types listed in Section 3.16.1 must develop, maintain, and annually test a Business Continuity/Recovery and Emergency Response Plan to manage unexpected events that may negatively and significantly impact its ability to deliver services to Members. Providers must develop a process to train key personnel and organizational staff to be familiar with and implement the Business Continuity/Recovery Plan and Emergency Response when necessary.

The Business Continuity and Emergency Response Plan must specify, at a minimum, strategies to address the following:

- 1) Indicate that the Plan is reviewed annually and updated
- 2) The Plan contains staff training requirements including how often training is conducted.
- 3) The Plan is specific to the Contractor's operations in Arizona and references local resources.

- 4) The Plan contains planning and training for:
 - a. Electronic/telephonic failure at the Contractor's main place of business and any satellite offices in or out of State;
 - b. Complete loss of use of the main site and any satellite offices out of State'
 - c. Loss of primary computer system/records;
 - d. Extreme weather conditions;
 - e. How the Contractor will communicate with The Health during a business disruption;
 - f. Directing the Contractor staff to contact AHCCCS Security at 602-417-4888 in the event of a disruption outside of normal business hours;
 - g. Provisions for periodic testing, at least annually. Results of the tests are documented.
- 5) The Plan must address key customer priorities and key factors that could cause disruption, including access to the following key customer priorities:
 - a. Member Services;
 - b. Scheduling;
 - c. Clinic and/or Physician Visits;
 - d. Transportation Services;
 - e. Prior Authorization;
 - f. Outpatient or Inpatient Procedures;
 - g. Utilization Review/ Concurrent Review;
 - h. Provider Services/Claims/ Provider Payments;
 - i. Grievance/Appeals and Quality of Care Concerns;
 - j. Any other critical services identified by the Contractor;
- 6) The Plan addresses emergency plan provisions for facilities and hospitals in the event members are displaced in an emergency;
- 7) The Plan includes timelines for resumption of services including percentages of recovery; and
- 8) The Contractor has designated a Business Continuity Planning Coordinator and includes contact information in the Plan.

(See the adjacent link for details; refer to [AHCCCS ACOM Policy 104, Attachment A](#) for additional template.

12.15.3 Pandemic

In the event of a pandemic, as declared the Governor of Arizona, U.S. Government or the World Health Organization, which makes performance of any term outlined in the AHCCCS Contract with The Health Plan impossible or impracticable, the State shall have the following rights:

- After the official declaration of a pandemic, the State or The Health Plan may temporarily void the provider agreement in whole or specific sections, if the provider cannot perform to the standards agreed upon in the initial terms

- The State and The Health Plan shall not incur any liability if a pandemic is declared and emergency procurements are authorized by the Director as per A.R.S. 41-2537 of the Arizona Procurement Code.
- Once the pandemic is officially declared over and/or the provider can demonstrate the ability to perform, the State or The Health Plan, at their sole discretion, may reinstate the temporarily voided provider agreement.
- The State or The Health Plan, at any time, may request to see a copy of the written plan from the provider. The provider shall produce the written plan within seventy-two (72) hours of the request.

12.15.4 Emergency Preparedness

Under the direction of The Health Plan or the State, the provider must participate in health emergency response planning, preparation, and deployment in case of a Presidential, State, or locally-declared disaster. The preparedness action must include:

- Participation in development of a comprehensive disaster response plan, including specific measures for:
 - Member management and transportation,
 - Plans for access to medications for displaced Members, and
 - Provision of critical incident interventions for Members exposed to a disaster.
- Collaboration with local hospitals, emergency rooms, fire, and police to provide emergency mental health supports for first responders.
- Coordination with other providers to assist in a disaster in Maricopa County or in the event of a disaster in another region of the State.

12.15.5 Heat Plan Requirements

Health Home Provider must have a Heat Plan in place to mitigate the effects of extreme heat on members. This plan must be reviewed and updated on an annual basis. The Heat Plan must include, at a minimum:

1. Address the Health Home process to ensure that medically-necessary routine transportation is available for individuals who are at increased risk, and unable to access public transportation.
2. Address a process to ensure that heat advisory messages and public health information on extreme heat protection are communicated to members.
3. Address a process of identifying and outreaching members who are at risk to extreme heat complications due to their living conditions.

12.16 Behavioral Health Home Requirements

The Health Plan has several requirements for contracted Health Home providers. These include recovery support, access to care, outreach and engagement, enrollment, staffing, and system partner coordination of care.

12.16.1 Screening and Serving Members with Complex Needs

Members with Complex Needs will be identified by The Health Plan utilizing the Integrated and Non-Integrated Risk Rosters. The risk rosters will be uploaded to the provider FTP sites monthly. Providers must review the uploaded documents to determine if any members have been added or removed to the rosters.

All children must be screened for High Needs at the time of the initial comprehensive assessment and annually thereafter, per the [AHCCCS AMPM 320-O](#), using the Child and Adolescent Service Intensity Instrument (CASII) for children ages 6-17. Providers must use **Provider Manual Form 3.17.3, Birth through Five High Needs Screening Tool** to assess for High Needs for children Birth through 5. This form can be obtained by calling the Provider Services Call Center at 866-796-0542.

Providers must place a copy of the children's High Needs screening tool in the Member's Electronic Health Record. A progress note is required following each screening, describing the actions taken as a result of the screening.

Providers must develop and implement service plans for Members with High/Complex Needs that include strategies to address a crisis and deliver all appropriate services to help the Member remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system

12.16.1.1 *Declination of Intensive Services*

Providers are required to follow evidenced based practices and must ensure Members with High Needs receive appropriate services and take action to address risk management concerns when Members decline against medical advice to receive services. Permitted actions include: 1) notifying Members, guardians and families in writing of the risks associated with declining to accept more intensive treatment, 2) seek a court order for treatment when the adult Member/guardian declines more intensive treatment and the Member is a risk to themselves or others, or 3) with sufficient notice to the Member, decline to continue to provide treatment services which are ineffective in meeting the Member's needs.

12.16.1.2 *Dedicated Health Care Coordinators (DHCCs)*

Health Homes providing services to children are responsible for ensuring that the ratio of DHCC's to Children with High Needs does not exceed 1:20. A ratio of 1:15 is preferred.

Health Homes providing services to adults are expected to employ an adequate number of Health Care Coordinators to maintain low member to staff ratios and meet the needs of Adult High Needs members.

The providers are responsible for ensuring the integrity of the role of the Dedicated Health Care Coordinator by empowering the DHCC to facilitate the delivery of behavioral health services; enhance treatment goals and treatment effectiveness; and coordinate services for Members with High Needs.

12.16.1.3 ***Requirements for Behavioral Health Homes in Meeting the Needs of Members with High/Complex Needs***

Behavioral Health Homes are expected to:

- Provide 24/7/365 services as clinically appropriate when planned in advance.
- Maintain low Dedicated Health Care Coordinator to member ratios. The AHCCCS “Meet Me Where I Am Initiative” (MMWIA) requires Health Homes that serve children with High Needs to ensure that the ratio of DHCC’s to Children with High Needs does not exceed 1:20. A ratio of 1:15 is preferred.
- Provide Intensive Community Based Support that improves member outcomes and reduces the number of members in Out Of Home placements, reduces Emergency Department visits, and reduces Inpatient stays by providing appropriate support in the member’s community and home.
- Maintain an adequate number of Direct Support Staff to meet the needs of adult High Needs members.

12.16.1.4 ***Transition to Adulthood***

Children turning 18 years of age may choose to remain with their current Health Home, transfer to another Health Home as desired or clinically indicated, or close out of the behavioral health system entirely.

12.16.2 **Health Home Access to Care Requirements**

Providers must adhere to the following access to care requirements.

12.16.2.1 ***Screening***

Providers must perform various screening and assessment services:

- Providers must apply for AHCCCS coverage on behalf of Members through Health-e Arizona and assist Members in renewing their AHCCCS enrollment by completing applications on their behalf through Health-e Arizona and not refer persons to DES offices.
- Offer in-person screenings and assessments for Medicaid, SMI, SABG and MHBG eligibility at no cost to Members or persons requesting the screening/assessment.
- Provide intake, assessment and coordination services in the community, hospitals, nursing homes, state agency offices, detention, jail and prison facilities, specialty provider offices and Member’s homes.
- Providers must screen all children age 8 to 18, and adults for substance use disorders utilizing a standardized screening tool, at minimum:
 - At intake;
 - Bi-annually for children and annually for adults; and
 - Within 7 days of reported or suspected problematic use.

If a screening yields positive results, members must receive a more comprehensive assessment to include substance use history, current use, and trauma, in accordance with Section 12.5 – Assessments, AHCCCS Clinical Guidance Document, Comprehensive Assessment and Treatment of Adults with Substance Use Disorders

and AHCCCS Clinical Guidance Document, Comprehensive Assessment and Treatment for Substance Use Disorders in Children and Adolescents.

- Ensure that all Comprehensive Assessments, Individualized Service Plans, and Assessment Updates are signed by a The Health Plan -Credentialed, Licensed Behavioral Health Professional or Behavioral Health Medical Professional within 72 hours after the member received the assessment.

12.16.2.2 ***Referrals***

- Establish written criteria and procedures for accepting and acting upon referrals, including emergency referrals. The written criteria must include the definition of a referral for health services as described by the State.
- When a Member requests to access Covered Services, there shall be no wrong door. The Health Plan and Provider are required to respond when a Member requests Covered Services and follow through to ensure the Member receives appropriate services. Provider is required to assist any Member with obtaining Covered Services for which the Member is eligible, from the Participating Health Care Providers best suited to deliver effective services to Member.
- Health Home providers must accept all referrals for intakes and services for populations identified provider's contract with The Health Plan, unless The Health Plan grants a written waiver or suspension of this requirement.
- Accept all referrals regardless of diagnosis, level of functioning, age, Member's status in family or level of service needs.
- Providers serving non-Title XIX/XXI must accept and respond to emergency referrals twenty-four (24) hours a day, seven (7) days a week.
- Make appropriate referrals to and schedule appointments with In-Network Specialty Providers to meet Members' treatment needs and effectively coordinate care.
- Have a process to verify all Network options have been explored and exhausted before completing a request for out-of-Network services. Provider must notify The Health Plan of all Out-of-Network requests.
- Provider understands that all community residents, including visitors are eligible to receive crisis services and provider must assist anyone experiencing a crisis in obtaining crisis services through a The Health Plan contracted crisis provider by calling the Crisis Call Center.

12.16.2.3 ***Outpatient Services***

Providers must offer outpatient services identified in the provider's agreement with The Health Plan, including intakes, comprehensive assessments, service planning, coordination of care and outpatient services to all populations specified in the provider's agreement with The Health Plan.

12.16.2.4 ***Transportation***

Providers are encouraged to ensure members have transportation to medically necessary services including pharmacy. Providers may contract with a transportation vendor or provide transportation through their own fleet of vehicles. Providers must complete and submit to

AHCCCS an AHCCCS Group Billing Packet located at <https://www.azahcccs.gov/PlansProviders/NewProviders/packet.html> in order to bill for subcontracted transportation services. The subcontracted transportation provider is required to be credentialed with The Health Plan. When billing for the transportation services, the rendering provider field must include the NPI of the subcontracted transportation provider.

Providers shall maintain all records in compliance with the noted specifications for record keeping related to transportation services. It is the responsibility of the provider to maintain documentation that supports each transport provided. As outlined in [AHCCCS AMPM Policy 310-BB](#), Transportation, non-emergency transportation services are covered to transport a member to one of the following local community-based support programs and are identified in the member's service plan:

- Alcoholics Anonymous (AA)
- Narcotics Anonymous (NA) Cocaine Anonymous
- Crystal Meth Anonymous
- Dual Recovery Anonymous
- Heroin Anonymous
- Marijuana Anonymous
- Self-Management and Recovery Training (SMART Recovery)
- National Alliance on Mental Illness (NAMI) Family Support
- Living Well with a Disability and Working Well with a Disability Program

12.16.2.5 ***Answering Service***

Providers must maintain an answering service and telephone prompts appropriate to direct Members to verify access to services 24/7. Include language on telephone prompts, voicemail, answering services and advertisements that identifies the provider as Member of The Health Plan's Network of Providers and informs Members what to do in case of an emergency.

12.16.3 **Health Home Outreach, Engagement, Re-Engagement and Closure Requirements**

In addition to the requirements of **Section 12.4 – Outreach, Engagement, Re-Engagement, and Closure**, Providers must cooperate with the State and The Health Plan outreach and marketing initiatives, and conduct outreach, engagement, re-engagement and closure as described in this Provider Manual. Providers funded to employ dedicated outreach staff must work closely with all community system partners and residents, including incarcerated community members to educate them about services and help them get enrolled in Medicaid and/ or the Health Exchange. Providers must offer outreach and engagement services to persons who are homeless, involved in the criminal justice system, experiencing co-occurring mental health disorders and at risk populations. Providers must offer regular contact with Members residing in detention centers with a sentence of six months or less, and resume contact with Members at least thirty (30) days prior to release for sentences greater than six months. Upon request, providers must provide outreach and dissemination of information to the general public, other human service providers, county and state governments, school administrators and teachers and other interested parties regarding available services.

Providers may be notified when a member has been booked into a detention center. For those members who are active, the provider must hold an emergency Integrated Team Meeting within

one (1) business day of notification of release. For those members who are inactive, the provider must outreach the individual upon notification of booking and schedule an intake to be held within seven (7) days of release.

Providers must facilitate and document in the Member's clinical record effective engagement, including obtaining and maintaining accurate support system names and contact information, up-to-date member information with contact information, following up after missed appointments, and engaging peers and support systems to facilitate effective engagement.

12.16.3.1 *Marketing Limitations*

Providers must comply with various outreach and marketing limitations. Any outreach or incentive item given to its Members shall not exceed \$50.00. Any marketing item given away by the provider shall not exceed \$10.00. The total cost of all marketing and outreach/incentive items given to each Member, at each event, may not exceed \$50.00 per Member. All marketing materials shall identify the provider as a The Health Plan, AHCCCS and the State provider.

In addition, all marketing materials produced by the provider that refer to the services defined in the agreement must specify that the services are funded through the provider agreement with The Health Plan. Provider is also required to list The Health Plan and the State as the funding source on all brochures, flyers, and other promotional materials that involve services funded by The Health Plan and the State. Provider must include The Health Plan logo on these promotional documents.

12.16.4 *Health Home Enrollment, Demographic, Connectivity, Software, Web and Electronic Health Record Requirements*

12.16.4.1 *Enrollment and Demographics*

Providers must meet all enrollment requirements as outlined by the State and The Health Plan, verifying the integrity and reliability of the data. At a minimum, providers must:

- Submit all enrollment (834) electronically. The Health Plan shall have the right to reject any claims without a current enrollment on record.
- Complete and submit the Enrollment (834) transaction for all non-Medicaid Members within two (2) calendar days of the completion of a clinical intake. Provider must submit a Closure (834) transaction within two (2) calendar days after the end of treatment at the agency, unless the Member is being transferred to another agency or otherwise remains eligible for services in The Health Plan Geographical Service Area (GSA).

12.16.4.2 *Electronic Health Record (EHR) and Health Information Exchange (HIE) Requirements*

Providers must meet various requirements regarding paper and electronic records. Providers must:

- Have a fully operational EHR; including, electronic signature, and remote access. In addition, allow the State and The Health Plan staff remote read-only access to the EHR for the purpose of conducting audits.

- Ensure all paper files are fully archived and the provider is no longer dependent on paper files to conduct or document treatment services.
- Ensure provider is EHR is certified to fully meet the Federal "Meaningful Use Requirements".
- Facilitate the effective, daily transmission of electronic data to The Health Plan Community Health Record (Passport) through a dedicated facsimile server that meets the specification required by The Health Plan. Provider must transmit to The Health Plan through the facsimile server completed and/or updated Comprehensive Assessments, Crisis and WRAP Plans, Annual Assessment Updates, Individualized Service Plans and Child and Family Team/Adult Recovery Team notes within twenty-four (24) hours of the date and time of the appointment/event.
- Explain to Members, families and staff the "coordination of care" and "emergency services" benefits of enrolling in Passport, The Health Plan Community Health Record, and encourage participation in Passport.
- Establish and maintain membership with, and bi-directional data connectivity to, the state Health Information Exchange, "The Network/AZHeC".

12.16.4.3 **Software**

Providers must meet various requirements regarding equipment and licenses. Providers must:

- Ensure each outpatient clinic location licensed by the ADHS Division of Licensing has access to video equipment to facilitate treatment and treatment team meetings for persons with health, or disability limitations and special circumstances that prevent them from traveling to an office. Provider must maintain availability of telemedicine and video equipment to meet this requirement.
- Ensure Members have access to specialty services and consultation services through telemedicine, portable telemedicine, or video equipment and not be required to travel more than thirty miles to receive specialty services (except when required by state or federal law). In addition, utilize clinical expertise through consultants when appropriate to provide treatment services in the community, prevent out-of-home placements and allow Members to remain in their communities.
- Ensure that each outpatient clinic location licensed by the ADHS Division of Licensing is equipped with at least one (1) fully functional Polycom Speaker Phone system with (2) two microphones to facilitate effective communication during treatment team meetings to allow access to system partners and family members who desire to attend treatment team meetings telephonically.

12.16.4.4 **Access to Web and Website**

Providers must make available to the Benefits Coordinator and Members at least one computer with internet access at each outpatient facility licensed by the ADHS Division of Licensing. The computers must be available during hours of operation to conduct eligibility screening activities through Health-e Arizona. Providers must make available easy access of information by Members, family members, providers, system partners, and the general public in compliance with the American with Disabilities Act (ADA).

In addition, providers must develop and maintain a website and include the following information on its website that is easy to find, understand and navigate:

- Identify The Health Plan as a MCO/Health Plan for your service area and provide a link to The Health Plan website.
- Toll-free customer service telephone number and a Telecommunications Device for the Deaf telephone number.
- General customer service information, including information on community resources, how to file a grievance or grievance, and interpreter services.
- Crisis phone numbers and how to access the crisis services.
- Identify site locations and services provided to Members.

12.16.4.5 *Management Information System (MIS) and Performance Criteria*

Providers must meet the following MIS and performance criteria:

- Use a The Health Plan approved MIS to collect, analyze, integrate, and report data.
- Utilize electronic transactions in conformance with requirements.
- Prior to implementation, notify The Health Plan of planned MIS changes, the estimated impact upon the interface process, and test with The Health Plan, if the provider plans to make any modifications that may affect any of the data interfaces. Provider shall not implement the proposed change until The Health Plan evaluates and approves such.
- Verify that changing or making upgrades to or implementing new systems that are or are related to the core MIS, claims processing, or any other business component, will be accompanied by a plan which includes a timeline, milestones, and adequate testing before implementation date, the Provider must provide the system change plan to The Health Plan for review and comment.
- Notify The Health Plan in advance of the exact implementation date of all changes and cooperate with The Health Plan if The Health Plan elects to monitor MIS changes for operability and sustainability.

12.16.4.6 *Compliance with Health Information Portability and Accountability Act (HIPAA)*

Providers must comply with all federal HIPAA requirements, verifying the safety of all Member information.

12.16.4.7 *Notice of Changes*

The Health Plan shall provide provider with at least ninety (90) days' notice before implementing a change to its MIS system unless The Health determines that the system change must be implemented sooner, and in that instance, provide provider with as much notice as possible under the circumstances.

12.16.5 *Health Home Staffing Requirements*

Health Homes are required to have organizational, management, and administrative systems capable of meeting all contract requirements with clearly defined lines of responsibility, authority, communication, and coordination within and between departments, units, or

functional areas of operation. Health Home's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with contract requirements, including the requirement to provide culturally competent services. Provider is required to have sufficient staff and utilize appropriate resources to comply with contract requirements. Provider must require all staff, whether employed or under contract, to have the training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties.

12.16.5.1 *Certified Health Care Coordinators*

Providers must maintain a sufficient number of Certified Health Care Coordinators who are able to coordinate services for Members. Providers must verify the Professional job responsibilities associated with the role of Certified Health Care Coordinator are clearly defined and include:

- A clear understanding of how to help facilitate an effective treatment team meeting.
- The empowerment of Members to direct their own care.
- Monitoring of treatment to verify services are identified and performed in accordance to the wishes of Members and clinical Evidenced Based Practices.
- Verify the availability of direct supports including support and rehabilitation services to optimize opportunities for recovery and increased resiliency.
- Verify appropriate coordination among providers of care and Stakeholders.
- Verify adult persons are encouraged to obtain employment, engage in meaningful activities and demonstrate altruism.
- Verify children have the resources and services to progress to be successful adults.

12.16.5.2 *Behavioral Health Professionals*

Providers must assign credentialed Behavioral Health Professionals to provide clinical oversight in the Member's care and monitor progress towards meeting goals in the Service Plan, coordinate and communicate with other systems where clinical knowledge of the Member's care is important (42 CFR 438 208(b) (1));and verify that all services provided to the Member, including Transportation meet medical necessity.

Providers must verify Behavioral Health Medical Professionals, Behavioral Health Professionals, Behavioral Health Technicians and Behavioral Health paraprofessionals meet all of the requirements as identified by the ADHS Division of Licensing. Verify all persons hired into these roles meet the requirements as defined by state regulation.

Providers must employ an adequate number of The Health Plan -Credentialed, Independently Licensed Behavioral Health Professionals to verify all Members are seen by a The Health Credentialed, Independently Licensed Professional within 7 and 23 days following referral.

12.16.5.3 *Child and Family Team & Adult Recovery Team Facilitators*

Providers must verify an adequate number of staff are trained and certified as Child and Family Team (CFT) Facilitators, and/or Adult Recovery Team (ART) Facilitators.

12.16.5.4 ***Administrator on Call***

Providers must maintain an administrator–on-call to address any after-hours, weekend or holiday concerns or issues related to coordination of care or the health and/or safety of Members. The Administrator-on-call must respond to all requests, including requests from The Health Plan contracted Crisis Line Provider, within one (1) hour of being called.

12.16.5.5 ***Independently Licensed Staff***

Provider must verify the availability of The Health credentialed independently licensed staff to determine medical necessity, provide adequate oversight and supervision of service delivery.

12.16.5.6 ***Clinical Supervisors***

Providers must verify all Clinical Supervisors meet the requirements of the appropriate Arizona Licensing Board to conduct Clinical Supervision.

12.16.5.7 ***Medical Director***

Providers must employ a Medical Director to oversee prescribing practices at the provider's facilities, process Court Ordered Treatment (COT) documents, provide clinical consultation and serve as the collaborating physician for Nurse Practitioners in the agency. Medical Directors, or their designee, need to be available after hours for revocations of outpatient court ordered treatment under Title 36. A.R.S. § 36-540. Providers must verify the Medical Director Attends the regular Medical Director Meetings with The Health Plan.

12.16.5.8 ***COT/COE Coordinator***

Providers must designate a staff person to serve as COT/COE Coordinator and Liaison for Title 36 and Court Ordered services.

12.16.5.9 ***Information Liaison of the Day/Point of Contact***

Providers must designate one person to serve as the Information Liaison of the Day (point-of-contact) for system partners, foster families seeking services, and specialty providers to call to obtain information about services, referrals, updated Comprehensive Assessments, Individualized Service Plans and monthly reports. They must provide the name and contact number for the Information Liaison of the Day monthly to The Health Plan as part of the key contact list. The phone number for the Information Liaison of the Day must be live answered. All calls to the Information Liaison of the Day must be addressed and resolved within one (1) business hour of the call. Callers must be warm line transferred to the Information Liaison of the Day and callers are not to be told to call another number.

12.16.5.10 ***Peer Support***

Health Homes are required to educate members about the role of Peer Support / Recovery Support Specialists and are required to make Peer Support / Recovery Support Specialists available to all members receiving services and to ensure members are introduced to Peer and Family Run Organizations.

In addition, providers must demonstrate that Peer Support Specialists and Family Support Specialists meet minimum training requirements. Providers must empower Members and family

members to take "personal ownership" of their Individualized Service Plans, Crisis and WRAP Plans, treatment services, recovery strategies, and advocate for themselves.

12.16.5.11 *Parent/Family Support Partners*

Health Homes are required to educate members about the role of Parent/Family Support Partners and are required to make Parent/Family Support Partners available to all families of members receiving services. Adult members' families are defined as "families of choice", determined by the adult member.

12.16.5.12 *Substance Use Treatment Staff*

Providers serving adults and youth with substance use disorders must train 100% of all Assessors, and Behavioral Health Professionals in the Best Practice of ASAM through a training program approved by The Health Plan. In addition, providers providing substance use treatment services must verify that services are delivered by staff competent to assess and treat substance use disorders in individuals and families. Providers serving adults must employ or make available an adequate number of registered/wavered Buprenorphine Prescribers to meet the needs of Members with substance use disorders under the Provider's care.

12.16.5.13 *Nursing Staff*

Providers must employ or make available adequate nursing staff to administer injectable psychotropic medications at all Outpatient Treatment Centers.

12.16.5.14 *Psychiatrists*

Providers must employ a sufficient number of BHMPs to meet member access to care standards.

12.16.5.15 *Telemedicine*

Providers delivering telemedicine services must ensure adequately and appropriately trained staff are available prior to the provision of the telemedicine service to conduct any required vitals.

Providers delivering telemedicine services must adhere to confidentiality expectations of the telehealth session by ensuring no other person, other than those agreed to by the member receiving services, will observe or monitor the service either electronically or from "off camera. For more information regarding confidentiality during a telemedicine session. Please see [AHCCCS AMPM Policy 320-I](#) and [AHCCCS AMPM Policy 550](#) for more information regarding confidentiality safeguards

The provider must however, offer the member the option of having a telepresenter present during the telehealth session. A telepresenter is defined as a designated individual who is familiar with the member's case and has been asked to present the member's case at the time of telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily a medical expert with the member's medical condition, in order to present the case accurately. The telepresenter also is required to assist the member after the telehealth session in scheduling any required follow-up appointments and/or getting prescriptions filled.

In addition, providers must verify that BHMPs and BHPs providing eighteen or more hours a week of telemedicine services on behalf of the provider must host semi-annual one-day “meet and greet” events “in person” in the communities where the telemedicine services are provided to give Members and system partners the opportunity to meet telemedicine BHMPs and BHPs in person. Exceptions to this requirement must be approved in writing by The Health Plan.

12.16.5.16 *Discharge Planners/Hospital Liaison Role Definition and Responsibilities*

In addition to the requirements of **Section 4.12 – Discharge Planning**, the Health Home discharge planner/hospital liaison is also responsible for the following:

- Health Home Discharge Planner/hospital liaison serves as the lead for coordination of care for members for the duration of hospitalization upon notification of admission.
- Health Home discharge planner/hospital liaison is responsible to notify the Health Care Coordinator of member’s inpatient status.
- Health Home discharge planner/hospital liaison is responsible to send the clinical packet of information to inpatient facility. Documents include:
 - Most recent psychiatric evaluation,
 - History & Physical from Primary Care Provider, if available,
 - Medications list from Behavioral Health Medical Provider & PCP,
 - Most recent BHMP note,
 - List of current diagnoses,
 - Current Individualized Service Plan & Crisis Plan,
 - Allergies or past poor reactions to medications,
 - Anticipated target level of functioning upon discharge from hospital services,
 - Tentative Discharge Plan
- Health Home discharge planner/hospital liaison is required to make contact with members within 48 hours of admission date/time. This can be via phone if admission occurs out of county or state, preferred method is a face to face visit. Contact between the Health Home discharge planner/hospital liaison and the member is required to occur every 48 hours after initial contact.
- Health Home discharge planner/hospital liaison is required to document discharge planning efforts in the Member’s medical record.
- Health Home discharge planner/hospital liaison is required to connect with The Health Plan Discharge Integrated Care Managers to provide an update on the initial discharge plan at 72 hours from date and time of admission, and to communicate updated discharge plans prior to discharge. The Health Home Discharge Planner/hospital liaison is required to communicate any barriers to discharge to The Health Plan Discharge Integrated Care Managers. If the Health Home discharge planner/hospital liaison encounters barriers related to the discharge plan and resources, The Health Plan Discharge Integrated Care Managers will outreach the Utilization Management Reviewer and/or the Integrated Care Managers/Care Coordinator for assistance.
- Health Home discharge planner/hospital liaison schedules an Adult Recovery Team Meeting (ART) /Child & Family Team (CFT) meeting to take place at the inpatient facility,

for every behavioral health admission and as clinically needed for physical health admissions. Attendees required to attend for both behavioral and physical health and behavioral health ART/CFT Meetings, should include the following at a minimum:

- Representation from inpatient facility such as hospital social worker/discharge planner/Health Care Coordinator (with updates on member status, medication changes, doctor recommendations, estimated discharge date),
 - Health Home Discharge Planner/Hospital Liaison, Health Home Health Care Coordinator, & Member, (Guardian if under 18, POA, Public Fiduciary or Title 14.)
 - The Health Home Discharge Planner/hospital liaison facilitates ART/CFT. Other attendees may include, therapist, peer support, member's natural support, and inpatient facility unit charge nurse.
- Health Home discharge planner/hospital liaison is required to facilitate scheduling a conversation between the Health Home BHMP and Attending Psychiatrist, PCP and attending physician, as requested or if the team is unable to agree on a safe disposition plan. Health Home medical director and The Health Plan medical director may take part in these discussions, as appropriate.
 - Health Home discharge planner/hospital liaison is required to create a new Individualized Service Plan and Crisis Plan that provides additional resources and supports to decrease chance of member readmission in addition to updating the annual assessment.
 - Health Home discharge planner/hospital liaison is required to work closely with Health Home Utilization Management Point of Contact and The Health Plan Utilization Management Reviewer regarding authorizations related to step down from the hospital to another level of care. Requests, which may come from the Health Home or the inpatient or out-of-home facility, are required to be submitted via Provider Portal or via fax according to instruction. Any questions related to receipt of authorization requests, status updates, or general questions related to authorization procedure or required documents should go to The Health Utilization Management PA #: 866-796-0542.
 - Modification for type of authorization: It is the responsibility of the Health Home discharge planner/hospital liaison to submit the request for authorization for Behavioral Health placement, and other behavioral health needs on the ISP;
 - It is the responsibility of the Hospital Social Worker/Discharge planner/Health Care Coordinator to submit authorization request for physical health placement, Durable Medical Equipment, Home Health-IC Inpatient Utilization Management reviewer to follow up with The Health Plan outpatient reviewer on status of authorizations related to discharge plan, such as placement, medical equipment, etc.
 - Health Home discharge planner/hospital liaison must provide the member with the following appointments:
 - For Behavioral Health Admission: behavioral health medical Provider within 7 calendar days of member's discharge from facility.
 - For Physical Health Admission: primary care provider within 7 calendar days of member's discharge unless medically indicated to see provider sooner.

- Health Home discharge planner/hospital liaison is required to complete a verbal and written handoff to the ongoing RC upon member discharge, including review of the discharge summary from the hospital.
- Ongoing, the Health Care Coordinator is required to outreach the member to ensure follow through with aftercare plan including but not limited to placement, behavioral health services, pharmacy issues, outpatient appointments, and medical equipment.
- Ongoing, the Health Care Coordinator is required to outreach The Health Plan Integrated Care Managers/Care Coordinators with a status update on the member's discharge and aftercare within 14 business days from date of discharge.

12.16.5.17 *Health Home Requirements Related to the Discharge Planner/Hospital Liaison Role*

- Discharge planning begins at the time of notification of admission to any inpatient facility for Physical and Behavioral Health needs.
- All Health Home discharge planners/hospital liaisons are required to have a dedicated phone number with voicemail and email address to communicate with the inpatient facility and The Health Plan Utilization Management Reviewer and The Health Plan Integrated Health Care Coordinator.
- Providers are required to review their dedicated discharge planner/hospital liaison ratios on a bi-annual basis at the start of each fiscal year, July 1st and again mid-year January 1st based on the total number of Open Episodes of Care and hire additional discharge planners/hospital liaisons as needed.
- The Health Home discharge planner/hospital liaison must be a Behavioral Health Technician or Behavioral Health Professional; complete the Discharge Planning Curriculum in Relias Learning Management System and pass post-test with at least 80% accuracy. If the position is filled by a Behavioral Health Technician, all clinical forms related to the discharge planning process must be reviewed and signed by a Behavioral Health Professional at the Health Home. This includes but is not limited to: Individualized Service Plan, Crisis Plan and Updated Annual Assessment.

12.16.5.18 *Health Home Dedicated Discharge Planner/Hospital Liaison Ratios*

Health Homes are required to employ adequate staff to assist in Inpatient Notification and Discharge Planning needs in accordance with the below requirements:

- Health Homes with fewer than 750 members are required to identify a Designated Utilization Management (UM) staff point of contact for Inpatient Notification and Discharge Planning Needs that will act in a supporting capacity to the member's Health Care Coordinator, who is responsible for the discharge planner/hospital liaison functions.
- Health Homes with between 750 members and 1499 members in treatment are required to employ a .25 FTE Discharge Planner/Hospital Liaison responsible for all discharge planning functions in addition to other duties within the Health Home for the remaining hours of each week.
- Health Homes with between 1500 members and 2999 members in treatment are required to employ a .5 FTE Discharge Planner/Hospital Liaison responsible for all discharge planning functions in addition to other duties within Health Home for remaining hours of each week.

- Health Homes with over 3000 members in treatment are required to employ a 1.0 plus FTE Discharge Planner/Hospital Liaison at 40 hours per week solely in this role with the responsibility for all discharge planning functions. Health Homes with over 3000 members in treatment are required to employ additional Discharge Planners/Hospital Liaisons in order to meet the 3000:1 Member to Dedicated Discharge Planner/Hospital Liaison ratio.

12.16.6 Health Home Requirements Related to Member and Family Involvement

Providers must verify that Members, their family members, and peers provide input and assist with decision making.

12.16.6.1 Member and Family Involvement

Providers must develop a process for Members to have regular and ongoing input to assist in decision making, program development, and enhancement of customer service at each provider site where Case Management services are delivered.

Providers must also collaborate with families, children and Members as partners, including Family-Run Organizations to facilitate child and family involvement in all aspects of the assessment process, service planning, service delivery, and the evaluation of services and the system.

Providers must verify that the following member-involvement activities are performed as part of the service delivery process:

- Ongoing engagement of the Member, family and others who are significant in meeting the needs of the Member, including active participation in decision-making process.
- Develop and implement service plans that address likely events in a Member's life including transitions to different stages of life, new relationships, new schools, new placements, and transitions to other service delivery systems.
- For Members referred for or identified as needing ongoing psychotropic medications for a health condition, verify the review of the initial assessment and treatment recommendations by a licensed medical practitioner with prescribing privileges.
- Members on psychotropic medications receive an updated annual psychiatric evaluation before the twelve (12) month anniversary of the date of last evaluation;
- Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the Member and input from the Member and other relevant persons resulting in modification to the Treatment Plan, if necessary.
- Child and Family Team/Adult Recovery Team Meetings are scheduled within three (3) business days for all Members placed in Brief Intervention Programs or the Assessment Intervention Center.
- Transfers out-of-area, or to an ALTCS Contractor, as applicable.
- Development and implementation of transition discharge, and aftercare plans prior to discontinuation of services.

- Documentation of the above is maintained in the Member's health record by the point of contact.
- Assist Members locate and obtain permanent housing.
- Providers must accept all transfer following a 24 hour mobile crisis intervention and engage member into services within seven (7) days.

Additional provider requirements include:

- Demonstrate documentary evidence to show participation of at least one peer or family member in the interview process when hiring all direct service staff positions. Maintain interview sign-in sheets and produce the sign-in sheets to document compliance with this expectation.
- Verify that every TXIS (T19) adult has a Peer Support Specialist available to be involved with the Member's Adult Recovery Team.
- Verify that Members, families and youth have a voice in their individual treatment decisions and a voice in the operations of the delivery system.
- Obtain and document in the Member's record, Member and family input in treatment decisions.
- Providers providing substance use treatment must involve peer support staff in all aspects of the treatment process; including outreach, engagement, assessing readiness for treatment, maintaining sobriety and re-engagement.
- Assess the Member's perspective on treatment progress, in order to verify that the Member and family's perspectives are honored and they are effectively engaged in treatment planning and in the process of care.

12.16.6.2 ***Councils and Meetings***

Behavioral Health Homes are required to:

- Establish Member and Family Advisory Councils with representatives from each community served by the Health Home, to provide direction, feedback and meaningful influence to their senior management team.
- Demonstrate documentary evidence (agenda, sign in sheets, minutes) to show that Member and Family Advisory Councils are being held at least monthly.
- Maintain a written Plan that includes a method to verify Members and families attend regular meetings with clinical leadership and are authorized to make recommendations.
- Recruit leaders from provider's Member and Family Advisory Councils to regularly attend The Health Plan monthly regional Member and Family Advisory Councils
- Facilitate regular attendance of these provider Member and Family Advisory Council leaders to The Health Plan monthly regional Member and Family Advisory Councils.

Providers must collaborate with Peer-Run and Family-Run Organizations, involving them in program development activities, peer support and family support training, staff trainings, committee meetings and strategic planning.

- Health Homes that serve youth are required to have a Youth Advisory Council (YAC). Members no younger than 14 and no older than 17 are eligible to participate in the

Health Home's Youth Advisory Council. All youth that meet this criteria at the Health Home are encouraged to participate.

- Health Home Youth Advisory Council must meet at a minimum of one time per month, but may meet as often as determined by the Youth Advisory Council.
- Each Health Home must have a sufficient amount of facilitators to assure safety and growth of the Youth Advisory Council.

Providers are expected to assist members to attend provider and The Health Plan committee meetings, provider Member and Family Advisory Councils, and The Health Plan Member and Family Advisory Councils and Boards.

12.16.7 Behavioral Health Home Requirements Related to System Partner Coordination of Care

12.16.7.1 Co-Location

Providers are encouraged to seek out and facilitate opportunities to co-locate with state agencies (The Department of Child Safety, Juvenile Probation, and Adult Probation), first responder settings (police, fire, emergency service) or other community settings that facilitate coordination of care between and among systems of care for Members receiving services through multiple systems.

12.16.7.2 Contract with Arizona Department of Economic Security (ADES)/Rehabilitation Services Agency (RSA)

Behavioral Health Homes must have systems in place to ensure effective collaboration with system partners in accordance with **Provider Manual Section 13.4, Coordination of Care with Other Governmental Agencies**, by communicating appropriate clinical information, to individuals or entities that are involved in the Member's care including primary care providers, schools, child welfare, juvenile or adult probations, ADES/Division of Developmental Disabilities (DDD), Arizona Department of Corrections (ADOC), Arizona Department of Juvenile Corrections (ADJC), ADES/RSA, ADES/Department of Child Safety (DCS) and other service providers.

12.16.8 Behavioral Health Home Requirements Related to Delivery of Care

12.16.8.1 Medically Necessary Covered Services

Providers must provide all Members with medically necessary covered services that are:

- In accordance with the this Provider Manual;
- In accordance with the State System Principles in this Provider Manual;
- Identified in collaboration with the Member and other persons identified by the Member that (a) determine strengths, needs and goals of the Member and (b) identify the need for further evaluations necessary for Service Plan development;
- Identified with clinical involvement by a credentialed and trained clinician who is either a Behavioral Health Professional or a Behavioral Health Technician under the supervision of a BHP (42 CFR 438 208 (2) and (3)); and
- Strengths-based and include an emphasis on goals to increase Members quality of life and involvement in meaningful community activities, including goals related to

living, learning, working, and social connectedness. Goals must reflect the Member's hopes, dreams, and recovery vision.

12.16.8.2 *Service Plans*

Providers must verify Service Plans meet State, AHCCCS and The Health Plan requirements as outlined in **Provider Manual Section 12.5, Assessment and Service Planning**.

12.16.8.3 *Transportation*

Providers must provide medically-necessary transportation services to Members receiving services as appropriate to facilitate access to care, including evenings and weekends as necessary.

12.16.8.4 *Assessment*

Providers must assess all Members for the need for specialty services and ensure the provision and monitoring of the quality and reliability of specialty services. Providers must also ensure that Members are assessed for co-occurring mental health conditions and physical disability/disease and these co-occurring issues are addressed.

12.16.8.5 *Psychiatric Care for Persons with Developmental Disabilities*

Providers must verify that all children and adults with Developmental Disabilities who are on psychotropic medications or need to be screened for the need for psychotropic medications receive treatment services from a psychiatrist trained specifically to work with children or adults (appropriate to the Member's age) and with persons with Developmental Disabilities.

12.16.8.6 *Alternatives to Out-of-Home Care*

Providers must promote community-based alternatives to out-of-home care. In situations where a more restrictive level of care is temporarily necessary, providers must work with the Member to transition back into community-based care settings as rapidly as is clinically feasible and partner with community provider agencies to develop and offer services that are alternatives to more restrictive institutionally based care.

Providers must deliver services to the extent possible, in the Member's home and community in order to minimize out-of-home placements and facilitate a rapid return to the home and community when a Member is in an out-of-home placement. Providers must notify The Health Plan Utilization Management (UM) department within 1 business days of placing a The Health Plan Member into an out-of-home placement.

12.16.9 Behavioral Health Home Requirements Related to Medical Integration

Providers must provide the following services related to medical integration:

- Encourage all adult Members to receive a full physical examination with labs at least once per year, facilitate, and coordinate access to PCP's to reach this goal and monitor Member compliance with this expectation.

- Develop and maintain a list of Members with chronic conditions including obesity, cardiac conditions, pulmonary conditions, and diabetes.
- Identify reasonable target dates for achieving medical integration goals and maintain acceptable progress toward reaching those goals.
- Collect and maintain vital signs for all adults including blood pressure, pulse and BMI.
- Collect and monitor lab results specific to any chronic condition including HbA1c (Hemoglobin A1c), Cholesterol, Low-Density Lipoprotein (LDL), High-Density Lipoprotein (HDL), and Triglyceride.
- Incorporate the eight dimensions of wellness into each Title XIX/XXI adult Member's Comprehensive Assessment and Individualized Service Plan.
- Collaborate with The Health Plan to reduce the use of emergency rooms for non-life threatening behavioral or medical reasons.
- Collect and submit outcome data as outlined by The Health Plan.
- Become a primary care provider or work with community health clinics to coordinate behavioral health and physical health services and provide integrated behavioral health and physical health care to Members.
- Maintain wellness programs and wellness equipment to serve Members in each community in which the Provider has an outpatient clinic licensed by the ADHS Division of Licensing.
- Ensure Health Care Coordinators are skilled in promoting wellness and coordinating health and wellness Treatment Plans, and are able to accompany Members to PCP appointments, arrange for other health care as needed and monitor health outcomes.

12.16.10 Behavioral Health Home Training and Information Dissemination Requirements

Providers must utilize The Health Plan approved web-based "e-learning" training program to verify compliance with The Health Plan training requirements and the training requirements outlined in this Provider Manual. New employees have ninety (90) days from the date of hire to complete the assigned competencies to their user profiles. Existing employees have ninety (90) days from the date that new training curriculums have been assigned to their profiles to complete the training modules. All provider required trainings must be registered through The Health Plan web-based e-learning training software program.

Providers must demonstrate evidence of employee orientation and training, which may include the number of Members, Member list, training calendars and sign-in sheets. Providers must also demonstrate evidence of all training to personnel, service providers and Members which may include the number of Members, Member list, training calendars and sign-in sheets. Providers must run quarterly compliance reports to monitor staff compliance with training competencies and meet a compliance standard of ninety percent (90%).

12.16.10.1 Annual Training Plan

Providers must develop, and maintain an annual training plan that incorporates all The Health Plan and State training requirements including involvement of Members and family members in

the development and delivery of trainings. Providers must maintain a Train-the-Trainer program to verify adequate capacity to provide training, orient new staff and verify all staff Members have the skills to perform the requirements outlined in the Agreement.

12.16.10.2 *Practice Protocols*

Providers must train staff and implement the identified service expectations on the Clinical and Recovery Practice Protocols as appropriate and relevant to services provided. All staff must receive training on all Practice Protocols within six (6) months of hire date. Providers must review the appropriate Practice Protocols annually. Additionally, providers must verify existing staff review new Practice Protocols within six (6) months of a new Practice Protocol being published. Providers must track initial training and annual review of the Practice Protocols by using the "e-learning" training program.

12.16.10.3 *Verify Attendance and Completion*

Providers must verify attendance at all required trainings and trainings for which staff have enrolled. Providers must also verify all staff complete an annual Fraud & Abuse Training and maintain documentation verifying completion of the training.

12.16.10.4 *ASAM and CASII*

Providers must maintain at least one current American Society of Addiction Medicine (ASAM) and/or Child and Adolescent Service Intensity Instrument (CASII) manual at each clinic location. Providers must conduct inter-rater reliability tests for all staff conducting CASII or ASAM assessments at least semi-annually. Provider shall require staff to achieve an inter-rater reliability score of above 80% to continue to provide CASII or ASAM assessments.

12.16.11 *Health Home Requirements Related to Hospital Admissions*

Providers must comply with all UM and Out-of-Home Provider requirements, per this Provider Manual.

12.16.11.1 *Information Upon Admission*

Providers must provide the following clinical information to the Licensed Hospital, or BH Inpatient Facility and unit staff for all Members admitted into the facility on the day of notification of the admission:

- Most recent psychiatric evaluation;
- History and Physical from the Primary Care Provider (PCP), if available;
- Current psychotropic medications to include dosages and frequencies from the Behavioral Health Medical Provider and current physical health medications from the PCP;
- Most recent BHMP note;
- List of current diagnoses;
- Current Individualized Service Plan (ISP) and Crisis Plan;
- Allergies or past poor reactions to medications;
- Anticipated target level of functioning upon discharge from Hospital services; and
- Initial, tentative Discharge Plan.

12.16.11.2 **Performance Requirements**

Providers must meet the following performance requirements:

- Demonstrate that 50% of Members that discharge from a Hospital facility keep a follow-up appointment within seven (7) days of that discharge;
- Provide a Member a minimum of two (2) appointments within eight (8) to thirty (30) days of discharge from a Hospital Facility;
- Demonstrate that 70% of Members that discharge from a Hospital Facility keep follow-up appointments within eight (8) to thirty (30) days of that discharge; and
- Demonstrate that readmissions within thirty (30) days do not exceed 12.5% of all Hospital admissions for provider members.

12.16.12 **Health Home Requirements Related to Facilities (Licensed Hospital Facility, Behavioral Health Inpatient Facility, Behavioral Health Residential Facility, Behavioral Health Supportive Homes, and HCTC Admissions)**

Providers must submit the **Out Of Home (OOH) request packet** to The Health Plan within two work days following a treatment team request for out-of-home placements, and receive prior authorization for Behavioral Health Inpatient Facilities (formerly RTC), Licensed Hospital Facilities (formerly Level I Inpatient), Behavioral Health Inpatient Facility (formerly Level I Sub-Acute Facilities), Behavioral Health Residential, Behavioral Health Supportive Home and Home Care Training for the Home Care Client (HCTC) services before admitting a Member, unless exemption in writing to this requirement is provided by The Health Plan. **See Provider Manual Form 10.1.6, Request for Out-of-Home Placement-Child or Adult** which can be obtained by calling the Provider Services Call Center at 866-796-0542.

Providers must verify all Child and Family Team (CFT) meetings and Adult Recovery Team (ART) meetings are coordinating regularly with the facility. In addition, providers must verify that all CFT/ART meetings involving persons admitted into out-of-home care include, at a minimum: Member and legal guardian, collateral parties, such as Juvenile Probation Officer (JPO), Division of Developmental Disabilities (DDD), or out-of-home facility staff, and provider agency staff who have clinical knowledge and a relationship with the Member. The Member's family/natural supports must be included in out-of-home treatment services once the Member is admitted.

In addition, providers must verify that an agency representative with clinical knowledge and a relationship with the Member attend all scheduled juvenile/adult court hearings in which participation of provider staff would be beneficial to the Courts.

12.16.12.1 **Discharge Plans/Outpatient Follow Up**

Providers must identify and develop discharge aftercare plans prior to admission to an out-of-home placement and must provide outpatient clinical services within seven (7) days of a Member's discharge from a facility. Providers must submit **Provider Manual Form 10.1.10, Inpatient Discharge Summary** by secure fax within:

- 72 hours of admission, and
- at time of concurrent review or if the discharge plan is revised

- upon discharge

This form can be obtained by calling the Provider Services Call Center at 866-796-0542 and must be completed fully and comprehensively.

12.16.12.2 *Performance Requirements*

Providers must meet the following performance requirements:

- Demonstrate that at least 50% of Members that discharge from a facility keep a follow-up appointment within seven (7) days of that discharge;
- Provide a Member a minimum of two (2) appointments within eight (8) to thirty (30) days of discharge from a facility;
- Demonstrate that at least 70% of Members that discharge from a facility keep follow-up appointments within thirty (30) days of that discharge.

12.16.13 Integrated Health Care Service Delivery for Health Homes

Providers must incorporate several elements into its Integrated Health Care service delivery system approach. This includes effective use of a comprehensive Care Management Program. There must be a Treatment Team with an identified single point of contact. The team must include a Psychiatrist or equivalent Behavioral Health Medical Professional and an assigned Primary Care Provider. Care must be whole person oriented and encompass Member and family voice and choice, plus use of peer and family delivered support services. There must be an emphasis on quality and safety, accessible care, coordination of care, health education and health promotion services, referrals to appropriate community and social support services, use of health information technology to link services, and improved whole health outcomes of Members.

12.16.13.1 *Health Education and Health Promotion*

Providers must provide assistance and education for appropriate use of health care services; health risk-reduction and health lifestyle choices including tobacco cessation and screening for tobacco use with the Ask, Advise, and Refer model and refer to the Arizona Smokers Helpline utilizing the proactive referral process; to Adults with SMI to access The Health Plan Crisis Line Provider; for self-care and management of health conditions including wellness coaching; EPSDT services for Members including identifying providers that are trained and use AHCCCS approved developmental screening tools; about maternity care programs and services for pregnant women; and self-help programs or other community resources that are designed to improve health and wellness.

12.16.14 Additional Health Home Referral Requirements

12.16.14.1 *Written Procedures for Referrals to Physical Health Specialists*

Providers must establish and implement written procedures for referrals to specialists or other services, to include, at a minimum, the following:

- Referrals to Specialty Physician Services must be from a PCP, except that women have direct access to in-network OB/GYN providers, including Physicians, Physician Assistants and Nurse Practitioners within the scope of their practice, without a referral for preventive and routine services (42 CFR 438.206(b)(2)).

- Adults with SMI that need a specialized course of treatment or regular care monitoring have a mechanism for direct access to a Specialist (for example through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. Any waiver of this requirement by The Health Plan is required be approved in advance by The Health Plan.
- A process for the Member's PCP to receive all Specialist and Consulting reports and a process for the PCP to follow-up on all referrals. A process to refer any Member who requests information or is about to lose AHCCCS eligibility or other benefits to options for low-cost or no-cost health care services.

12.16.14.2 **Notification of Change**

Provider shall notify The Health Plan before making any material change in the size, scope, or configuration of Provider's services. Provider is required to notify The Health Plan in writing within one (1) day of knowledge of or anticipation of the following: (i) any unexpected material change or deficiency; (ii) any material change to Provider's license, certification or registration; (iii) any condition which terminates, suspends or limits Provider from effectively participating in the network, including the necessity for transition of Members to a different provider; (iv) any situation which develops involving Provider when notice of that situation must be given to any regulatory body with authority over Provider; or (v) when a change in Provider's license to operate is affected, or may reasonably be affected, as a result of any investigation conducted by, or complaint filed with, the official body with regulatory authority over Provider.

Providers of behavioral health services shall submit notification to The Health Plan 75 days prior to the effective date of change via the Notification of Change deliverable (RF-1016) for any material change to (i) the Provider's license, certification or registration; (ii) a change in programming or population served; (iii) a site move, closure, or opening of a new site; or (iv) the addition or closure of a program. **See Section 16 – Deliverable Requirements.**

All providers must update credentialing or other personnel information filed with The Health Plan within 15 days of new hires or terminations by the provider agency. Providers are responsible for the maintaining the accuracy of their staff and facility information, so that the provider listings made available to members by The Health Plan is current and relevant.

12.17 **Laboratory Provider Requirements**

Laboratory services must be provided by a Participating laboratory provider. Services provided by a non-participating provider or facility must be authorized by The Health Plan prior to the services being provided or the member is responsible for payment. Medically necessary diagnostic testing and screening are covered services.

Participating providers may offer laboratory work in their offices; however, some services are considered bundled charges and are not paid in addition to an office visit fee.

12.17.1 **Clinical Laboratory Improvement Amendments (CLIA) Certificate**

Providers must have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver or a certificate of registration along with a CLIA Identification number. In addition, providers must meet all the requirements of 42 CFR § 493, Subpart A. Providers must provide

verification of CLIA Licensure or Certificate of Waiver during the provider registration process. Failure to do so shall result in termination of the Agreement and denial of laboratory claims.

12.17.2 Rules

Pass-through billing or other similar activities with the intent to avoid the requirements listed above is prohibited. Laboratories with certificates of waiver are limited to providing only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration are allowed to perform a full range of laboratory tests. Providers must manage and oversee the administration of all laboratory services in accordance with all state and federal laws.

Medical tests ordered for diagnosis, screening or monitoring of a condition will be paid by The Health Plan as defined and limited in the AHCCCS Covered Behavioral Health Services Guide and in accordance with the fee schedule in provider's agreement with The Health Plan.

12.17.3 Service Standards/Provider Qualifications

Laboratory and medical imaging services may be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of their practice. With the exception of specimen collections in a medical practitioner's office, laboratory services must be provided in CLIA approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4, Federal Clinical Laboratory Improvement Amendments in AAC R9-14-101 and the Federal Code of Regulations 42 CFR 493, Subpart A.

12.17.4 Billing/Coding Specific Information

Current Procedural Terminology (CPT) codes are restricted to independent practitioners with specialized training and licenses as outlined in the AHCCCS B-2 Allowable Procedure Code Matrix.

12.18 Specialty Provider Requirements

12.18.1 Specialty Providers

12.18.1.1 *Staffing Requirements*

Specialty Agencies are required to have organizational, management, and administrative systems capable of meeting all contract requirements with clearly defined lines of responsibility, authority, communication, and coordination within and between departments, units, or functional areas of operation. Specialty Agency's resource allocation must be adequate to achieve outcomes in all functional areas within the organization. Adequacy will be evaluated based on outcomes and compliance with the requirements of this section, including the requirement to provide culturally competent services. The provider is required to have sufficient staff and utilize appropriate resources to comply with this Provider Manual. Providers must require all staff, whether employed or under contract, to have the training, education, experience, orientation, and credentialing, as applicable, to perform assigned job duties.

12.18.1.2 Referrals

Providers must accept all referrals for specialty services that are consistent with its program admission criteria, licensure status, and level of care.

Specialty Providers are responsible for ensuring their agency's compliance with medical records standards mandated by licensure and/or certification authorities at all times. Crisis providers must obtain appropriate documentation to effectively provide and bill for Crisis Services.

12.18.1.3 Refusal/Termination of Services

Specialty providers are not allowed to refuse to serve a referred person except for good cause related to inability of the provider to meet the person's needs safely and professionally, or due to inability to serve the member due to capacity restrictions. Providers may not refuse or terminate services to a The Health Plan enrolled Member or discharge a The Health Plan enrolled Member without first coordinating and arranging interim, follow-up or alternative services.

12.18.1.4 After-Hours Services

Specialty providers must provide after-hours clinical on-call services to address Member concerns and facilitate treatment services as needed. Providers must maintain an administrator-on-call to address any after-hours, weekend or holiday concerns or issues related to coordination of care or the health and/or safety of Members.

12.18.1.5 Individualized Service Plan

Specialty providers must ensure services identified on the Individualized Service Plan are provided in the timeframe, frequency, and duration as identified on the Service Plan.

12.18.1.6 Child and Family Team & Integrated Treatment Team Participation

Specialty providers must participate in person or telephonically in Child and Family Team or Integrated Treatment Team meetings pertaining to Members receiving services from the provider as clinically appropriate.

12.18.1.7 Treatment Updates

Specialty providers must provide the PCP and Behavioral Health Home (if the member has a Behavioral Health Home) with regular treatment updates related to services rendered to Members as clinically appropriate.

12.18.1.8 Diagnosis on Claims

Specialty providers must ensure claims submitted for services contain a diagnosis identified on either the Health Homes Comprehensive Assessment or the Specialty Agency Assessment at the time of the date of service. Failure to meet this requirement can result in recoupment of payment. Crisis providers must maintain appropriate documentation to effectively bill for Crisis Services.

12.18.1.9 *Community-Based Alternatives*

Specialty providers must promote community-based alternatives instead of treatments that remove the Members from their family and community. In situations where a more restrictive level of care is temporarily necessary, providers must work with the Member to transition back into community-based care settings as rapidly as is clinically feasible and will partner with community provider agencies to develop and offer services that are alternatives to more restrictive institutionally based care.

12.18.1.10 *Continuity of Care*

Specialty providers must ensure coordination and continuity within and between service providers and natural supports to reduce premature discharge/disenrollment and support continuity of care over time.

12.18.1.11 *Individualized Services and Member Involvement*

Specialty providers must ensure services are individualized to meet the needs of Members and families. In addition, providers must assess the Member's perspective on treatment progress, in order to verify that the Member's perspectives are honored and they are effectively engaged in treatment planning and in the process of care. Providers must obtain and document ongoing engagement of the Member, family and others who are significant in meeting the needs of the Member, including active participation in treatment decisions which may result in modifications to the Member's service plan.

12.18.1.12 *HIV Education and Screening*

Specialty providers must provide or make available HIV education and screening services to all persons receiving Substance Use Disorder (SUD) treatment services. Providers must work with The Health Plan's contracted providers of HIV education and screening services to verify all persons have access to the services.

12.18.1.13 *SUD Treatment Services*

Specialty Providers offering SUD treatment services must ensure adherence to the Health Plan's **Provider Manual Section 14.13, Substance Use Disorder Treatment Requirements.**

12.18.1.14 *Quality Improvement Activities*

Providers must participate in clinical quality improvement activities that are designed to improve outcomes for Arizona Members.

12.18.1.15 *Notification of Change*

Providers shall notify the Health Plan before making any material change in the size, scope, or configuration of Provider's services. The Provider is required to notify The Health Plan in writing within one (1) day of knowledge of or anticipation of the following: (i) any unexpected material change or deficiency; (ii) any material change to Provider's license, certification or registration; (iii) any condition which terminates, suspends or limits the Provider from effectively participating in the network, including the necessity for transition of Members to a different provider; (iv) any situation which develops involving the Provider when notice of that situation must be given to any regulatory body with authority over Provider; or (v) when a change in

Provider's license to operate is affected, or may reasonably be affected, as a result of any investigation conducted by, or complaint filed with, the official body with regulatory authority over the Provider.

12.18.1.16 *Electronic Health Record/Electronic Medical Record*

Providers are encouraged to have in place a fully operational Electronic Health Record (EHR); including, electronic signature, and remote access, as required to meet Federal Medicaid and Medicare requirements. In addition, providers must allow AHCCCS and The Health Plan staff access to the EHR for the purpose of conducting audits. Providers are required to establish and maintain membership with, and bi-directional data connectivity to, the state Health Information Exchange, "The Network/AZHeC".

12.18.1.17 *Peer Support Training*

Providers must verify that all staff and family of Members who provide Peer Support or Family Support have the required training to support them in successfully fulfilling the requirements of their position.

12.18.2 Behavioral Health Inpatient Facilities and Licensed Hospitals

Providers must comply with The Health Plan's quality improvement programs and the utilization control and review procedures specified in 42 CFR, Parts 441 and 456, as implemented by AHCCCS and the State. Providers must participate in periodic Quality Management audits and respond to Corrective Action Letters (**CALs**) related to trends in average length of stay and Member satisfaction, polypharmacy, timeliness of staffings, discharge planning and quality care. Providers must not arbitrarily or prematurely reject or eject a Member from services without prior authorization The Health Plan from the Health Plan.

Providers must comply with all Utilization Management and facility requirements as outlined in this Provider Manual. This includes the following:

- Timeliness for submission of the Certification of Need (CON) and Re-Certification of Need (RON).
- Required contact with The Health Plan UM Department to discuss clinical rationale for emergent admissions.
- Appropriate documentation of the need for emergent services, including admitting psychiatric evaluation and other clinical data.
- Documentation required within seventy-two (72) hours of the admission date.

12.18.2.1 *Inpatient Care Assessments*

Providers delivering inpatient care (AHCCCS provider types 2, 71, B1, B2, B3, B5 and B6) must provide a comprehensive assessment and treatment plan involving close daily (including holidays and weekends) psychiatric and/or medical supervision based upon provider type and reason for admission. Failure to provide a daily psychiatric and/or medical claim or encounter verifying daily contact with the physician or nurse practitioner will result in a denial of payment.

12.18.2.2 **Lab Work**

All lab work for Members must be conducted within industry standards for completeness and timeliness. For example, therapeutic blood levels must be reported within thirty-six to forty-eight (36-48) hours.

12.18.2.3 **Discharge Planning**

In addition to the requirements of **Section 4.12 – Discharge Planning**, providers must demonstrate that discharge planning is started at the time of admission for emergent admissions. Provider must submit the discharge plan to The Health within forty-eight (48) hours of discharge from the facility.

12.18.2.4 **Medical Care Evaluation Study Methodology and Study Results**

Providers must submit the Medical Care Evaluation Study Methodology and Study Results in accordance with this Provider Manual, State Policy and Procedures, AHCCCS Quality Management/Utilization management Plan as requested by The Health Plan.

12.18.3 **Licensed Hospitals – Specific Requirements**

12.18.3.1 **Licensing**

Providers must meet the requirements of 42 CFR 440.10 and Part 482 and be licensed pursuant to A.R.S. 36, Chapter 4, Articles 1 and 2; or,

- For adults age twenty-one (21) or over, certified as a provider under Title XVIII of the Social Security Act; or,
- For adults age twenty-one (21) or over, currently determined by ADHS Assurance and Licensure to meet such requirements.

Providers must be licensed as a Hospital by the ADHS Division of Licensing if providing emergency inpatient services beyond seventy-two (72) hours. If providers maintain a freestanding psychiatric facility, providers must meet the specific requirements of the ADHS Division of Licensing (i.e., provision of psychiatric acute care). If seclusion and restraint is provided, the facility must meet the requirements set forth by the ADHS Division of Licensing.

12.18.3.2 **Billing**

Providers must abide by the billing limitations as outlined in the AHCCCS Covered Behavioral Health Services Guide; including the following limitations:

- Medical supplies provided to a person while in a hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- Laboratory, Radiology and Medical Imaging provided by the hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- Medication provided/dispensed by the hospital/psychiatric hospital are included in the per diem rate and cannot be billed separately.
- The hospital/psychiatric hospital cannot bill for therapeutic leave/bed hold.

- No more than 30% of an individual's gross monthly household income be used for the purposes of room and board. This limitation applies only to beneficiaries enrolled with the RBHA, determined to have a serious Mental Illness and residing in a Behavioral Health Residential Facility.

Case management, medical services, family support and peer support services may be billed on the same day as H0018 as long as they are billed through an Outpatient Clinic (77) and not excluded on the AHCCCS B-5 matrix (billing limitations). Providers must accept the Medicaid payment as "payment in full" for all Medicaid enrolled Members receiving residential services and cannot bill the Member for any ancillary costs.

12.18.3.3 Medical Clearance

Providers must maintain capacity to provide basic medical clearance, including vitals, medical history and review of symptoms. Providers must not require Members to obtain a medical clearance prior to accepting the Member unless there is an obvious identifiable present or past medical concerns warranting formal medical evaluation or medical tests.

12.18.4 Behavioral Health Hospital Facilities – Specific Requirements

Providers must provide continuous treatment to a person who is experiencing acute and severe behavioral health and/or substance use symptoms. Crisis services may include: emergency reception and assessment; crisis intervention and stabilization; individual, group and family counseling; detoxification and referral.

12.18.4.1 Accreditation and Licensing

Providers must ensure all Behavioral Health inpatient facilities are accredited by the Joint Commission on Accreditation of Healthcare Organizations ("**JCAHO**"), Commission on Accreditation of Rehabilitation (CARF), or a similar agency and licensed by the ADHS Division of Licensing as a Behavioral Health Inpatient Facility. Providers must meet the requirements set forth by the ADHS Division of Licensing in accordance with 42 CFR 441 and 483 for seclusion and restraint, if the facility has been authorized by ADHS Division of Licensing to provide seclusion and restraint. Crisis intervention services may be provided in a setting licensed as a Behavioral Health Inpatient Facility, but which does not require the Member to be admitted to the facility.

12.18.4.2 Laboratory Services

Providers must complete routine lab services and not refer to emergency rooms to complete routine labs. Laboratory and medical imaging services may be prescribed by a licensed physician, nurse practitioner, or physician assistant within the scope of their practice. With the exception of specimen collections in a medical practitioner's office, provider must verify laboratory services are provided in CLIA approved hospitals, medical laboratories and other health care facilities that meet state licensure requirements as specified in A.R.S. Title 36, Chapter 4, Clinical Laboratory Improvement Amendments in AAC R9-14-101 and the federal code of regulations 42 CFR 493, Subpart A.

12.18.4.3 Medical Clearance Exams

Providers must maintain capacity to provide basic medical clearance, including vitals, medical history and review of symptoms. Providers must not require Members to obtain a medical clearance prior to accepting the Member unless there are obvious identifiable present or past

medical concerns warranting formal medical evaluation or medical tests. Providers must conduct uncomplicated medical clearance examinations and refer to emergency rooms for medical clearance only when medical complications warrant such a referral.

12.18.4.4 *Weekend and Holiday Discharges*

Providers must facilitate weekend and holiday discharges from Behavioral Health Inpatient Facilities, and coordinating discharges through The Health Plan Crisis Line provider and the Member's affiliated Health Home.

12.18.5 Behavioral Health Inpatient Facilities – Specific Requirements

Providers must provide an integrated residential inpatient program of therapies, activities, and experiences provided to Members who are under twenty-one (21) years of age and have severe or acute behavioral health symptoms.

12.18.5.1 *Notification of Placement*

Providers must notify The Health Plan UM department within 2 business days of accepting placement of a The Health Plan Member into provider's facility.

12.18.5.2 *Accreditation and Licensing*

Provider Behavioral Health inpatient facilities must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Commission on Accreditation of Rehabilitation (CARF) and licensed by the ADHS Division of Licensing as a Behavioral Health Inpatient Facility meeting the specific requirements of the ADHS Division of Licensing. Behavioral Health Inpatient Facilities must meet the requirements set forth by the ADHS Division of Licensing, and in accordance with 42 CFR 441 and 483 for seclusion and restraint, if the facility has been authorized by the ADHS Division of Licensing to provide seclusion and restraint.

12.18.5.3 *Bed Holds*

Providers must reserve a Member's bed (bed hold) in the Behavioral Health Inpatient Facility while the Member is on an authorized/planned overnight leave. Payment for bed holds is limited to:

- Therapeutic leave to enhance psychosocial interaction or as a trial basis for discharge planning, or
- Admittance to a hospital for a short stay.

Payment for bed hold leave days is limited to up to twenty-one (21) days per year (July 1st through June 30th) per Member. In addition, Providers must manage bed hold days so as to verify billed bed hold days do not exceed twenty-one (21) days per year.

12.18.5.4 *Coordination with Health Care Coordinators*

Providers must create opportunities for Health Home Health Care Coordinators to provide face-to-face contact at least once a month with all Members placed in out-of-home care.

12.18.5.5 *Involvement of Family and Other Parties*

Providers make reasonable efforts to verify that all Child and Family Team meetings involving children placed in Behavioral Health Licensed Facilities include, at a minimum: Member and legal guardian, collateral parties, such as Juvenile Probation Officer, Division of Developmental Disabilities, or out-of-home facility staff, and provider agency staff who has clinical knowledge and a relationship with the child. Providers must make reasonable efforts to verify that at least one facility staff Member who has clinical knowledge and a relationship with the Member attends all scheduled court hearings. Providers must make reasonable efforts to verify that the child's family/natural supports are included in out-of-home treatment services while the child is in placement.

12.18.5.6 *Discharge Plans*

Providers must assist in the development of discharge aftercare plans prior to accepting a referral. Providers must make reasonable efforts to provide continuity of care services for children who are placed in detention and assist with discharge and transitional planning to an alternative setting if they are not able to treat the Member upon discharge from the detention facility.

12.18.6 Residential Facilities – Specific Requirements

Providers must provide an integrated residential program of therapies, activities, and experiences to Members in compliance with all relevant provisions in A.R.S § 36-1201.

12.18.6.1 *Services*

Providers must verify that treatment is provided to all Members while in the facility including daily life skills training, behavioral management training, emotional regulation training, vocational/academic preparation and support, and social skills training. All Members must receive regular medical (PCP) examinations and treatment, as appropriate.

Providers must assist Members in preparing for employment as appropriate and in accordance with AHCCCS protocols. In addition, providers must verify educational resources are available and accessible based upon the individual needs of the Member. Provider must provide tutoring at the facility Monday through Friday, as appropriate, to meet the Members' educational needs.

12.18.6.2 *Referrals*

Providers may not arbitrarily or prematurely reject or eject a Member from services without prior approval The Health Plan from the Health Plan. Providers must notify The Health Plan's UM department within 1 business days of accepting placement of a The Health Plan Member into a facility. Providers must immediately notify The Health Plan Crisis Line provider whenever a Member leaves a facility against medical advice (or AMA), is hospitalized or arrested.

12.18.6.3 *Prior Authorization and Continued Stay Requirements*

Providers must meet all prior authorization and continued stay requirements for residential services as spelled out in this Provider Manual, unless granted an exception to this requirement in writing from The Health Plan. Only prior authorized services are eligible for payment by The Health Plan. Respite services provided in a Residential facility do not require prior authorization.

12.18.6.4 ***Treatment Setting and Supervision***

Providers must provide residential services that provide a structured treatment setting with twenty-four (24) hour supervision and counseling or other therapeutic activities for persons who do not require on-site medical services, under the supervision of an on-site or on-call Behavioral Health Professional.

12.18.6.5 ***Licensing and Staffing***

Residential facilities must be licensed by the ADHS Division of Licensing as a BH Residential Facility. Providers must provide appropriate staffing (including one-on-one staff as needed) to accommodate all referrals who do not require a higher level of care.

12.18.6.6 ***Program Outcomes***

Providers must promote and demonstrate the following program outcomes:

- Improved self-regulation;
- Development of appropriate social skills;
- Expeditious return to less restrictive environment;
- Minimal readmission rate;
- Increase in Member self-sufficiency;
- Development of health leisure activities;
- Engagement in ongoing services;
- Decreased risk factors (less runaway behavior, self-harm, aggressive behavior);
- Increased community connections and readiness for employment.

12.19 Requirements for Service Delivery on the Tohono O’odham Nation

Per the Memorandum of Agreement between the Tohono O’odham Nation and The Health Plan, any provider wishing to deliver services within the exterior boundaries of the Tohono O’odham Nation will need prior approval from The Health Plan and the Tohono O’odham Nation.

12.19.1 **Approved Providers**

A listing of providers approved by The Health Plan and the Tohono O’odham Nation to provide services within the boundaries of the Nation can be located on The Health Plan’s website at <https://www.azcompletehealth.com>.

12.19.2 **Quarterly Reporting**

All approved providers, located and/or delivering services within the exterior boundaries of the Nation, must submit a quarterly service report OI-217 Tohono O’odham Nation Quarterly Report using the designated template outlined in Provider Manual **Section 16 – Deliverable Requirements**.

12.19.3 Requesting Approval

Any provider that would like to request approval to deliver services on the Nation should contact The Health Plan's Tribal Program Development team to initiate the process.

12.20 Requirements of Organizations Providing Employment Services

All contracted behavioral health providers and integrated health care providers are required to deliver or assist members in obtaining employment and rehabilitation services. Provider Organizations delivering and billing employment and rehabilitation related activities shall employ at least one fully dedicated Employment Specialist. Provider Organizations delivering and billing for employment and rehabilitation services are required to employ an adequate number of fully dedicated Employment Specialists to meet the needs of the members served in each clinic. It may be permissible for the employment/rehabilitation staff to cover more than one clinical team or split time with other duties, based on staffing, availability, regional locations and enrollment numbers.

Provider Organizations delivering employment and rehabilitation services are required to:

- Monitor employment service utilization including job placement data and ensure accurate and reliable employment status within the Supplemental Member Data Provider Portal.
- Implement Supported Employment and meet SAMHSA Supported Employment fidelity.
- Fulfill the requirements listed in all employment Technical Assistance Documents and provide annual training to all clinical staff on the Technical Assistance Documents.
- Provide benefits planning utilizing Disability Benefits 101 (DB101).
- Adhere to the guidelines within the Interagency Service Agreement (ISA) between AHCCCS and ADES/RSA.
- Provider Organizations serving adults determined Seriously Mentally Ill (SMI) are responsible for a 7% increase of newly-referred members to RSA/VR.
- Make all reasonable efforts to become mutually contracted with ADES/RSA.

Employment Specialists must:

- Obtain certification from Arizona Complete Health as an Employment Specialist.
- Connect members to sustainable employment resources in the community including RSA/VR, AZ@Work, Linkages of Arizona, etc.
- Provide individualized supports to assist members in obtaining and maintaining competitive employment.
- Fulfill responsibilities listed in the ISA/Collaborative Protocol with ADES/RSA and refer all adults interested in employment services to the RSA VR

Program. • Participate in Arizona Complete Health sponsored meetings/events and Bi-Annual Vocational Task Force meetings with AHCCCS and ADES/RSA.

Section 13 - HEALTH PLAN COORDINATION OF CARE REQUIREMENTS

13.1 Transition of Persons

Persons receiving services in the State system may experience transitions during the course of their care and treatment. Examples of transitions of care include changing service providers, establishing eligibility under Arizona Long Term Care Services (ALTCS), and moving out of The Health Plan geographic service area. During transitions of care, providers must ensure that services are not interrupted and that the person continues to receive needed services. Coordination and continuity of care during transitions are essential in maintaining a person's stability and avoiding relapse or decompensation in functioning.

Transition of Enrollment for Persons Turning 18 Regardless of the youth's decision regarding their continued behavioral health enrollment, an updated Arizona Health Care Cost Containment System (AHCCCS) application must be submitted prior to the youth's 18th birthday and with sufficient time to allow for AHCCCS to process the application (at least 45 days). The application should be completed at least six months prior to the child's 18th birthday. The provider must assist the member in applying for AHCCCS coverage at the appropriate interval.

Upon turning 18 years of age, if the person is not eligible for services as a person determined to have a Serious Mental Illness or the person has been determined ineligible for Title XIX/XXI services, providers can continue to provide services under block grant funds (as applicable) or per **Section 7.22 - Copayments**.

When the youth turns 18, the provider must ensure that new consents and release of information documents are signed, reflecting correct diagnosis codes and behavioral health category consistent with **Section 6.1 - Enrollment, Disenrollment and other Data Submission**. Once the child's behavioral health category assignment has been changed, ongoing behavioral health service appointments must be provided according to the timeframes for routine appointments in **Section 12.2 - Appointment Standards and Timeliness of Services**.

13.1.1 Transition Due to a Change of the Behavioral Health Provider or the Behavioral Health Category Assignment

Upon changes of a Member's provider or behavioral health category assignment, the provider must:

- Review the current individual service plan and, if needed, coordinate the development of a revised individual service plan with the person, clinical team, and the receiving behavioral health provider;
- Ensure the transfer of responsibility for court ordered treatment, if applicable; and
- Coordinate the transfer of any other relevant information between the provider and other provider agencies, if needed.

The Health Plan agency changes are coordinated between The Health Plan agencies.

13.1.2 Transition to ALTCS Program Contractors

This section does not apply to persons enrolled in the Arizona Long Term Care Services/Division of Developmental Disabilities (ALTCS/DDD). ALTCS/DDD eligible persons receive all covered services through The Health Plan and their providers.

Once a person is determined eligible and becomes enrolled with the Arizona Long Term Care Services/Elderly or Physically Disabled (ALTCS/EPD) Program, providers must not submit claims or encounters for Title XIX/XXI covered services to The Health Plan. To determine if a person is ALTCS/EPD eligible, providers shall contact The Health Plan Customer Service for assistance at 866-796-0542. The provider must, however, continue to provide and encounter needed non-Title XIX/XXI covered SMI services (e.g. housing) to persons determined to have a Serious Mental Illness.

Providers who contract as an ALTCS provider must not submit encounters for an ALTCS/EPD enrolled person to The Health Plan after a person transfers to ALTCS, but must submit bills/claims for payment to the ALTCS Program Contractor who in turn submits the encounters to AHCCCS.

Providers must facilitate effective transitions for Members who became eligible for ALTCS services. Providers must complete the following coordination efforts for ALTCS-eligible Members:

- Provide continuity of care between inpatient and outpatient settings, services, and supports;
- Develop and implement transition, discharge, and aftercare plans prior to discontinuation of services in accordance with this Provider Manual;
- Include the Member in transition planning and provide any available information about changes in physician, services, etc.;
- Ensure that the clinical and fiscal responsibility for Title XIX/XXI services shifts to the ALTCS Program Contractor;
- Complete a transfer packet and letter of transition that provides clinical information to the ALTCS Program Contractor regarding the person's on-going needs for services to assist them in effectively meeting the ongoing health and cultural needs of the Member and ensure continuity of care during the transition period;
- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving ALTCS provider and/or Health Care Coordinator;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the ALTCS program contractor; and
- Provide information as follows:
 - For Title XIX/XXI eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year (October 1 – September 30);
 - For all persons, the number of hours of respite received in the contract year (October 1 - September 30); and

- Whether there is a signed authorization for the release of information contained in the comprehensive behavioral health record pursuant to **Section 9.6.1 - Disclosure of Health Information.**

13.1.3 Transition of Persons Receiving Court Ordered Services

This Section pertains to court ordered treatment under [A.R.S. § 36, Chapter 5](#) (see **Section 12.9, Pre-petition Screening, Court Ordered Evaluation and Treatment**) and the Arizona Administrative Code R9-21-507.

A person ordered by the court to undergo treatment and who is without a guardian may be transferred from one provider to another provider, as long as the medical director of the provider initiating the transfer has established that:

- The member's Court Ordered Treatment is not expiring within 90 days of the transfer,
- There is no reason to believe that the person will suffer more serious physical harm or serious illness as a result of the transfer;
- The person is being transitioned to a level and kind of treatment that is more appropriate to the person's treatment needs; and
- The medical director of the receiving provider has accepted the person for transition.

The medical director of the provider requesting the transition must have been the provider that the court committed the person to for treatment or have obtained the court's consent to transition the person to another provider as necessary.

The medical director of the provider requesting the transition must provide notification to the receiving provider allowing sufficient time (but no less than 3 days) for the transition to be coordinated between the providers. Notification of the request to transition must include:

- A summary of the person's needs;
- A statement that, in the medical director's judgment, the receiving provider can adequately meet the person's treatment needs;
- A modification to the individual service plan, if applicable;
- Documentation of the court's consent, if applicable;
- A written compilation of the person's treatment needs and suggestions for future treatment by the medical director of the transitioning provider to the medical director of the receiving provider. The medical director of the receiving provider must accept this compilation before the transition can occur; and

Transportation from the initiating provider to the receiving provider is the responsibility of the initiating behavioral health provider.

Members Assigned to an Outpatient Provider and become Court Ordered.

A Provider serving as a Behavioral Health Home is required to provide all services including outpatient treatment plan services for members on Court Ordered Treatment.

However, there are some Outpatient Providers who cannot typically provide the services required by the Outpatient Treatment Plan for Court Ordered Treatment. If the member is

currently receiving services from one of these providers, the member may need to be transferred/assigned to an Outpatient Provider who will assume responsibility for the members Court Ordered Outpatient Treatment Plan. An Outpatient Provider should be designated prior to the member being discharged to the hospital so that a court ordered treatment plan can be submitted to the Court. A transfer/assignment of the member should occur upon discharge from inpatient stay.”

Should this occur, please contact the Health Plan Title 36 Coordinator for additional Technical Assistance”

13.1.4 Transition of Persons Being Discharged from Inpatient Settings

Discharge planning and communication with the Adult Clinical Team or CFT must begin at admission to ensure a smooth transition for Members being discharged from inpatient settings in accordance with the guidelines in Section 3.14 Discharge Planning. Furthermore, re-engagement activities must occur for persons who are discharged from inpatient settings in accordance with **Section 12.4 - Outreach, Engagement, Re- engagement and Closure**. If a Member will be moving to a different GSA, coordination must occur between RBHA/Health Plans, if applicable, to verify appropriate services/placement and necessary re-engagement activities occur upon discharge and must not occur while member is in an inpatient setting (see **Section 13.2 - Inter-RBHA/MCO Coordination of Care**).

13.1.5 Transition of Persons Receiving Behavioral Health Services from Indian Health Services

American Indian persons may choose to receive services through a TRBHA/Health Plan, or at an IHS or 638 tribal provider. The Health Plan providers must respond to referrals in accordance with **Section 12.3 – Referral and Intake Process**, and ensure necessary coordination of care occurs. Contact The Health Plan telephone number at 888-788-4408.

13.1.6 Inter-Agency Coordination of Care Transfers (Transferring Member Coordination of Care Responsibility to a Different Agency)

All coordination of care inter-agency transfers between Outpatient Providers must be completed through the Provider Portal. Each transfer is required to be posted to the portal by the transferring agency and accepted or rejected by the receiving agency within 7 days of the date the transfer was entered into the transfer system.

The Health Plan Network Development Coordinator will monitor inter-agency transfers to ensure the transfer is complete within 7 days from the date the transfer was entered into the system. The transfer is considered timely when the receiving agency accepts or rejects the transfer within 7 days. The following steps must be documented in the medical record to ensure compliance with requirements.

13.1.6.1 Sending Agency Requirements

- Evidence the sending agency staff discussed the transfer with the Member and documented the conversation and Member request in the medical record.
- Documentation that the assigned staff from the sending agency coordinated with the receiving agency within 7 business days of the Member request.

- Evidence the sending agency gathered the required documentation, including the full completion of **the Provider Manual Form 4.1.1 Inter-Agency Transfer Checklist**; and evidence the sending agency provided the transfer packet to the receiving agency. This form can be obtained from the Provider Services Call Center at 866-796-0542 if needed.
 - Evidence the **Provider Manual Form 4.1.1 Inter-Agency Transfer Checklist** and packet were completed by the sending agency and provided to the receiving agency no later than the date of the transfer CFT/ART.
 - Evidence the receiving agency documented confirmation of receipt of the transfer packet documents, or a follow up plan for missing documents required as part of the Inter-agency Transfer Checklist. Missing documentation should not delay a transfer from occurring.
- Evidence the sending agency coordinated with the Member/guardian, system partners, and receiving agency to verify a transfer CFT/ART occurred.
 - Evidence that once the documentation was provided and the transfer CFT/ART was completed with the receiving agency, the sending agency submitted the transfer through the Provider Portal. The sending agency is required to submit the transfer through the Provider Portal within 2 days following the transfer CFT/ART.

13.1.6.2 ***Receiving Agency Requirements***

- Documentation that the receiving agency coordinated with the sending agency to schedule a transfer Child and Family Team/Adult Recovery Team (CFT/ART) appointment.
- Evidence the receiving agency CFT/ART included the following:
 - Attendance by:
 - Member/guardian,
 - Sending agency staff,
 - Receiving agency staff, and
 - Other system partners as appropriate.
 - Completion of an Inter-agency Transfer Checklist/SBAR (Situation, Background, Assessment, Recommendation) Tool in its entirety.
 - Completed Inter-agency Transfer Checklist/SBAR Tool was filed in the medical record within 7 days of completion and is easily accessible.
- Evidence that once the transfer CFT/ART was completed and paperwork was confirmed by the receiving agency, the transfer was accepted by the receiving agency on the Provider Portal.
- Evidence Transfer was accepted or rejected by the receiving agency within 5 days following the receipt of request.
- Evidence the intake appointment was completed. The intake appointment may be combined with the transfer CFT/ART.
- Evidence the receiving agency scheduled the next appointment within 7 days following the transfer.

13.1.7 At Risk Member Transitions

The Health Plan Outpatient Providers are recommended to notify The Health Plan Integrated Care Management department immediately anytime a high risk member is scheduled to be transferred between providers, or payers. Outpatient Providers are required to contact The Health Plan Member Transition Coordinators at 1-888-788-4408. Notification is recommended for all at risk members including but not limited to the following members:

- Members with significant medical conditions such as: a high-risk pregnancy or pregnancy within the last trimester; the need for organ or tissue transplantation; chronic illness resulting in hospitalization or nursing facility placement, etc.
- Members who are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition;
- Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media;
- Members who have received prior authorization for services such as scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, or nursing home admission; and Continuing prescriptions, Medical Equipment and Appliances (previously called Durable Medical Equipment) and medically necessary transportation ordered for the transitioning member by the relinquishing Contractor; and
- Members transitioning to Comprehensive Medical and Dental Plan (CMDP).

The Health Plan Outpatient Providers are required to fully cooperate with The Health Plan, "receiving and sending providers and health plans" and proactively coordinate care to meet the member's needs throughout the transition. Outpatient Providers are required to timely release medical records of the transitioning member (the cost, if any, of reproducing and forwarding medical records shall be the responsibility of the provider).

13.2 Inter-RBHA/MCO Coordination of Care

Coordination between Tribal and Regional Behavioral Health Authority /Health Plans must occur in a manner that ensures the provision of continuous covered services that are consistent with the treatment goals and identified needs for persons who:

- Receive services outside of the Geographical Service Area served by their designated T/RBHA/Health Plan (non-enrolled persons),
- Receive services outside of the Geographical Service Area served by their home T/RBHA/Health Plan (enrolled persons), or
- Move to another Geographical Service Area.

13.2.1 Computation of Time

In computing any period of time 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 a 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 of time 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.

13.2.2 Jurisdictional Responsibilities

For adults (persons 18 years and older), T/RBHA/Health Plan responsibility is determined by the person's current place of residence, except persons who are unable to live independently but are involved with ADES/DDD. This is applicable regardless of where the adult guardian lives.

Responsibility for service provision, other than crisis services, remains with the home T/RBHA/Health Plan when the enrolled person is visiting or otherwise temporarily residing in a different T/RBHA/Health Plan area but:

- Maintains a place of residence in their previous location with an intent to return, and the anticipated duration of the temporary stay is less than three months.
- When an Arizona Long Term Care System (ALTCs)/DDD Member is placed temporarily in a group home while a permanent placement is being developed in the home T/RBHA/Health Plan service area, covered services remain the responsibility of the home T/RBHA/Health Plan.

For children (ages 0-17 years), Health Plan responsibility is determined by the current place of residence of the child's parent(s) or legal guardian. For children who have been adjudicated as dependent by a court, the location of the child's court of jurisdiction determines which T/RBHA/Health Plan has responsibility.

The Health Plan may agree to coordinate an Inter-RBHA/Health Plan transfer for individuals unable to live independently on a case-by-case basis. Inter-RBHA/Health Plan transfers must be completed within 30 days of referral by the home T/RBHA/Health Plan. The home T/RBHA/Health Plan must ensure that activities related to arranging for services or transferring a case does not delay a person's discharge from an inpatient or residential setting.

13.2.3 Out-of-Area Service Provision

13.2.3.1 Crisis Services

Crisis services must be provided without regard to the person's enrollment status. When a person presents for crisis services, providers must:

- Provide needed crisis services;
- Ascertain the person's enrollment status with all Health Plans and determine whether the person's residence in the current area is temporary or permanent;
- If the person is enrolled with another RBHA/Health Plan, the provider is required to notify the home RBHA/Health Plan within 24 hours of the person's presentation. The home RBHA/Health Plan is fiscally responsible for crisis services and must:
 - Make arrangements with the Health Plan at which the person presents to provide needed services, funded by the home RBHA/Health Plan;
 - Arrange transportation to return the person to the home RBHA/Health Plan area; or
 - Determine if the person intends to live in the new Health Plan's geographic service area and if so, initiate a transfer. Persons who are unable to live

independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home RBHA/Health Plan must make arrangements for housing and consider this a temporary placement for three months. After three months, if the person continues to clearly express an intent/desire to remain in this new service area, the RBHA/Health Plan transfer can proceed.

- If the person is not enrolled with the Health Plan and lives within the service area of the Health Plan at which the person presented for services, providers must notify the Health Plan to initiate enrollment. A person can obtain a referral by calling The Health Plan Customer Service at 866-796-0542.
- If the person is not enrolled with the Health Plan and lives outside of the service area of the Health Plan at which the person presented for crisis services, providers must enroll the person, provide needed crisis services and initiate the Inter-RBHA/Health Plan transfer.
- In the event that The Health Plan or a provider receives a referral regarding a hospitalized person whose residence is located outside the Health Plan's GSA, the provider must immediately coordinate the referral with the person's designated Health Plan.

13.2.3.2 ***Non-Emergency Services***

If the person is not enrolled with a RBHA/Health Plan, lives outside of the service area in which they present, and requires services other than a crisis or urgent response to a hospital, the provider must notify the designated RBHA/Health Plan associated with the person's residence within 24 hours of the person's presentation. The designated RBHA/Health Plan must proceed with the person's enrollment if the person is determined eligible for services. The designated RBHA/Health Plan is fiscally responsible for the provision of all medically necessary covered services, including transportation services, for eligible persons.

13.2.3.3 ***Courtesy Dosing of Methadone***

A person receiving methadone administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone from the Health Plan while the person is traveling out of the home T/RBHA/Health Plan's area. All incidents of provision of courtesy dosing must be reported to the home T/RBHA/Health Plan. The home T/RBHA/Health Plan must reimburse the Health Plan providing the courtesy doses upon receipt of properly submitted bills or encounters.

13.2.3.4 ***Referral to Another T/RBHA/Health Plan for Service Provision***

If The Health Plan provider initiates a referral to another T/RBHA/Health Plan or a service provider in another T/RBHA/Health Plan's area for the purposes of obtaining behavioral health services, The Health Plan provider must:

- Maintain enrollment and financial responsibility for the person during the period of out-of-area behavioral health services,
- Contact the Member Transitions Coordinators at 1-888-788-4408 so that an Out of Service Area Placement Request form (form 520-B) can be completed to maintain member's enrollment and financial responsibility with current service plan

- Establish contracts with out-of-area service providers and authorize payment for services,
- Maintain the responsibilities of the behavioral health provider, and
- Provide or arrange for all needed services when the person returns to The Health Plan's area.

13.2.4 **Inter-T/RBHA Transfer**

A transfer will occur when:

- An adult person voluntarily elects to change their place of residence to an independent living setting from one T/RBHA/Health Plan's area to another.
- Persons who are unable to live independently but clearly express an intent/desire to permanently relocate to another service area can be transferred. However, the home T/RBHA/Health Plan must make arrangements for housing and consider this a temporary placement for three months. After three months, if the person continues to clearly express an intent/desire to remain in this new service area, the inter-T/RBHA transfer can proceed.
- Persons who are unable to live independently and are involved with ADES/DDD can be transferred to another T/RBHA/Health Plan. Persons involved with ADES/DDD who are permanently placed and reside in a supervised setting are the responsibility of the T/RBHA/Health Plan in which the supervised setting is located. This is applicable regardless of where the adult guardian resides.
- The parent(s) or legal guardian(s) of a child change their place of residence to another T/RBHA/Health Plan's area; or
- The court of jurisdiction of a dependent child changes to another T/RBHA/Health Plan's area.

Inter-T/RBHA transfers are not to be initiated when a person is under pre-petition screening or court ordered evaluation (see **Section 12.9 - Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment**).

Please reference **Section 13 Behavioral Health Provider's Responsibilities During an Inter-RBHA/MCO Transfer**

13.2.4.1 **Timeframe**

The home T/RBHA/Health Plan or its providers must initiate a referral for an Inter-T/RBHA transfer within the following timeframes:

- At least 30 days prior to the date on which the person will move to the new area; or
- If the planned move is in less than 30 days, immediately upon learning of the person's intent to move.

13.2.4.2 **Inter-T/RBHA Process**

An adult person enrolled with The Health Plan, family, guardian, behavioral health provider, state agency staff or other health provider staff is responsible for the initiation of an Inter-

T/RBHA transfer. The referral is initiated when the home T/RBHA/Health Plan provides a completed **Provider Manual Form 4.2.1 AzCH Inter-Transfer and Coordination of Services Request Form**. This form can be obtained by calling the Provider Services Call Center at 866-796-0542. In addition, the following information must be provided to the receiving T/RBHA/Health Plan as quickly as possible:

- The person's comprehensive clinical record;
- Consents for release of information pursuant to **Section 9.6 - Confidentiality**;
- For Title XIX/XXI eligible persons between the ages of 21 and 64, the number of days the person has received services in an IMD in the contract year (October 1 – September 30); and
- The number of hours of respite care the person has received in the contract year (October 1 – September 30).

The receiving T/RBHA/Health Plan must not delay the timely processing of an Inter-T/RBHA transfer because of missing or incomplete information.

Upon receipt of the transfer packet, the T/RBHA/Health Plan must:

- Notify the home T/RBHA/Health Plan within seven calendar days of receipt of the referral for Inter-T/RBHA transfer,
- Proceed with making arrangements for the transfer, and
- Notify the home T/RBHA/Health Plan if the information contained in the referral is incomplete.

Within 14 days of receipt of the referral for an Inter-RBHA transfer, the receiving T/RBHA/Health Plan or its providers must:

- Schedule a meeting to establish a transition plan for the person. The meeting must include:
 - The person or the person's guardian or parent, if applicable;
 - Representatives from the home T/RBHA/Health Plan;
 - Representatives from the Arizona State Hospital (AzSH), when applicable;
 - The provider and representatives of the CFT/adult clinical team;
 - Other involved agencies; and
 - Any other relevant Member at the person's request or with the consent of the person's guardian.
- Establish a transition plan that includes at least the following:
 - The person's projected moving date and place of residence;
 - Treatment and support services needed by the person and the timeframe within which the services are needed;
 - A determination of the need to request a change of venue for court ordered treatment and who is responsible for making the request to the court, if applicable;
 - Information to be provided to the person regarding how to access services immediately upon relocation;

- The enrollment date, time and place at the receiving RBHA/Health Plan and the formal date of transfer, if different from the enrollment date;
- The date and location of the person's first service appointment in the receiving T/RBHA/Health Plan's GSA;
- The individual responsible for coordinating any needed change of health plan enrollment, primary care provider assignment, and medication coverage;
- The person's provider in the receiving RBHA/Health Plan's GSA, including information on how to contact the behavioral health provider;
- Identification of the person at the receiving T/RBHA/Health Plan who is responsible for coordination of the transfer, if other than the person's behavioral health provider;
- Identification of any special authorization required for any recommended service (e.g., non-formulary medications) and the individual who is responsible for obtaining needed authorizations; and,
- If the person is taking medications prescribed for the person's behavioral health issue, the location and date of the person's first appointment with a practitioner who can prescribe medications. There must not be a gap in the availability of prescribed medications to the person.

On the official transfer date, the home T/RBHA/Health Plan must enter a closure and disenrollment into CIS. The receiving T/RBHA/Health Plan must enter an intake and enrollment into CIS at the time of transfer. If the person scheduled for transfer is not located or does not show up for their appointment on the date arranged by the T/RBHA/Health Plans to transfer the person, the T/RBHA/Health Plans must collaborate to ensure appropriate re- engagement activities occur (see **Section 12.4, Outreach, Engagement, Re- Engagement and Closure**) and proceed with the inter-T/RBHA transfer, if appropriate. Each T/RBHA/Health Plan must designate a contact person responsible for the resolution of problems related to enrollment and disenrollment.

When a person presents for crisis services, providers must first deliver needed behavioral health services and then determine eligibility and T/RBHA/Health Plan enrollment status. Persons enrolled after a crisis event may not need or want ongoing behavioral health services through the T/RBHA/Health Plan. Providers must conduct re- engagement efforts as described in **Section 12.4, Outreach, Engagement, Re- Engagement and Closure** however; persons who no longer want or need ongoing behavioral health services must be dis-enrolled (i.e., closed in the CIS) and an inter-T/RBHA transfer must not be initiated. Persons who will receive ongoing behavioral health services will need to be referred to the appropriate T/RBHA/Health Plan and an inter-T/RBHA transfer initiated, if the person presented for crisis services in a GSA other than where the person resides.

Timeframes specified in **13.1 Transition of Persons** cover circumstances when Members inform their provider or T/RBHA/Health Plan prior to moving to another service area. When Members inform their provider or T/RBHA/Health Plan less than 30 days prior to their move or do not inform their provider or T/RBHA/Health Plan of their move, the designated T/RBHA/Health Plan must not wait for all of the documentation from the previous T/RBHA/Health Plan before scheduling services for the Member.

13.2.4.3 ***Behavioral Health Provider's Responsibilities During an Inter-RBHA/Health Plan Transfer***

- As part of an Inter-RBHA/Health Plan transfer, the provider must (see **Provider Manual Section 13.2 Inter-T/RBHA/MCO Coordination of Services**):
- Schedule a meeting to establish a transition plan for the person. Include the person in transition planning and provide any available information about changes in physician, services, etc.;
- Provide information regarding the person's on-going needs for services to verify continuity of care during the transition period;
- Review the current treatment plan and, if needed, coordinate the development of a revised treatment plan with the clinical team and the receiving provider;
- Transfer responsibility for any court ordered treatment;
- Coordinate the transfer of records to the new behavioral health provider; and
- Provide information as follows:
 - For Title XIX/XXI eligible 21-64 year olds, the number of days the person has received services in an Institution for Mental Disease (IMD) in the contract year October 1 – September 30;
 - For all persons, the number of hours of respite received in the contract year October 1 - September 30; and
 - Any signed authorizations for the release of information contained in the person's comprehensive clinical record pursuant to **Section 9.6.1 - Disclosure of Health Information**.

For Members who are on court ordered treatment:

- The Health Home shall inform the T36 Liaisons at AZCHtitle36@azchcompletehealth.com that must include all court ordered treatment documents along with transfer packet;
- The Receiving Agency shall schedule an Intake appointment and inform the Health Plan Transition Coordinators at AZCHtitle36@azchcompletehealth.com and the Sending Agency the date of the appointment;
- The Receiving Agency must inform the Health Plan Transitions Coordinators and the Sending Agency that intake appointment has been completed ;
- The Receiving Agency must send the Letter of Intent to the Health Plan Transitions Coordinators at AZCHtitle36@azchcompletehealth.com and the Sending Agency;
- Member Transitions and the Sending Agency must acknowledge receipt of the Letter of Intent;
- The Sending Agency shall file the court document to transfer the Court Ordered Treatment from their County to the new County.

13.2.5 Complaint Resolution

A person determined to have a serious mental illness (SMI) that is the subject of a request for out-of-area service provision or Inter-T/RBHA transfer may file an appeal as provided for in **Section 8.4 -Notice Requirements and Appeal Process for Title XIX/XXI Eligible Persons**. Any party involved with a request for out-of-area service provision or Inter-T/RBHA transfer may initiate the grievance procedure. Parties include the home T/RBHA/Health Plan, receiving T/RBHA/Health Plan, person being transferred, or the person's guardian or parent, if applicable; the Arizona State Hospital (AzSH), if applicable, and any other involved agencies.

The following issues may be addressed in the grievance resolution process:

- Any timeframe or procedure contained in this policy,
- Any dispute concerning the level of care needed by the person, and
- Any other issue that delays the person's discharge from an inpatient or residential setting or completion of an Inter-T/RBHA transfer.

13.2.5.1 *Procedure for Non-Emergency Disputes*

First Level

- A written grievance shall be addressed to:
 - The person's provider at the home T/RBHA/Health Plan, or other individual identified by the T/RBHA/Health Plan, if the issue concerns out-of-area service provision, or
 - The identified provider at the receiving T/RBHA/Health Plan, or other individual identified by the T/RBHA/Health Plan, if the issue concerns an Inter-T/RBHA transfer.
- The provider must work with involved parties to resolve the issue within five days of receipt of the grievance.
- If the problem is not resolved, the provider must, on the fifth day after the receipt of the request, forward the grievance to the second level.

Second Level

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home T/RBHA/Health Plan.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA/Health Plan.
- The Chief Executive Officer must work with the Chief Executive Officer of the other involved T/RBHA/Health Plan to resolve the issue within five days of receipt of the grievance.
- If the problem is unresolved, the Chief Executive Officer must, on the fifth day after the receipt of the request, forward the request to the Deputy Director of the AHCCCS.

Third Level

- The Deputy Director of the AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate based on the grievance.

- The Deputy Director will issue a final decision within five days of receipt of the request.

13.2.5.2 ***Procedure for Emergency Disputes***

An emergency dispute includes any issue in which the person is at risk of decompensation, loss of residence, or being in violation of a court order. The home T/RBHA/Health Plan must ensure that medically necessary behavioral health services continue pending the resolution of an emergency dispute between T/RBHA/Health Plans.

First Level

- Issues concerning out-of-area service provision must be forwarded to the Chief Executive Officer, or designee, of the home T/RBHA/Health Plan.
- Issues concerning Inter-T/RBHA transfers must be forwarded to the Chief Executive Officer, or designee, of the receiving T/RBHA/Health Plan.
- The Chief Executive Officers of the involved T/RBHA/Health Plans must work to resolve the issue within two days of receipt of the grievance.
- If the problem is unresolved, the Chief Executive Officer must, on the second day after the receipt of the request, forward the request to the Deputy Director of AHCCCS.

Second Level

- The Deputy Director of AHCCCS, or designee, will convene a group of financial and/or clinical personnel as appropriate based on the grievance, to address and resolve the issue.
- The Deputy Director will issue a final decision within two days of receipt of the request.

13.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers

In Arizona, the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI) were developed as behavioral health "carve-outs," a model in which eligible persons receive general medical services through health plans and covered services through behavioral health managed care organizations, also known as T/RBHA/Health Plans. Because of this separation in responsibilities, communication and coordination between providers, the Arizona Health Care Cost Containment System (AHCCCS), Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of persons receiving services from both systems.

Some Members are Medicaid (Title XIX) and Medicare (Title XVIII) eligible and are referred to as "dual eligible" persons. Medicare covers limited inpatient services, outpatient services, and prescription medication coverage. Medicare covered services are provided on either a fee-for-service basis or a managed care basis (through Medicare Advantage Plans). The term Medicare provider refers to both the fee-for-service Medicare providers and the Medicare Advantage

Plans. Coordination of care must also occur with Medicare providers to achieve positive health outcomes for Medicare eligible Members.

Holistic treatment requires integration of physical health with behavioral health to improve the overall health of an individual. Members may be receiving care from multiple health care entities. Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a person. For this reason, communication and coordination of care between providers, PCPs, and Medicare providers must occur on a regular basis to ensure safety and positive clinical outcomes for persons receiving care. For The Health Plan enrolled persons not eligible for Title XIX/XXI coverage, coordination and communication should occur with any known health care provider(s).

13.3.1 Coordinating Care with AHCCCS Health Plans

The Health Plan employs Transitions Coordinators to manage all coordination with other Health Plans for members who receive their medical services through an AHCCCS health plan and behavioral health services through the RBHA/Health Plan (e.g. ALTCS, DDD, CMDP). Their role is to respond to coordination of care inquiries from AHCCCS Health Plans, primary care providers (PCPs) and other involved clinicians to facilitate clinical coordination of care. When coordinating care with the person's PCP, Medicare provider or other health care provider, information must be disclosed in accordance with **Section 9.6.1 - Disclosure of Health Information**.

The following procedures, however, will assist providers in coordinating care with AHCCCS Health Plans:

- If the identity of the person's primary care provider (PCP) is unknown, a provider must contact the Acute Health Plan and Provider Coordinator(s) for The Health Plan or the Behavioral Health Coordinator of the person's designated health plan to determine the name of the person's assigned PCP. See the **AMPM AHCCCS Contracted Health Plans** for contact information for the Behavioral Health Coordinators for each AHCCCS Health Plan;
- The Health Plan enrolled persons who have never contacted their PCP prior to entry into the behavioral health system should be encouraged to seek a baseline medical evaluation. The Health Plan enrolled persons should also be prompted to visit their PCP for routine medical examinations annually or more frequently if necessary;
- Providers should request medical information from the person's assigned outpatient provider. Examples include current diagnosis, medications, pertinent laboratory results, last PCP visit, Early Periodic Screening, Diagnosis and Treatment (EPSDT) screening results and last hospitalization. A sample request form that may be utilized for this purpose (see **Provider Manual Form 4.3.1, Request for Information from PCP or Medicare Provider** which can be obtained by calling the Provider Services Call Center at 866-796-0524). If the PCP does not respond to the request, contact the health plan's Behavioral Health Coordinator for assistance; and
- Providers must address and attempt to resolve coordination of care issues with AHCCCS Health Plans and outpatient providers at the lowest possible level. If problems persist, contact the Health Plan Coordinator by calling 866-796-0542 and ask to be connected with the designated The Health Plan Coordinator.

13.3.2 Acute Health Plan and Provider Coordinator

The Health Plan has designated an Acute Health Plan and Provider Coordinator who gathers, reviews, and communicates clinical information requested by PCPs, Acute Care Plan Behavioral Health Coordinators and other treating professionals or involved stakeholders.

The Health Plan maintains a designated and published phone number to contact the Acute Health Plan and Provider Coordinator and has a clearly recognized prompt on an existing phone number that facilitates prompt access to the Acute Health Plan and Provider Coordinator that is staffed during business hours.

The Health Plan Acute Health Plan and Provider Coordinators receive training which includes, at a minimum, the following elements:

- Provider inquiry processing and tracking (including resolution timeframes);
- Health Plan procedures for initiating provider contracts or AHCCCS provider registration;
- Claim submission methods and resources (see **Section 7.3 - Submitting Claims and Encounters to the RBHA/Health Plan**);
- Claim dispute and appeal procedures (**Section 8.6- Provider Claims Disputes**); and
- Identifying and referring quality of care issues.

The Health Plan utilizes the following training modules that providers are required to complete, in order to understand the above listed elements:

- Provider Performance Improvement;
- Claims and Encounters;
- Notice of Action (NOA) and Grievance and Appeals;
- Quality of Care; and
- Overview of RBHA, AHCCCS and The Health Plan.

In addition, The Health Plan meets quarterly with other Health Plans to identify barriers or issues that exist within the delivery of care system for health plan Members and behavioral health enrolled Members.

13.3.3 Sharing Information with PCPs, AHCCCS Health Plans, Other Treating Professionals, and Involved Stakeholders

To support quality medical management and prevent duplication of services, providers are required to disclose relevant behavioral health information pertaining to Title XIX/XXI eligible persons to the assigned Outpatient Provider, AHCCCS Health Plans, other treating professionals and other involved stakeholders within the following required timeframes:

- “Urgent” – Requests for intervention, information, or response within 24 hours; and
- “Routine” – Requests for intervention, information, or response within 10 days.

13.3.3.1 ***Coordination of Care for Members with a Serious Mental Illness***

For all Members referred by the Outpatient Provider and determined to have a Serious Mental Illness and/or a diagnosis of a chronic medical condition on Axis III, the following information must be provided to the person's assigned Outpatient Provider:

- The Member's diagnosis;
- Critical lab results as defined by the laboratory and prescribed medications; and
- Changes in class of medications.

Providers with the assistance of The Health Plan must provide the required information annually, and/or when there is a significant change in the person's diagnosis and/or prescribed medications.

Providers are required to pro-actively coordinate behavioral health and medical care for Members with a Serious Mental Illness and/or a diagnosis of a chronic medical condition on Axis III. This includes helping Members identify their health and wellness goals, include those goals in the Members' Individualized Service Plans, and coordinating with medical professionals to help Members achieve those goals.

13.3.3.2 ***Coordination of Care for Title XIX/XXI Members***

For all Title XIX/XXI enrolled persons, providers are required to:

- Notify the assigned Outpatient Provider of the results of PCP initiated behavioral health referrals;
- Provide a final disposition to the health plan Behavioral Health Coordinator in response to PCP initiated behavioral health referrals, (for more information on the referral process, see **Section 12.3 – Referral and Intake Process**);
- Coordinate the placement of persons in out-of-state treatment settings as described in **Section 12.13 - Out-of State Placement for Children and Young Adults**;
- Notify, consult with, or disclose information to the assigned PCP regarding persons with Pervasive Developmental Disorders and Developmental Disabilities, such as the initial assessment and treatment plan and care and consultation between specialists;
- Provide a copy to the PCP of any executed advance directive, or documentation of refusal to sign an advance directive, for inclusion in the Member's medical record; and
- Notify, consult with, or disclose other events requiring medical consultation with the person's PCP.

Upon request by the PCP or Member, information for any enrolled Member must be provided to the PCP consistent with requirements outlined in **Section 9.6.1 - Disclosure of Health Information**.

When contacting or sending any of the above referenced information to the person's PCP, providers must provide the PCP with an agency contact name and telephone number in the event the PCP needs further information.

Provider Manual Form 4.3.2, Communications Document can be used for coordinating care with the AHCCCS Health Plan PCP or Behavioral Health Coordinator. The form includes the required elements for coordination purposes and must be completed in full for coordination of care to be considered to occur. For complex problems, direct provider-to-provider contact is recommended to support written communications. This form can be obtained by calling the Provider Services Call Center at 866-796-0542.

Provider Manual Form 4.3.2, Communications Document will not have to be used if there is a properly documented progress note. To be considered properly documented the progress note must:

- Include a header that states “Coordination of Care”;
- Be legible; and
- Include all of the required elements contained in **Provider Manual Form 4.3.2, Communications Document**.

13.3.4 **Responsibility for Fee-for-Service Persons**

The Health Plan provides fee-for-service services to Title XIX/XXI eligible persons not enrolled with an AHCCCS Health Plan. The Health Plan provides all inpatient emergency services for fee-for-service persons with psychiatric or substance abuse diagnoses. The Health Plan provides services to tribal Title XIX/XXI eligible persons referred by an Indian Health Services (IHS) or tribal facility for emergency services rendered at non-IHS facilities.

13.3.5 **Responsibility for Persons Enrolled in an AHCCCS Health Plan**

Services which may have been covered by the AHCCCS Health Plan Contractor for Prior Period Coverage will now be the responsibility of The Health Plan. This is limited to the services only after the individual has been medically cleared. The Health Plan Contractor is still obligated to provide all necessary medical services.

The rules below apply for other areas of coverage.

13.3.5.1 ***Pre-Petition Screenings and Court Ordered Evaluations***

The Health Plan works closely with each county to collaborate regarding pre-petition screenings and court ordered evaluations. Payment for pre-petition screenings and court ordered evaluations are the responsibility of the county except for Pima County. The Health Plan facilitates and pays for pre-petition screenings in Pima County. The Health Plan develops protocols with each county to effectively coordinate crisis services. The Health Plan contracted providers are required to adhere to the county crisis protocols and facilitate constructive collaboration to meet the needs of members in each county. The county protocols can be located on The Health Plan website www.azcompletehealth.com

13.3.5.2 ***Emergency Behavioral Health Services***

When a Title XIX/XXI eligible person presents in an emergency room setting, the person's AHCCCS Health Plan is responsible for all emergency medical services including triage, physician assessment, and diagnostic tests.

The Health Plan, or when applicable, its designated behavioral health provider, is responsible for psychiatric and/or psychological evaluations in emergency room settings provided to all Title XIX/XXI persons enrolled with The Health Plan.

The Health Plan is responsible for providing all non-inpatient emergency services to Title XIX/XXI eligible persons. Examples of non-inpatient emergency services include assessment, psychiatric evaluation, mobile crisis, peer support and counseling⁵.

The Health Plan is responsible for providing all inpatient emergency services to persons with psychiatric or substance abuse diagnoses for all Title XIX/XXI eligible persons.

Emergency transportation of a Title XIX/XXI eligible person to the emergency room (ER) when the person has been directed by The Health Plan or a The Health Plan provider to present to this setting in order to resolve a behavioral health crisis is the responsibility of The Health Plan. The Health Plan or its provider directing the person to present to the ER must notify the emergency transportation provider of The Health Plan and fiscal responsibility for the service.

Emergency transportation of a Title XIX/XXI eligible person required to manage an acute medical condition, which includes transportation to the same or higher level of care for immediate medically necessary treatment, is the responsibility of the person's AHCCCS Health Plan.

For information on emergency services for Non-Title XIX/XXI persons see **Section 2.8, Crisis Intervention Services**.

13.3.5.3 ***Non-Emergency Behavioral Health Services***

For Title XIX/XXI eligible persons, The Health Plan is responsible for the provision of all non-emergency services.

If a Title XIX/XXI eligible person is assessed as needing inpatient psychiatric services by The Health Plan or its provider prior to admission to an inpatient psychiatric setting, The Health Plan is responsible for authorization and payment for the full inpatient stay, as per **Section 4.1 - Securing Services and Prior Authorization**.

When a medical team or health plan requests a behavioral health or psychiatric evaluation prior to the implementation of a surgery, medical procedure, or medical therapy to determine if there are any behavioral health contraindications, The Health Plan is responsible for the provision of this service. Surgeries, procedures, or therapies can include gastric bypass, interferon therapy or other procedures for which behavioral health support for a patient is indicated.

⁵ Note: in inpatient settings, these services would be included in the per diem rate.

13.3.5.4 ***Non-Emergency Transportation***

Transportation of a Title XIX/XXI eligible person to an initial behavioral health intake appointment is the responsibility of The Health Plan.

13.3.5.5 ***Medical Treatment for Persons in Behavioral Health Treatment Facilities***

When a Title XIX/XXI eligible person is in a behavioral health residential treatment center and requires medical treatment, the AHCCCS Health Plan is responsible for the provision of covered medical services.

If a Title XIX/XXI eligible person is in a behavioral health inpatient facility and requires medical treatment, those services are included in the per diem rate for the treatment facility. If the person requires inpatient medical services that are not available at the behavioral health inpatient facility, the person must be discharged from the psychiatric facility and admitted to a medical facility. The AHCCCS Health Plan is responsible for medically necessary services received at the medical facility, even if the person is enrolled with The Health Plan.

13.3.6 **Primary Care Providers (PCPs) Prescribing Psychotropic Medications**

Within their scope of practice and comfort level, an AHCCCS Health Plan PCP may elect to treat select behavioral health disorders. The select behavioral health disorders that AHCCCS Health Plan PCPs can treat are:

- Attention-Deficit/Hyperactivity Disorder;
- Uncomplicated depressive disorders; and
- Anxiety disorders.

13.3.6.1 ***The “Agreed Conditions”***

Certain requirements and guiding principles regarding medications for psychiatric disorders have been established for persons under the care of both a health plan PCP and behavioral health provider simultaneously. The following conditions apply:

- Title XIX/XXI eligible persons must not receive medications for psychiatric disorders from the health plan PCP and provider simultaneously. If a person is identified to be simultaneously receiving medications from the health plan PCP and behavioral health provider, the provider must immediately contact the PCP to coordinate care and agree on who will continue to medically manage the person’s behavioral health condition.
- Medications prescribed by providers within The Health Plan system must be filled by The Health Plan subcontracted pharmacies under The Health Plan pharmacy benefit (see exceptions to this requirement for dual eligible persons in **Section 13.3.7 - Coordination of Care with Medicare Providers**). This is particularly important when the pharmacy filling the prescription is part of the subcontracted pharmacy network for both the prescribing provider and the person’s AHCCCS Health Plan. The Health Plan and its providers must take active steps to ensure that prescriptions written by providers within The Health Plan system are not charged to the person’s AHCCCS Health Plan.

13.3.6.2 ***One-Time Face-to-Face Psychiatric Evaluations***

Providers must be available to conduct a face-to-face evaluation with a Title XIX/XXI eligible person upon the PCPs request in accordance with **Section 12.2 - Appointment Standards and Timeliness of Service**.

A one-time face-to-face evaluation is used to answer PCPs specific questions and provide clarification and evaluation regarding a person's diagnosis, recommendations for treatment, need for behavioral health care, and/or ongoing behavioral health care or medication management provided by the PCP.

The PCP must have seen the person prior to requesting a one-time face-to-face psychiatric evaluation with the behavioral health provider.

AHCCCS Health Plan PCPs must be provided current information about how to access psychiatric consultation services. The Health Plan Customer Care Department maintains all current information on how to access psychiatric consultation services in The Health Plan geographic service area. Customer Care can be contacted by calling 888-788-4408. The Health Plan is obligated to offer general consultations and one-time face-to-face psychiatric evaluations and must provide direct and timely access to behavioral health medical practitioners (physicians, nurse practitioners and physician assistants) or other behavioral health practitioners if requested by the PCP.

For additional information on how to obtain a one-time consultation for the evaluation and diagnosis of Autism Spectrum Disorder, please reference **Provider Manual Section 12.3.13**.

13.3.7 **Coordination of Care with Medicare Providers**

13.3.7.1 ***Medicare Advantage Plans***

Medicare health plans, also known as Medicare Advantage (MA) plans, are managed care entities that have a Medicare contract with the Centers for Medicare and Medicaid Services (CMS) to provide services to Medicare beneficiaries. MA plans provide the full array of Medicare benefits, including Medicare Part A, hospital insurance, and Medicare Part B, medical insurance. As of January 1, 2006, MA plans also included Medicare Part D, prescription drug coverage.

Many of the AHCCCS Contracted Health Plans are MA plans. These plans provide Medicare Part A, Part B and Part D benefits in addition to Medicaid services for dual eligible persons and are referred to as Medicare Advantage- Prescription Drug/Special Needs Plans.

The Health Plan offers a Medicare Advantage Dual Eligible Special Needs Plan through University of Arizona Health Plans, University Care Advantage.

13.3.7.2 ***Medicare Fee-for-Service Program***

Instead of enrolling in a Medicare Advantage plan, Medicare eligible Members may elect to receive all Medicare services (Parts A, B and/or D) through any provider authorized to deliver

Medicare services. Therefore, Members in the Medicare Fee-for-Service program may receive services from Medicare registered providers in The Health Plan provider network.

13.3.7.3 *Inpatient Psychiatric Services*

Medicare has a lifetime benefit maximum for inpatient psychiatric services. The Health Plan's cost sharing responsibilities and billing for inpatient psychiatric services must be in accordance with **Section 7.23 - Third Party Liability and Coordination of Benefits**, and **Section 7.3 - Submitting Claims and Encounters to The Health Plan**.

The Health Plan requires all contracted providers to bill all third parties prior to billing The Health Plan. The Health Plan is the payer of last resort. When a member has primary insurance through another Health Plan and The Health Plan has been notified of the member's admission to the hospital, The Health Plan will coordinate with that other Health Plan. The Health Plan will coordinate with the hospital staff to ensure that member's needs upon discharge are coordinated and meet their needs.

13.3.7.4 *Outpatient Behavioral Health Services*

Medicare provides some outpatient services that are also State covered services. The Health Plan cost sharing responsibilities and billing for outpatient services must be in accordance with **Section 7.22 - Third Party Liability and Coordination of Benefits** and **Section 7.3 - Submitting Claims and Encounters** to The Health Plan.

The Health Plan requires all contracted providers to bill all third parties prior to billing The Health Plan. The Health Plan is the payer of last resort.

13.3.7.5 *Prescription Medication Services*

Medicare eligible Members must enroll in a Medicare Part D Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD) to receive the Part D benefit. PDPs only provide the Part D benefit and any Medicare registered provider may prescribe medications to Members enrolled in PDPs. Some MA-PDs may contract with RBHA/Health Plans or their providers to provide the Part D benefit to Medicare eligible Members.

While PDPs and MA-PDs are responsible for verifying prescription drug coverage to Members enrolled in their plans, there are some prescription medications that are not included on plan formularies (non-covered) or are excluded Part D drugs. The RBHA/Health Plan is responsible for covering non-covered or excluded Part D behavioral health prescription medications listed on the RBHA/Health Plan formulary, in addition to Part D cost sharing, in accordance with **Section 7.23 - Third Party Liability and Coordination of Benefits**.

13.4 Coordination of Care with Other Governmental Entities

Effective communication and coordination of services are fundamental objectives for providers when serving Members involved with other government entities. When providers coordinate care efficiently, the following positive outcomes can occur:

- Duplicative and redundant activities, such as assessments, service plans, and agency meetings are minimized;
- Continuity and consistency of care are achieved;
- Clear lines of responsibility, communication, and accountability across service providers in meeting the needs of the Member and family are established and communicated; and
- Limited resources are effectively utilized.

The Health Plan recognizes the importance of a responsive behavioral health system, especially when the needs of vulnerable Members have been identified by other government entities. For example, the State strongly supports the timely response and coordination of services for children who have been, or imminently will be, removed from their homes by the Arizona Department of Child Safety (see **Section 12.2 - Appointment Standards and Timeliness of Service**). The State expects all providers to collaborate and provide any necessary assistance when DCS initiates requests for covered services or supports.

The intent of this Section is to communicate The Health Plan's expectations for providers who must cooperate and actively work with other agencies serving Members. The Health Plan expects any system partner involved with a member to be invited to Child and Family Team (CFT)/Interdisciplinary Care Team (ICT) meetings.

AHCCCS has Intergovernmental Agreements (IGAs), Interagency Service Agreements (ISAs), and Memorandums of Understanding (MOUs) with several State, county, tribal, and local agencies to collaborate while serving Members involved with multiple systems. The Health Plan and The Health Plan contracted providers are required to adhere to the applicable provisions of the IGAs, ISAs and MOUs.

In addition, providers are required to adhere to collaborative protocols established between The Health Plan, the community and the state stakeholders. These protocols can be accessed at www.azahcccs.gov

13.4.1 Department of Child Safety (DCS)

When a child Member receiving services is also receiving services from DCS, the provider must work toward effective coordination of services with the DCS Specialist. Providers are expected to provide 72 Hour Rapid Response in accordance with **Provider Manual Section 6.2.1, 72-Hour Rapid Response Requirements** coordination of care and services in accordance with The Health Plan's **Department of Child Safety Collaborative Protocol**.

ADES Arizona Families F.I.R.S.T. (Families in Recovery Succeeding Together) Program

Providers must ensure coordination for parents/families referred through the Arizona Families F.I.R.S.T (AFF) program (see **Provider Manual Attachment 4.4.1 Arizona Families F.I.R.S.T. Program Model and Referral Process**).

The AFF program provides expedited access to substance abuse treatment for parents and caregivers referred by Department of Child Safety and the ADES/ Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the

program with ADES (see [A.R.S. § 8-881](#)). The Health Plan providers who are contracted with AFF are required to:

- Accept referrals for Title XIX/XXI eligible and enrolled Members and families referred through AFF;
- Accept referrals for Non-Title XIX and Non-Title XXI persons and families referred through AFF and provide services, if eligible;
- Ensure that services made available to persons who are Non-Title XIX and Non-Title XXI eligible are provided by maximizing available federal funds before expending State funding as required in the Governor’s Executive Order 2008 -01;
- Collaborate with ADES/DCS, the ADES Family Assistance Administration (FAA) Jobs Program and Substance Use Treatment providers to minimize duplication of assessments and achieve positive outcomes for families; and
- Develop procedures for collaboration in the referral process to verify effective service delivery through The Health Plan. Appropriate authorizations to release information must be obtained prior to releasing information.

The Health Plan and the Department of Child Safety (DCS) Central, Southeast and Southwest Districts have combined efforts to establish a mutually agreed upon protocol to verify effective and efficient delivery of behavioral health services. “Collaborative Protocol between The Health Plan, Behavioral Health of Arizona and the Department of Child Safety (DCS)” defines the respective roles and responsibilities of each party.

The goal of the AFF Program is to promote permanency for children, stability for families, protect the health and safety of abused and/or neglected children and promote economic security for families. Substance abuse treatment for families involved with DCS must be family centered, provide for sufficient support services and must be provided in a timely manner (see **Section 12.2 – Appointment Standards and Timeliness of Service** and **Section 12.10 - Special Populations**).

13.4.2 Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities

AHCCCS has delegated the functions and responsibilities as a State Placing Agency to The Health Plan for Members in The Health Plan’s Geographic Service Areas. The Health Plan works in collaboration with the ADE for the placement of children with behavioral health service providers.

Providers serving children can gain valuable insight into an important and substantial element of a child’s life by soliciting input from school staff and teachers. Providers can collaborate with schools and help a child achieve success in school by:

- Working in collaboration with the school and sharing information to the extent permitted by law and authorized by the child’s parent or legal guardian (see **Section 9.6.1 - Disclosure of Health Information**);
- For children receiving special education services, actively consider information and recommendations contained in the Individual Education Plan (IEP) during the

ongoing assessment and service planning process (see **Section 12.5, Assessment and Service Planning**);

- For children receiving special education services, ensuring that the provider or designee participates with the school in developing the child's IEP and share the behavior treatment plan interventions, if applicable;
- Inviting teachers and other school staff to participate in the CFT if agreed to by the child and legal guardian;
- Having a clear understanding of the Individualized Education Plan (IEP) requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004;
- Ensuring that students with disabilities who qualify for accommodations under 504 of the Rehabilitation Act of 1973 are provided adjustments in the academic requirements and expectations to accommodate their needs and enable them to participate in the general education program; and
- Ensuring that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

13.4.3 Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD)

Persons qualifying for services through DDD can fall into several different categories based on their eligibility status and the extent of their diagnosed disability. There are three general groupings:

Type of DDD Eligibility	What services are available?	Who is responsible for providing the services?
Title XIX/XXI and eligible for ALTCS	All Title XIX/XXI covered services	The Health Plan and providers
Title XIX/XXI and not eligible for ALTCS	All Title XIX/XXI covered services	The Health Plan and providers
Non-Title XIX	Services available through special funding (i.e. Substance Abuse Block Grant, Non-Title XIX SMI funds)	The Health Plan and providers receiving special funding

Providers must ensure effective coordination of services with Members receiving services through DDD as outlined in the **Collaborative Protocol between The Health Plan and DDD**.

13.4.3.1 Consultation and Clinical Intervention Program Requirements

To enhance collaboration efforts between The Health Plan and DDD, and meet the need of members often at greatest risk of placement disruption or institutionalization due to behavioral issues, the Consultation and Clinical Intervention (CCI) program was developed in compliance

with [AHCCCS AMPM, Policy 570, Community Collaborative Care Teams](#). For more information about the Consultation and Clinical Intervention (CCI) Program, reference **Provider Manual Attachment 4.4.2, Consultation and Clinical Intervention Program Requirements**. Which can be obtained by calling the Provider Services Call Center at 866-796-0542, if needed.

13.4.4 Department of Economic Security/Arizona Early Intervention Program (ADES/AzEIP).

Providers can work toward effective coordination of care for children identified as having, or likely having, disabilities or developmental delays by:

- Ensuring that children birth to three years of age are referred to AzEIP in a timely manner when information obtained in their behavioral health assessment reflects developmental concerns;
- Ensuring that children found to require services as part of the AzEIP evaluation process receive appropriate and timely service delivery (see **Section 12.2 – Appointment Standards and Timeliness of Service**);
- Ensuring that, if an AzEIP team has been formed for the child, the provider will coordinate team functions so as to avoid duplicative processes between systems; and
- Coordinating enrollment in The Health Plan's children's system of care when a child transfers to the children's DDD system.

13.4.5 Courts and Corrections

The Health Plan and its providers are expected to collaborate and coordinate care for Members involved with:

- The Arizona Department of Corrections (ADC);
- Arizona Department of Juvenile Corrections (ADJC); or
- Administrative Offices of the Court (AOC).

When a Member receiving services is also involved with a court or correctional agency, providers work towards effective coordination of services by:

- Working in collaboration with the appropriate staff involved with the Member;
- Inviting probation or parole members to participate in the development of the ISP and all subsequent planning meetings as members of the Member's clinical team with Member's approval;
- Actively considering information and recommendations contained in probation or parole case plans when developing the ISP; and
- Ensuring that the provider evaluates and participates in transition planning prior to the release of eligible Members and arranges and coordinates care upon the person's release (see **Section 12.3 – Referral and Intake Process**). For a copy of the Criminal Justice Release of Information Form, see Form 4.4.6 Authorization for Use or Disclosure of Protected Health Information – Criminal Justice System Referral.

Criminal Justice Reach-In Care Coordination Program and the Arizona Department of Corrections:

- The Health Plan staff will receive a notification when a member meeting Reach-In criteria is identified as nearing release. The Health Plan staff will schedule the member's Intake and Assessment appointment via MyHealthDirect (The Health Plan's provider office scheduling vendor) to occur within seven days post release with the member's chosen Health Home.
- The provider shall conduct the Intake and Assessment appointment. During the Intake and Assessment appointment, the provider must educate the member on the benefits of peer support and submit an automatic referral for peer support services through a Health Home or Specialty Provider, if the member consents.
- The provider shall schedule an ART meeting to occur within 10 days post release. With authorization from the member, the provider must make every attempt to include The Health Plan's Care Coordinator, probation/parole officer and other partners the provider identifies as supports to participate in the ART meeting.
- If transportation assistance is required for the member to attend any of the appointments, the provider must coordinate and provide for the transportation. The provider must provide coordination and services for both behavioral and physical health.
- If the member does not appear for a scheduled appointment/service, the provider must attempt to contact the member no fewer than three times. Attempts must be assertive and not simply a phone call, but documented in person attempts and other avenues utilized for communication. For those members identified as not attending the required 7 day appointment, provider must coordinate with The Health Plan's Justice Team to identify and document the reason for the missed appointment.
- The provider must continue to engage the member and provide services identified on the Individualized Service Plan (ISP).

13.4.6 Arizona County Jails

When someone detained in jail is believed by jail personnel to have a behavioral health diagnosis and the person does not have alternative means to obtain services, jail personnel may request the assistance of The Health Plan's contracted providers to coordinate care as outlined below. In addition, The Health Plan's Health Home Providers are required to proactively assist persons detained in jail who are determined to have, or perceived to have, a Serious Mental Illness (see **Section 4.6.4 - SMI Eligibility Determination**). Health Home Providers are required to accept all requests for Coordination of Care assistance from county jails and perform the following duties:

- Timely and proactively collaborate with the appropriate jail and court staff involved with the Member;
- Proactively ensure that screening, assessment, and coordination of care services are provided;
- Upon receiving notification of a member being detained (either through a phone call or through a data feed), Health Homes are required to provide the list of prescribed medications to the respective Detention Center Health Care Provider within 24

hours of notification; Provide consultation services to advise jail staff related to diagnosis, medications, and the provision of other behavioral health services to jailed Members upon request;

- Verify that the Member has a viable release plan, that includes access to medications, peer support services, counseling, transportation, and housing;
- Facilitate continuity of care if the Member is discharged or incarcerated in another correctional institution;
- Share pertinent information with all staff involved with the Member's care or incarceration with Member approval and in accordance with **Section 9.6.1 - Disclosure of Health Information**. For a copy of the Criminal Justice Release of Information Form, see Form 4.4.6 Authorization for Use or Disclosure of Protected Health Information – Criminal Justice System Referral.; and
- Provide assistance in the determination of whether the Member is eligible for Mental Health Court or a Jail Diversion Program.
- Assure systems and processes are designed for discussion with detention and detention healthcare staff of services and resources needed for individuals to safely transition into the community upon release from jail if those individuals are designated as seriously mentally ill (SMI) or are categorized as General Mental Health (GMH) and/or substance abuse and have one or more of the following complicated/high cost medical needs: skilled nursing facility level of care, continuous oxygen, invasive treatment for cancer, kidney dialysis, home health services (i.e., infusions, wound vacs), terminal hospice care, HIV positive, pregnant, insulin dependent diabetic, or seizure disorder.

Criminal Justice Reach-In Care Coordination Program and the County Detention Centers:

- Providers will be notified weekly when a member meeting Reach-In criteria is identified as nearing release from a detention center. Notification will include members in active care and members not currently in an active status (inactive). The Health Plan's contracted provider Jail Liaisons will serve as the hub for Reach-In coordination and receive a weekly list of all eligible Reach-In members. The Jail Liaisons will meet with each member in person, when permissible by the detention center, within five business days of notification that a member is nearing release. If an in person meeting is not permissible by the detention center, the Jail Liaisons must meet with the member via video conference and within five business days.
- During the in person meeting, the Jail Liaisons will work diligently to engage the member into services to include: Provide education regarding behavioral health services; discuss the importance of physical health services; discuss services available such as peer support, housing, employment and other resources available; provide appointment scheduling and health plan information, if applicable; and education on the importance of obtaining medications or prescriptions and discharge plan from detention center treating provider. The Jail Liaisons will schedule the members Intake and Assessment appointment via MyHealthDirect to occur within seven days post release with the members chosen Health Home.
- The provider shall conduct the Intake and Assessment appointment. During the Intake and Assessment appointment, the provider must educate the member on the

benefits of peer support and submit an automatic referral for peer support services through a Health Home or Specialty Provider, if the member consents.

- The provider shall schedule an ART meeting to occur within 10 days post release. With authorization from the member, the provider must make every attempt to include The Health Plan's Care Coordinator, probation/parole officer and other partners the provider identifies as supports to participate in the ART meeting.
- If transportation assistance is required for the member to attend any of the appointments, the provider must coordinate and provide for the transportation. The provider must provide coordination and services for both behavioral and physical health.
- If the member does not appear for a scheduled appointment/service, the provider must attempt to contact the member no fewer than three times. Attempts must be assertive and not simply a phone call, but documented in person attempts and other avenues utilized for communication. For those members identified as not attending the required 7 day appointment, provider must coordinate with The Health Plan's Justice Team to identify and document the reason for the missed appointment.
- The provider must continue to engage the member and provide services identified on the Individualized Service Plan.

For additional information or assistance regarding providing coordination services to incarcerated Members, contact the Court Liaison at 866-495-6738.

13.4.7 Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

The purpose of RSA is to work with individuals with disabilities to achieve increased independence or gainful employment through the provision of comprehensive rehabilitative and employment support services.

Supportive employment services available through the AHCCCS system are distinct from vocational services available through RSA. Please refer to the AHCCCS Covered Behavioral Health Services Guide for more details.

When a Member determined to have a Serious Mental Illness is receiving services and is concurrently receiving services from RSA, the provider ensures effective coordination of care by:

- Working in collaboration with the vocational rehabilitation (VR) counselors or employment specialists in the development and monitoring of the Member's employment goals;
- Ensuring that all related vocational activities are documented in the comprehensive clinical record (see **Section 9.2 - Medical Record Standards**);
- Inviting RSA staff to be involved in planning for day programming to ensure that there is coordination and consistency with the delivery of vocational services;
- Participating and cooperating with RSA in the development and implementation of a Regional Vocational Service Plan; and

- Allocating space and other resources for Vocational Rehabilitation (VR) counselors or employment specialists working with enrolled Members who have been determined to have a Serious Mental Illness.

13.4.8 Arizona Department of Health Services/Office of Assisted Living Licensing

When a Member receiving services is residing in an assisted living facility, providers must coordinate with the Office of Assisted Living Licensing to ensure that the facility is licensed and that there are no existing violations or legal orders. Providers must also determine and verify that the Member living in an assisted living facility is at the appropriate level of care. The provider can coordinate with the Office of Assisted Living Licensing to determine the level of care that a particular assisted living facility is licensed to provide.

13.4.9 First Responders and Community Agencies

The Health Plan and its providers proactively collaborate with municipal first responders: police, fire, Emergency Medical Services (EMS) and community agencies, such as: acute AHCCCS health plans and hospital emergency departments. Providers are expected to develop strong, effective relationships with first responders and community agencies in the communities they serve. Further information and assistance in engaging with first responders and community agencies may be obtained by contacting The Health Plan's Justice System and System Partner Relations Department at 866-495-6738.

13.4.10 Veterans Administration

The Veteran's Administration (VA) is a federally funded health system that provides benefits to qualified persons who served in the active military, naval, or air service, and who were discharged or released under conditions other than dishonorable (Congressional Research Center, 2012). The Health Plan's Members with Veterans benefits can receive services from The Health Plan's contracted providers. Veterans who are eligible for VA services have a choice from whom they receive services. Veterans can receive mental and/or physical health benefits through The Health Plan's network or they may receive mental and/or physical health services through the VA, or medication only from one or the other, or any combination thereof. The Health Plan and its contracted providers are responsible to work collaboratively with the VA to share information and coordinate care.

13.4.11 Indian Health Services

Indian Health Services (IHS) is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaskan Natives. Individuals who are eligible for IHS benefits through an IHS provider or 638 licensed facility and are eligible to receive services from The Health Plan's contracted providers have a choice in whom they prefer to receive services. American Indian and Alaskan Natives can receive mental health benefits through The Health Plan's network and physical health services through the IHS, or medication only from one or the other, or any combination thereof. The Health Plan and its contracted providers are responsible to work collaboratively with IHS to share information and coordinate care. See **Section 13.1 - Transition of Persons** for more information.

13.5 Partnerships with Families and Family-Run Organizations in the Children's Behavioral Health System

Arizona holds a distinction in the United States for promoting various family roles within the children's behavioral health system. The involvement of families is credited as making a significant contribution in improving the service system. Providers should reference [AHCCCS Practice Protocol, Family and Youth Involvement in the Children's Behavioral Health System](#) found on the AHCCCS website.

13.6 Warm Line Provider Program

A Warm Line is a peer-run support line designed to help members manage life stressors. Warm lines are required to provide support through listening and offer resources to support members in the development of natural supports and independence, as appropriate.

13.6.1 Service Requirements

Warm line providers must follow these requirements:

- Be widely publicized within the covered service area;
- Be staffed with a sufficient number of peers to manage the Warm Line call volume and comply with the requirements of The Health Plan contract;
- Be answered within three (3) telephone rings, or within 15 seconds on average; and an average call abandonment rate of less than 3% each month;
- Be answered by a certified Peer Support staff person at a minimum Monday through Friday, 8:00 AM to 10:00 PM;
- Include the ability to triage calls, make referrals to appropriate resources, dispatch service providers and patch capabilities to and from 911 and crisis line providers as applicable;
- Offer interpretation or language translation services to members, including the deaf and hard of hearing;
- Warm Line staff must participate in all trainings and coordination meetings required or requested by the AHCCCS and/or The Health Plan;
- Warm Line staff must be trained in identifying crisis calls and transferring calls between systems.

13.6.2 Staff Requirements

Warm Line providers must follow these staffing requirements:

- Maintain adequate Peer Support staff to answer calls in a timely manner and document the resolution of calls;
- Maintain bilingual (Spanish/English) capability on all shifts and be able to effectively utilize interpreter services to facilitate Warm Line telephone peer support for all callers;

- Provide consistent clinical supervision to ensure services are in compliance with the Arizona Principles and all State supervision requirements.

Section 14 - SPECIFIC BEHAVIORAL HEALTH PROGRAM REQUIREMENTS

14.1 Urgent Engagement (UE) Program Requirements

Urgent Engagement is the process of engaging people into care who have experienced a crisis or have been admitted to an inpatient facility. It is intended to engage persons into care, rather than fulfilling an administrative function. The process includes ensuring effective coordination of care, engagement, discharge planning, a Serious Mental Illness (SMI) screening when appropriate (reference Provider Manual section 3.6), screening for eligibility, referral as appropriate, and prevention of future crises. Once the Health Home completes the urgent engagement process, the Health Home is the entity that is responsible for coordination of necessary service and discharge planning. Urgent Engagements are required to be started within one hour (at a Community Observation Center) or 24 hours (at a Behavioral Health Inpatient Facility).

14.1.1 Health Home Urgent Engagement Responsibility

Health Homes must accept referrals and requests for Urgent Engagements 24 hours a day and seven days a week. Providers are required to record, report and track completion of Urgent Engagements.

Urgent Engagement is a no wrong door approach and therefore, all persons are eligible, regardless of benefit or assigned health plan. If the member is enrolled with another health plan or private insurance, the Health Home role is to coordinate care with the current provider and health plan, determine the need for an SMI evaluation, and work directly with the health plan to ensure the member is receiving needed services and follow up. For persons who are not yet

enrolled in Medicaid, Block Grant programs or the Marketplace, Health Homes are required to continue to pursue coverage for the person for up to 45 days.

One Hour Urgent Engagements at a Community Observation Center (COC)

Every person who receives services at a Community Observation Center and is not in active care must be referred for urgent engagement. The Health Home must arrive within one hour of the request. Once a Health Home makes contact with the member, they are responsible for discharge planning for that member, including transportation and a follow up appointment. The urgent engagement at a COC should be an abbreviated intake in order to quickly gather the information needed. The engagement process can be completed in a follow up appointment (preferably within the next 24-48 hours).

24-hour Urgent Engagements at a Behavioral Health Inpatient Facility (BHIF)

Every person who lives in The Health Plan covered service area and is hospitalized at a Behavioral Health Inpatient Facility for psychiatric reasons, and is not in active care with a Health Home, is eligible for an urgent engagement. The Health Home has 24-hours to arrive at the facility and complete the Urgent Engagement assessment. In the event the individual is sleeping or otherwise unable to participate in the Urgent Engagement process, the Health Home shall reschedule the Urgent Engagement assessment within 24-hours and inform The Health Plan of the status.

The Health Home shall transmit the **Provider Manual Form 6.1.1 Urgent Response Disposition** form to AzCHSMIUE@azcompletehealth.com within 24-hours of completing assessment.

Provider Manual Form 6.1.1 Urgent Response Disposition can be obtained by calling the Provider Services Call Center at 866-796-0542.

24-hour Urgent Engagements at a Physical Health Inpatient Facility

Every person who lives in The Health Plan covered service area and is hospitalized at a Physical Health Inpatient Facility and is not in active care with a Health Home, is eligible for an urgent engagement assessment. Health Homes are required to arrive at the facility and complete the urgent engagement assessment within 24 hours of the request. In the event the individual is sleeping or otherwise unable to participate in the urgent engagement process, the Health Home shall reschedule the urgent engagement assessment within 24-hours and inform The Health Plan of the status.

24-hour SMI Evaluation at a Behavioral Health Facility (BHIF)

Every person who lives in a The Health Plan covered service area and is hospitalized at a Behavioral Health Inpatient Facility for psychiatric reasons, and is not in active care with a Health Home, and presents with a need for an SMI evaluation is eligible to be assessed for an SMI diagnosis.

The Health Home shall complete the Urgent Engagement assessment with 24-hours and transmit the **Provider Manual Form 6.1.1 Urgent Response Disposition** form to AzCHSMIUE@azcompletehealth.com within 24-hours of completing assessment.

The Health Home shall submit the SMI evaluation packet within seven days of the Urgent Engagement assessment to the designated SMI Evaluation provider, Community Response Network (CRN).

SMI Evaluation at the Arizona State Hospital (ASH)

The purpose of the SMI evaluation services for persons from The Health Plan geographic area admitted to ASH are for discharge planning. The Health Home has seven calendar days to complete the assessment and submit the **Provider Manual Form 6.1.1 Urgent Response Disposition** form to AzCHSMIUE@azcompletehealth.com within 24-hours.

Health Homes activated by the Urgent Engagement process are required to enroll members and non-eligible members *refusing* services during the COE process. Once the member is Court Ordered, the Health Home is required to proceed with engagement and service delivery; including, an SMI screening.

14.1.2 Capacity to Travel

Health Homes must maintain capacity to travel to locations within Arizona to complete Urgent Engagements.

14.1.3 Computer and Wireless Specifications

Health Homes must verify Urgent Engagement staff have access to a laptop, mobile printer and wireless web connectivity to allow access to electronic medical information in the field. The computer and wireless specifications meet or exceed The Health Plan requirements.

14.2 Comprehensive Medical and Dental Plan (CMDP) Eligible Children Involved with Department of Child Safety (DCS)

14.2.1 72-Hour Rapid Response Requirements for Children

Health Plan contracted Health Homes must complete a rapid response assessment within 72 hours of Health Plan activation for all children who are taken into the custody of DCS, regardless of Title XIX/XXI eligibility status.

Within 72-hours of the Health Plan Rapid Response dispatch, the Health Home must conduct a face-to-face visit with the child in their placement in order to:

- Complete an assessment to identify immediate safety needs and presenting problems of the child to stabilize behavioral health crises and to be able to offer immediate services the child may need;
- Provide behavioral health services to each child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term;
- Provide or arrange needed behavioral health services to each child's new caregiver, including guidance about how to respond to the child's immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in

responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health system;

- Ensure that each child and family is referred for ongoing behavioral health services as indicated by the assessment and service plan and ensure that services start within 21 days of the Rapid Response Assessment.
- Initiate the development of the Child and Family Team (CFT) for each child (see Child and Family Team Practice Tool); and
- Provide the DCS Specialist with written findings and recommendations for medically necessary covered services within 24 hours of Rapid Response assessment. This information shall be utilized during the initial Preliminary Protective Hearing, which occurs within 5 to 7 days of the child's removal. (See **Provider Manual Attachment 3.2.1, DCS Child Welfare Timelines and Provider Manual Attachment 6.1 Rapid Response Guidance Manual** which can be obtained by calling the Provider Services Call Center at 866-796-0524 for more information.

Additionally, Health Homes are expected to engage the family from which the child was removed within 5 days of the Rapid Response in order to engage them in the assessment process and invite them to participate in the Child and Family Team meeting. The Health Home is expected to help the parents identify appropriate services and support them in the enrollment process.

Health Homes are required to attend the Pre-Hearing Conference and Preliminary Protective Hearing to present their assessment and recommendations and continue to engage the family.

14.2.1.1 *Capacity to Travel*

Health Homes must maintain capacity to travel to locations within Arizona to complete a 72 Hour Rapid Response assessment.

14.2.1.2 *Tracking of Transfers*

When applicable following a Rapid Response, Health Homes must track the transfer of enrolled Members to other Health Plan contracted Health Homes through the Health Plan Provider Portal and continue providing coordination and treatment services until the receiving agency has fully accepted the transfer as indicated in the Provider Portal.

14.2.1.3 *Computer and Wireless Specifications*

Health Homes must verify Rapid Response staff have access to a laptop, mobile printer and wireless web connectivity to allow access to electronic medical information in the field. Computer and wireless specifications must meet or exceed Health Plan requirements. Ongoing Service Requirements for Comprehensive Medical and Dental Plan (CMDP) Eligible DCS Involved Children. Health Homes are expected to provide services for a period of at least six months following the Rapid Response assessment unless the Health Home receives a written request from the guardian or the DCS case closes.

14.2.2 Ongoing Service Requirements for CMDP Eligible DCS Involved Children

Behavioral Health Services for DCS involved children must stay open for at least six months following the Rapid Response assessment unless the Health Homes receives a written request from the guardian or DCS closes out the member.

DCS Involved Children must receive at least one service, identified on their service plan each calendar month.

Health Homes must ensure that services are provided to children within 21 days of the following:

- Rapid Response Assessment
- Initial/Intake Assessment
- Update of the Comprehensive Assessment
- Agreement of the Child Family Team

Health Homes are expected to participate in all court hearings as appropriate for members in their care.

Health Homes are required to coordinate care for all CMDP members who become detained in a county detention facility located outside of the Health Plan service area.

Health Homes are expected to engage the biological parents, foster parents, kinship parents and adoptive parents throughout the course of treatment. The purpose of this engagement is to engage the parents and caretakers in the assessment process and invite them to participate in the Child and Family Team meeting. The Health Home is expected to help the parents identify appropriate services and support them in the enrollment process.

When the DCS Specialist/Legal Guardian is not available, the Health Home must recognize the signature of the foster or kinship placement for the purpose of coordinating outpatient behavioral health services. Foster and kinship placements may sign a release of information, consent to treat, the service plan and other necessary documentation. If there is a disagreement between the placement and the DCS Specialist about services, the Legal Guardian/DCS Specialist shall make the final decision.

The DCS Specialist/Legal Guardian must be the one to sign a child in the legal custody of DCS in to a Home Care Training for the Home Care Client (HCTC), Behavioral Health Residential Facility (BHRF), Behavioral Health Inpatient Facility (BHIF), Brief Intervention Program (BIP) or a hospital.

14.2.3 Requirements of Jacobs Law/ ACOM Policy 449

14.2.3.1 Requirements of the Foster Care Hotline

NurseWise shall maintain a Foster Care Hotline for the specific purpose of answering calls about DCS involved children from Foster, Kinship and Adoptive Parents. The Foster Care Hotline shall be available 365/24/7 to meet the needs of the child and family.

Appropriate calls to the NurseWise Foster Care Hotline may include but are not limited to:

- Initiate a Rapid Response at the 73rd hour, not previously initiated by DCS
- Placement initiated Request for 72 Hour Out of Home Determination due to dangerous or threatening behaviors
- Request for Crisis Mobile team
- Request for referral to a Secondary Responder/Placement Stabilization Program

When a foster parent, kinship placement, group home or law enforcement official calls the Foster Care Hotline to initiate a Rapid Response, the Foster Care Hotline staff must immediately email the Health Plan Rapid Response Program at AzCHDCSRR@azcompletehealth.com and the DCS Child Services liaison.

14.2.3.2 ACOM Policy 449 Requires

The Foster Care Hotline is required to send out a Crisis Mobile Team if a foster, kinship or adoptive parent requests a 72 Hour Higher Level of Care Determination.

The Crisis Mobile Team shall determine if the child needs to go to a hospital, CRC or BIP to ensure the safety of the child while the team meets to determine further clinical needs of the child. If the CMT determines the child is safe to stay in the current environment, a safety plan must be developed prior to leaving the home.

The Crisis Mobile Team shall immediately inform the Health Home and The Health Plan CMDP Coordinators at the AzCHDCS@azcompletehealth.com email of the call and the need for an Emergency CFT.

The Health Home is required to have an Emergency CFT to identify the needs of the member and if appropriate follow the Health Plan process for securing the appropriate level of care for the member.

14.2.3.3 Crisis Response for DCS Involved Members and Adopted Children

When the NurseWise Crisis Line or Foster Care Hotline is called because the member is in crisis or is showing dangerous or threatening behaviors, a crisis mobile team shall be dispatched. Crisis Mobile Team providers are required to arrive within 2 hours of dispatch.

Crisis Mobile Teams that do not arrive within 2 hours are expected to call the Foster Care Hotline and report the missed timeframe

Nursewise is required to notify the DCS Child Services Liaison via email of any CMT dispatches that do not meet the 2 hour required response time.

All calls received by the NurseWise Foster Care Hotline must be tracked and reported to The Health Plan using Deliverable EC-301-25 Foster Care Hotline Call Report.

The EC-301.25 Foster Care Hotline Call Report is due the 10th of every month for the previous month.

14.3 Behavioral Health Respite Home Requirements

Behavioral Health Respite Home Providers must meet the requirements of AAC R9-10-1601.

14.3.1 Authorization and Continued Stay Requirements

Behavioral Health Respite Home providers must meet all prior authorization and continued stay requirements for Behavioral Health Supportive Homes as spelled out in this Provider Manual and as directed by The Health Plan.

14.4 Birth To Five Provider Program Requirements

Birth to Five providers must provide screening, assessment, service planning, interventions and practices specifically designed to meeting the unique needs of children age Birth to Five and their families. Providers are required to utilize the AHCCCS Practice Tools **“Working with the Birth to Five Population”** and **“Psychiatric and Psychotherapeutic Best Practices for Children Birth Through Five Years of Age”** (for additional guidance.

Birth to Five providers must demonstrate active participation in state, regional and community sponsored best practices development and committed to working to build community knowledge base and expertise.

14.5 Brief Intervention Provider Program Requirements

Brief Intervention Program providers must maintain an intensive treatment program to deliver services 24 hours a day, 7 days a week, 365 days a year with the purpose of helping persons live successfully in the community. Brief Intervention Program providers must deliver supportive and treatment services necessary to support the Member in the community and must verify access to the services 24 hours a day, 7 days a week, 365 days a year to respond to crises, as appropriate.

14.5.1 Staffing

Brief Intervention Program providers must provide adequate staffing to maintain the safety of the Members and protect them from harm.

14.5.2 Participation Limit

Brief Intervention Program providers must limit participation in the program to ten (10) days per episode. Members cannot be readmitted to a Brief Intervention Program within 72 hours of discharge from any Brief Intervention Program.

14.5.3 Coordination with Teams and Family

Brief Intervention Program providers must coordinate with treatment teams and family members, as appropriate, to verify continuity of care. Child and Family Teams/Adult Recovery Teams must be conducted within 72 business hours after admission. Each Brief Intervention Program provider must submit a report as indicated in **Section 16 – Deliverable Requirements**.

14.6 Consumer Operated Provider Program Requirements

Providers can be considered “Consumer Operated” if they comply with the requirements as outlined in the **SAMHSA Consumer Operated Services Evidence-Based Practices Kit**. Consumer Operated Providers can hold a behavioral health license from the Arizona Department of Health Services Division of Licensing, or in some situations can be certified as a Community Service Agency per **AHCCCS AMPM 961, Community Service Agency Title XIX Certification**. Community Service Agency Application forms can be found on the AHCCCS website at <https://www.azahcccs.gov/shared/MedicalPolicyManual/>.

14.7 Crisis Line Provider Program Requirements

14.7.1 General Requirements for Crisis Line providers

14.7.1.1 *Referrals*

Crisis Line providers must comply with the requirements outlined in **Provider Manual Section 14.13, Substance Use Disorder Treatment Requirements**.

14.7.1.2 *After Hours*

Crisis Line providers must maintain an administrator–on-call to address any after-hours, weekend or holiday concerns or issues.

14.7.1.3 *Services*

Services must be individualized to meet the needs of Members and families. Crisis Line providers must assess the Member's perspective on treatment progress, in order to verify that the Member's perspectives are honored and they are effectively engaged in treatment planning and in the process of care. Crisis Line providers must provide monitoring, feedback and follow up after crisis based on the changing needs of the individual. The family must be treated as a unit and included in the treatment process, when determined to be clinically appropriate. Crisis Line providers must obtain and document child, family and Member input in treatment decisions.

14.7.1.4 *Substance Use Disorders (SUD) Services*

Crisis Line providers providing SUD services must develop services that are designed to reduce the intensity, severity and duration of substance use and the number of relapse events, including a focus on life factors that support long-term recovery as appropriate.

14.7.1.5 *Coordination of Care*

Crisis Line providers must contact the Health Home following a member's utilization of crisis services. Crisis Line providers must verify coordination and continuity within and between service providers and natural supports to resolve initial crisis and to reduce further crisis episodes over time.

14.7.1.6 *Community-Based Alternatives*

Crisis Line providers must promote community-based alternatives instead of treatments that remove the Members from their family and community. In situations where a more restrictive

level of care is temporarily necessary, Crisis Line providers must work with the Member to transition back into community-based care settings as rapidly as is clinically feasible and must partner with community provider agencies to develop and offer services that are alternatives to more restrictive institutionally or facility based care.

14.7.1.7 *Staff Requirements and Training*

All Clinical Supervisors must meet the appropriate Arizona Board of Behavioral Health Examiners requirements to conduct clinical supervision. Crisis Line providers must demonstrate completion of all Arizona Department Health Services Division of Licensing training requirements are met for all direct care staff. All staff Members must complete an annual training in Cultural Competency and annual Fraud & Abuse Training, and providers must maintain documentation verifying completion of the training. In addition, providers must verify that all staff and family of Members who provide Peer Support or Family Support have adequate training to support them in successfully fulfilling the requirements of their position

Crisis Line providers must notify The Health Plan of any staff changes or incidents impacting credentialing involving Behavioral Health Professionals or Behavioral Health Medical Professionals within forty-eight (48) business hours of any additions, terminations or changes.

14.7.1.8 *Quality Improvement*

Crisis Line providers must participate in clinical quality improvement activities that are designed to improve outcomes for Arizona Members.

14.7.1.9 *Electronic Health Record (EHR)*

Crisis Line providers are highly encouraged to have in place a fully operational EHR; including, electronic signature, and remote access, as required to meet Federal Medicaid and Medicare requirements. In addition, Crisis Line providers must allow State and The Health Plan staff access to the EHR for the purpose of conducting audits.

14.7.2 *Service Requirements*

Crisis Line providers must maintain a twenty-four (24) hours per day, seven (7) days per week crisis response system that has a single toll-free crisis telephone number and the discretion to establish a local crisis telephone number. The crisis line must:

- Be widely publicized within the covered service area and included prominently on The Health Plan website, the Member Handbook, Member newsletters, and as a listing in the resource directory of local telephone books;
- Be staffed with a sufficient number of staff to manage a telephone crisis response line to comply with the requirements of the Agreement;
- Be answered within three (3) telephone rings, or within 15 seconds on average, with an average call abandonment rate of less than 3% for the month.
- Include triage, referral and dispatch of service providers and patch capabilities to and from 911 and other crisis providers as applicable;
- Offer interpretation or language translation services to persons who do not speak or understand English and for the deaf and hard of hearing; and

- Provide Nurse On-Call services twenty-four (24) hours per day, seven (7) days per week to answer general healthcare questions from SMI Members receiving physical health care services and to provide them with general health information and self-care instructions.

14.7.2.1 Staff Requirements

Crisis Line providers must follow the requirements below:

- Establish and maintain the appropriate ADHS Division of Licensing license to provide required services.
- Maintain appropriate Arizona licensed medical staff, Arizona licensed Behavioral Health Professionals, ADHS Division of Licensing facility licenses, qualified Behavioral Health Technicians and Paraprofessionals, and Peer Support staff to adequately address and triage Member calls and verify the safe and effective resolution of calls.
- Maintain bilingual (Spanish/English) capability on all shifts and employee interpreter services to facilitate crisis telephone counseling for all callers.
- Provide consistent clinical supervision to verify services are in compliance with the Arizona Principles and all ADHS Division of Licensing, and State supervision requirements are met.
- Employ adequate staff to implement the Crisis AfterCare Recovery program.
- Employ one (1) full-time American Indian Warm-line Program Coordinator and part-time tribal Member employees representing the Tribal Nations served by The Health Plan who have tribal Members living on tribal lands in Arizona.

14.7.2.2 Telephone Call Response Requirements

Crisis Line providers must verify that all calls for Crisis Mobile Teams and Nurse Line are answered within three telephone rings, or within fifteen (15) seconds, as measured by the monthly Average Speed of Answer. All crisis calls and Nurse Line calls must be live answered.

Crisis Line providers must report monthly, quarterly, and annually, all phone access statistics to include: total number of calls received, number and percent abandoned, average speed of answer, and number of calls outside standards. Crisis Line providers must report daily a phone access report that identifies number of calls outside standards, amount of time to answer call for each call outside standards, and number of abandoned calls associated with call outside standards.

14.7.2.3 Crisis Counseling, Triage, Tracking, Mobile Team Dispatch and Resolution

Crisis Line providers must meet the following requirements:

- Provide crisis counseling, triage and telephonic follow-up 24/7/365. All crisis calls must be live answered. Crisis callers must not receive a prompt, voice mail message, or be placed in a phone queue.
- Provide crisis counseling and triage services to all persons calling The Health Plan Crisis Line, regardless of the caller's eligibility for Medicaid services.

- Review Wellness Recovery Action Plans (WRAP Plans) and Crisis Plans identified in The Health Plan data system to assist with crisis resolution and suggest appropriate interventions.
- Dispatch mobile team services delivered by provider agencies and must track mobile team intervention resolution in compliance with protocols established or approved by The Health Plan. Crisis Line providers must report on a weekly and monthly basis these dispatches in a format approved by The Health. Daily reports may be required as needed.
- Assess the safety of a crisis scene prior to mobile team dispatch and track mobile teams to monitor the safety of the mobile team staff.
- Follow-up with Members, crisis mobile team staff, Integrated Care Managers, and system partners to verify appropriate follow-up and coordination of care.
- Assess Member dangerousness to self and others and provide appropriate notification to The Health Plan, Health Home Health Care Coordinator, and obtain information on Member's consistent use of medications to minimize dangerousness and promote safety to the Member and community.
- Follow community standards of care and best practice guidelines to warn and protect Members, family members and the community due to threats of violence.
- Document all interactions and triage assessments to facilitate effective crisis resolution and validate interventions.
- Conduct a follow-up call within seventy-two (72) hours to make sure the caller has received the necessary services. Verify Members are successfully engaged in treatment before closing out the crisis episode and follow-up to verify system partner and Member satisfaction with the care plan.
- Support the mobile teams and arrange for transports, ambulance, etc.
- Dispatch and track requests for 1 hour Urgent Engagements. Dispatch and Track requests for 24 hour Urgent Engagement referrals after hours.
- Monitor and make best efforts to verify that 1 hour Urgent Engagements are completed within 1 hour of Health Home activation. Provider must document and report any reported response delay reason, monitor and make best efforts to verify that 24 hour Urgent Engagements are completed within twenty-four (24) hours of notification by health plans, hospitals, or detention centers. Provider must document and report any reported response delay reasons.
- Track all Urgent Engagement requests to verify Members are engaged in follow-up care.
- Provide reports that track and summarize the requests for, daily pending inpatient report, daily call statistics report, CMT timeliness report, re-entry reports, urgent response report, acute health plan inquiry log, crisis indicator data report, client activity report, second responder tracking and 24 Hour Mobile Urgent Intake requests the disposition of such assessments in a format established or approved by The Health Plan.
- Make reasonable attempts to verify that the dispositions and intake appointments are completed.

- Document and report any delay reasons to The Health Plan in real time for all Urgent Response requests.

14.7.3 **Customer Service, Member Outreach, Engagement**

14.7.3.1 **Customer Service**

Crisis Line providers must provide customer service functions on behalf of The Health Plan when The Health Plan offices are closed. Crisis Line providers must complete transactions for Customer Service after-hours without referring anyone to call back during regular business hours unless the call is regarding a claim. The Health Plan Customer Service telephone number must be forwarded to The Crisis Call Center whenever The Health Plan offices are closed and occasionally, as arranged in advance, through Work Force Management.

14.7.3.2 **Safety Net**

Crisis Line providers must serve as a "safety net" to The Health Plan Members by re-engaging Members into treatment, as identified by The Health Plan and per data provided by The Health Plan.

14.7.3.3 **Documentation and Monitoring**

Crisis Line providers must document and monitor consistent use of crisis services for persons identified as High Need by The Health Plan, provider agencies or by family report. All High Need situations involving dangerousness to self or others must be staffed immediately with an independent licensed supervisor and the supervision must be documented in the record.

14.7.3.4 **Grievances and Service Gaps**

Crisis Line providers must notify The Health Plan through The Health Plan data systems of any service delivery problems, grievances, service gaps and concerns raised by Members, family members, and system partners.

14.7.3.5 **Encounters**

Crisis Line providers must encounter and document all services in compliance with the AHCCCS Covered Behavioral Health Service Guide.

14.7.3.6 **Quality Improvement**

Crisis Line providers must conduct outreach calls, The Health Plan, to facilitate quality improvement initiatives, as determined by The Health Plan, such as but not limited to the timely completion of Service Plans, use of medications, Health Care Coordinator selection and Member satisfaction, consistent use of treatment services, and frequency of treatment team meetings. Crisis Line providers must participate in satisfaction surveys sponsored by the State and The Health Plan as requested and must conduct satisfaction surveys from reports generated by The Health Plan.

14.7.3.7 *Coordination of Care*

Crisis Line providers must facilitate effective coordination of care with provider agency staff to promote effective recovery for Members. Crisis Line providers must track resolution until Member reports being successfully engaged in care and consistently engages in treatment.

14.7.3.8 *Member Assistance and Providing Information*

Crisis Line providers must assist Members in getting their prescriptions filled, obtaining services, resolving access to care problems, and obtaining medically-necessary transportation services. Crisis Line providers must also refer Members for outpatient services and warm transfer callers to agencies or service providers whenever possible upon completion of the call. Follow up calls shall be made to verify referred caller made and kept appointment. Crisis Line providers must explain to callers the process to access services, authorization process for Behavioral Health Inpatient and Hospital services and provide names and locations of intake agencies accessible to the caller.

Members must be informed about The Health Plan website, Member rights and grievance and appeal procedures as appropriate. Crisis Line providers must assist Members in addressing third party liability and "payer of last resort" issues related to accessing services including pharmacy services.

Crisis Line providers must assist Members in managing their own care, in better understanding their rights, in identifying and accessing resources and in more effectively directing their care.

14.7.3.9 *Member Eligibility*

Crisis Line providers must research Member eligibility for services on behalf of providers and Members and make available eligibility information to callers to assist access to care. Crisis Line providers must make available to Members, family members, and provider agencies treatment information about Evidenced Based Practices and shall assist callers in becoming better informed about services and recovery.

14.7.3.10 *Peer Outreach and Coordination*

Crisis Line providers must successfully coordinate services with PFRs; including, Peer Crisis AfterCare Programs, Peer Warm Lines, Peer Community Reentry Programs, and Peer Hospital Discharge Programs.

14.7.3.11 *Crisis*

Crisis Line providers must participate in all trainings and crisis coordination meetings required or requested by the State and/or The Health Plan. Crisis Line providers must successfully implement a Crisis AfterCare Recovery Team, employing program staff during peak hours Monday through Friday. The Crisis AfterCare Recovery Team must conduct outreach, service coordination and crisis stabilization services to Members following mobile crisis team visits, crisis telephone calls, hospitalization and The Health Plan coordination of care requests. In addition, Crisis Line providers must document coordination efforts in The Health Plan software systems.

14.7.3.12 *Certified Health Care Coordinator*

Crisis Line providers must support and strengthen the role of the Certified Health Care Coordinator through care facilitation, being careful to not diminish the relationship between the Member and the Health Care Coordinator.

14.7.3.13 *American Indian Warm-line Program (aka Tribal Warm Line)*

Providers must successfully implement an American Indian Warm-line Program and transfer system that includes (at least) part-time tribal Member employees (aka Tribal Support Partners) from the tribes served by The Health Plan. Tribal Support Partners must conduct calls (inbound/outbound) to facilitate member engagement in treatment, instill hope and promote recovery.

14.7.3.14 *Tribal Warm Line (TWL) Service Requirements*

- The TWL must be answered by a Tribal Support Partner Monday through Friday, 9:00 AM to 9:00 PM.
- Outside of these hours, the TWL must be answered by the crisis line, with a follow-up call by a Tribal Support Partner during the TWL operating hours.
- Tribal Support Partners must be trained in identifying crisis calls and transferring calls between systems.
- Tribal Warm Line staff must participate in all trainings and coordination meetings required or requested by the State and/or The Health Plan.

14.7.3.15 *24/7 Online Scheduling System*

Crisis Line providers must successfully implement a 24/7 online scheduling system to schedule emergent follow-up appointments and urgent intake assessments with an outpatient provider following a crisis episode.

14.8 Crisis Mobile Team Provider Program Requirements

Crisis Mobile Team providers must provide crisis mobile team services in the assigned geographic areas and in accordance to State and The Health Plan requirements.

14.8.1 Supervision by Independently Licensed Behavioral Health Professional

Crisis Mobile Team providers must verify that the Crisis Mobile Team Program is clinically supervised by a The Health Plan Credentialed Independently Licensed Behavioral Health Professional. Crisis Mobile Team providers must verify all Risk Assessments and crisis notes are reviewed and signed off by a The Health Plan Credentialed Independently Licensed Behavioral Health Professional within 24 business hours.

14.8.2 Crisis Mobile Team Provider

Crisis Mobile Team providers must coordinate all services through The Health Plan Crisis Mobile Team provider and follow crisis protocols established by The Health Plan and community stakeholders. Crisis Mobile Team providers must work collaboratively with The Health Plan Crisis Line Provider to receive mobile team dispatches, coordinate all services, and facilitate crisis resolution planning. Crisis Mobile Team providers must report all staffing changes to The Health

Plan Network Development Department through the EC-312 deliverable. Crisis mobile team providers are required to carry, and use as required, GPS enabled phones provided by crisis line provider. Crisis Mobile Team Agencies are required to have a super-user available within their agency for technical support. GPS phones will enable one number electronic dispatching from the crisis line provider. GPS phones must be kept with crisis mobile team staff on shift at all times. Crisis Mobile Team staff must be trained in appropriate use of the GPS phones. Crisis Mobile Team providers are required to cover the cost of damaged or lost GPS phones as requested by The Health Plan crisis phone provider. If you are assigned a GPS enabled cellular device, it is a condition precedent that you read and sign your specific User Agreement prior to receiving any such cellular device or devices.

14.8.3 Coordination Calls and Coordination with Outpatient Department

Crisis Mobile Team providers must participate in crisis coordination calls and meetings to facilitate effective working relationships. Crisis Mobile Team providers must verify mobile team services are closely linked to the provider's outpatient department and that coordination of care is occurring with outpatient providers for members who have been in a crisis. If the crisis occurs during business hour, the expectations is that the coordination occurs in real time.

14.8.4 Staffing and Training

Crisis Mobile Team providers must employ adequate staff to consistently meet the requirements for crisis mobile teams. Crisis mobile teams must have the capacity to serve specialty needs of population served including youth and children, Tribal members, and developmentally disabled. Crisis Mobile Team providers must ensure adequate coverage to maintain full crisis team capacity as a result of staff illnesses and vacations. All direct care crisis staff must be Critical Incident Stress Management (CISM) trained. Crisis Mobile Team providers must participate in training events sponsored by The Health Plan and the State to enhance the performance of the crisis system.

14.8.5 Mobile Crisis Vehicles

A mobile crisis team must be able travel to the place where the individual is experiencing the crisis. Crisis Mobile Team providers must provide and maintain mobile crisis vehicles to facilitate transports and field interventions.

14.8.6 Title 36 Screenings

Crisis Mobile Team providers must ensure Title 36 screenings are conducted by staff other than mobile team staff unless The Health Plan n holds a contract with the applicable County, in which case the mobile crisis team should follow the requirements specified in that contract. **See Section 3.9 - Pre-Petition Screening.**

14.8.7 Telephone and Internet Connectivity

Crisis Mobile Team providers shall be provided GPS enabled cell phones for all crisis staff on duty and must verify effective connectivity. Crisis Mobile Team providers must provide internet and telephone connectivity through cell phone technology to verify staff have the capacity to communicate spontaneously by phone and the internet while in the field. Crisis Mobile Team providers must verify each mobile team has the capability to wirelessly connect and access the

electronic medical information in the field as well as email. In addition, Provider must verify the computer and wireless specifications meet or exceed The Health Plan requirements.

14.8.8 Safety

Crisis Mobile Team providers must verify the safety of Members under the care of the Crisis Mobile Team at all times, and verify at-risk Members are monitored and supervised by professional staff in person as long as the person remains at a Danger to Self/Danger to Others (DTS/DTO).

14.8.9 Follow Up Care

Crisis Mobile Team providers must record referrals, dispositions, and overall response time. Crisis Mobile Team providers must verify all Members are effectively engaged in follow up care before terminating crisis services.

14.8.10 Billing

Crisis Mobile Team providers must bill all mobile team services utilizing crisis service codes (H2011 with a Y indicator), including follow up services performed by the mobile team.

14.8.11 Services

Crisis Mobile Team assessment and intervention services in the community are available to any person in the county regardless of insurance or enrollment status. Upon dispatch, Crisis Mobile Team response time expectations are as follows: No Crisis Mobile Team response should be greater than 90 minutes; or if the Crisis Mobile Team is presently located in the same town/city as the law enforcement call, the response time will be no greater than 30 minutes; or if the Crisis Mobile Team is not presently located in the same town/city as the law enforcement call, the response time is no greater than 90 minutes

Crisis Mobile Teams must have the ability to assess and provide immediate crisis intervention and make reasonable efforts to stabilize acute psychiatric or behavioral symptoms, evaluate treatment needs, and develop individualized plans to meet the individual's needs. Crisis Mobile Team providers must deliver crisis response, crisis assessment and crisis stabilization services that facilitate resolution, not merely triage and transfer. Crisis Mobile Team providers must initiate and maintain collaboration with fire, law enforcement, emergency medical services, hospital emergency departments, AHCCCS Complete Care Health plans and other providers of public health and safety services to inform them of how to use the crisis response system, to coordinate services and to assess and improve the crisis services.

14.8.12 Tracking

Crisis Mobile Teams must maintain adequate licenses to allow each team to utilize and update The Health Plan Risk Management/High Needs Tracking System to effectively coordinate care for Members in crisis.

14.9 Crisis Stabilization/Crisis Living Room Provider Program Requirements

Crisis Stabilization providers must provide crisis stabilization services in the assigned areas on a 24/7/365 basis and in accordance to State and The Health Plan requirements. Crisis assessment and crisis services must facilitate resolution, not merely triage and transfer. Crisis Living Rooms must be furnished to resemble a home living area, including the following: showers, rest rooms, living room furniture, kitchen, refrigerator, dining table, microwave oven, and exercise equipment.

14.9.1 Supervision and Staffing

Crisis Stabilization providers must verify that the Crisis Living Room Program is clinically supervised by a The Health Plan Credentialed Independently Licensed Behavioral Health Professional. Crisis Stabilization providers must verify all Crisis Living Room Assessments are reviewed and signed off by a The Health Plan Credentialed, Independently Licensed Behavioral Health Professional. Crisis Stabilization providers must verify adequate staff capacity to meet variations in the demand for services. Crisis Stabilization providers must verify all direct care crisis staff are CISM trained.

14.9.2 Coordination through Crisis Line Provider

Crisis Stabilization providers must coordinate all services through The Health Crisis Line Provider and follow crisis protocols established by The Health. Crisis Stabilization providers must work collaboratively with The Health Plan Crisis Line Provider to coordinate all services, and facilitate crisis resolution planning.

14.9.3 Outpatient Coordination and Follow Up

Since the Crisis Living Room is an outpatient facility, Crisis Stabilization providers must verify Members are not allowed to remain in the living room for more than 23 hours a day. Crisis Stabilization providers must verify crisis living room services are closely linked to the provider's outpatient department and that coordination of care is occurring with outpatient providers for members who have been in a crisis. Crisis Stabilization providers must verify all Members are effectively engaged in follow-up care before terminating crisis services.

14.9.4 Accepting Referrals

Crisis Stabilization providers must embrace a "No Wrong Door" philosophy and accept all voluntary referrals, regardless of ability to pay, clinical presentation, degree of intoxication, or benefit status. Crisis Stabilization providers must accept all referrals from law enforcement and the community.

In a health emergency, Provider is required to verify eligibility for Covered Services in accordance with The Health Plan Provider Manual and with federal, State, and local laws relating to the provision of Emergency Medical Services (including but not limited to A.A.C. R9-22-201 et seq. and 42 CFR 438.114), provided that nothing in this provision shall be deemed to require Provider to violate federal or State law regarding the provision of Emergency Medical Services. Provider is required to notify The Health Plan-designated crisis hotline provider within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Medical Services to a Member.

14.9.5 Transportation

Crisis Stabilization providers must provide and maintain transportation to facilitate or coordinate transports.

14.9.6 Participation in Training and Coordination Calls

Crisis Stabilization providers must participate in training events sponsored by The Health Plan and the State to enhance the performance of the crisis system. Crisis Stabilization providers must participate in crisis coordination calls and meetings to facilitate effective working relationships.

14.9.7 Tracking and Electronic Medical Information

Crisis Stabilization providers must maintain adequate licenses to allow Crisis Living Room staff to utilize The Health Plan Risk Management /High Needs Tracking System to effectively coordinate care for Members in crisis. Crisis Stabilization providers must verify the Crisis Living Room is equipped with a computer, printer and web connectivity to allow access to electronic medical information.

14.10 Crisis Transportation Provider Program Requirements

Crisis Transportation providers must provide medically-necessary transportation services in the assigned geographic areas and in accordance to State and The Health Plan requirements. Crisis Transportation providers must establish and maintain appropriate licenses to provide transportation services identified in the Scope of Work.

14.10.1 Coordination

Crisis Transportation providers must coordinate all services through The Health Plan Crisis Line Provider and follow crisis protocols established by The Health Plan. Crisis Transportation providers must participate in crisis coordination calls and meetings to facilitate effective working relationships as requested.

14.10.2 Staff Requirements

Staffing must consistently meet AHCCCS, the State, ADHS Division of Licensing, and The Health Plan requirements. Crisis Transportation providers must verify staff capacity to meet availability requirements as identified in provider's contract with The Health Plan. Crisis Transportation providers must maintain appropriately trained, supervised, and ADHS Division of Licensing and AHCCCS qualified transportation professionals to conduct transports.

Crisis Transportation providers must provide consistent supervision to verify services are in compliance with the Arizona Principles, and verify all ADHS Division of Licensing regulations and State supervision requirements are met. In addition, all staff transporting Members must maintain DES Fingerprint Clearance cards and maintain copies in Personnel files.

14.10.3 Training

Crisis Transportation providers must participate in training events sponsored by The Health Plan and the State as requested, and verify staff complete all required trainings and document trainings through Relias Learning Management System.

14.10.4 Vehicles and Cell Phones

Crisis Transportation providers must provide and maintain safe, clean and updated vehicles to facilitate transportation. Crisis Transportation providers must provide cell phones for all transportation staff on duty to verify effective connectivity and safety.

14.10.5 Billing and Paperwork

Crisis Transportation providers must bill all medically-necessary transportation services utilizing transportation service codes. Crisis Transportation providers must maintain appropriate paperwork in accordance with State and AHCCCS regulations. Crisis Transportation providers must encounter and document all services in compliance with the AHCCCS Covered Behavioral Health Service Guide.

14.11 Health Education, Health Promotion And Counseling Program Requirements Related To Human Immunodeficiency Virus (HIV)

Behavioral Health providers must make available HIV education, screening and counseling services to The Health Plan-enrolled Members.

14.11.1 HIV Risk Assessments

Behavioral Health Providers must make available HIV Risk Assessments to Members which includes pre-test discussions and counseling that assists the client in identifying the behaviors that may have possibly exposed the person to HIV.

14.11.2 Health Education, Health Promotion and Counseling

Health Education and Health Promotion services (including assistance and education about health risk reduction and lifestyle choices) must be provided to Members at substance use, mental health and community facilities in Arizona. Providers must make available to Members information regarding HIV transmission and prevention, and should assist Members in identifying the behaviors that may expose them to HIV.

Behavioral Health providers must make available Pre-Test Counseling to Members to assist in identifying the behaviors that may have possibly exposed them to HIV, focusing on the Member's own unique circumstances and risk and helping the Member set and reach an explicit behavior-change goal to reduce the chance of acquiring or transmitting HIV. Provider must make available to Members information regarding HIV transmission and prevention and the meaning of HIV test results. In addition, providers must help the Member to identify the specific behaviors putting them at risk for acquiring or transmitting HIV and commit to steps to reduce their risk.

Providers must make available Post-Test Counseling including summarization of identified risks, review of the Member's risk reduction plan, discussion of next test time or when the confirmation blood draw shall occur if the Member tested positive for HIV, scheduling an appointment for receiving future results, obtaining information on sexual or drug using contacts to enable partner notification process to occur, and providing information and assistance in accessing the HIV Care System.

14.11.3 Prevention Case Management

Providers must provide HIV Prevention Case Management services to any individual requesting assistance from the provider in obtaining resources and accessing needed social services.

14.11.4 Clinical Laboratory Improvement Amendment (CLIA)

Providers of HIV testing services must obtain and retain a Clinical Laboratory Improvement Amendments (CLIA) certificate and verify all HIV Testing is administered in accordance with the CLIA requirements.

14.12 Home Care Training to Home Care Client (HCTC) Services to Children – Program Requirements

14.12.1 Authorization and Continued Stay Requirements

HCTC Providers must meet all licensing and scope of work requirements as outlined by licensing, the Covered Behavioral Health Services Guide, and all prior authorization and continued stay requirements for HCTC as listed in Provider Manual Section 10 and as directed by The Health Plan. HCTC shall be utilized as an alternative to more restrictive levels of care when clinically indicated.

14.13 Substance Use Disorder Treatment Requirements

Providers are required to provide culturally-competent, evidence-based substance use treatment to a person who is experiencing acute and severe behavioral health and/or substance use symptoms, which may include emergency reception and assessment; crisis intervention and stabilization; individual, group and family counseling; outpatient detoxification and referral. Services provided to each member must be individualized to meet the member's unique treatment needs.

Substance use disorders may include a range of conditions that vary in severity over time, from problematic, short-term use of substances, to severe and chronic disorders requiring long-term and sustained treatment and recovery management.

All substance use treatment programs delivered by any provider within The Health Plan system of care must:

- Provide for:
 - Member and family education and involvement;
 - Brief intervention;

- Acute stabilization and treatment;
- Assessment of other needs including housing and vocational interests and goals;
- A focus on life factors that support long-term recovery to facilitate reduction of the intensity, severity and duration of substance use and the number of relapse events; and
- A return of the member to the workplace or school, as appropriate.
- Monitor member retention in treatment, provide engagement efforts and outcomes of treatment, modify treatment approaches as needed;
- Provide physician oversight of medical treatment including methadone, medication and detoxification services, as clinically appropriate;
- Provide or make available Tuberculosis (TB), HIV, and Hepatitis B and C education, screenings and treatment services;
- Coordinate continuity of care between service providers and other agencies;
- Utilize the American Society of Addiction Medicine (ASAM) in assessing persons with substance use disorders. In addition, the provider must screen all persons with substance use disorders for the need for residential treatment services and document the screening. All Members seeking treatment for Substance Use Disorders must receive an ASAM assessment at intake and at least every six months during treatment;
- Promote the use of Motivational Interviewing Principles in substance use treatment; verify access to new treatment alternatives targeted to the needs of specific high-risk populations, such as Members with co-occurring substance use and mental illness, according to the Arizona Principles for behavioral health care;
- Demonstrate which evidence based practice is utilized, how training is conducted and how fidelity is monitored;
- Document in each member record which evidence based practice is being utilized during treatment of the member, and;
- Be provided by clinicians who are overseen by a Behavioral Health Professional (BHP) with experience in substance use disorders and treatment.

Providers must maintain the capacity to conduct drug screening/testing on members, as defined by AHCCCS Covered Behavioral Health Services Guide and as deemed clinically appropriate by the member's treatment team.

While not required, The Health Plan supports the use of drug screening during the substance use screening, assessment and treatment process.

14.13.1 Psychosocial Outpatient Services

Substance use treatment providers must make individualized outpatient services available to assist the client in reducing or eliminating substance use/abuse. A continuum of services including therapy (individual, group, family), case management, peer support, vocational services and any other service identified in the AHCCCS Covered Behavioral Health Services Guide must be available and must utilize and maintain fidelity to evidence-based methods.

14.13.2 Intensive Outpatient Services

Substance use treatment providers that offer intensive outpatient programming must ensure that operates at least three (3) hours per day and at least three (3) times per week, as required by AHCCCS Covered Behavioral Health Services Guide.

14.13.3 Residential Services Treatment

Residential Substance Use Treatment services are available to adults and adolescents who are TXIX eligible and to individuals who are NTXIX, but eligible for Substance Abuse Block Grant (SABG) funds, as described in Provider Manual 3.10, Special Populations, and who are screened using the ASAM as needing this level of care.

Behavioral health residential facilities (BHRFs) providing substance use treatment must ensure length of stay is consistent with member's needs and meets medical necessity. Treatment must remain individualized for each member, dependent upon ASAM placement criteria and treatment needs.

All residential treatment facilities are subject to Utilization Management review as per Provider Manual Section 10.

14.13.4 Substance Abuse Transitional Facilities

Substance Abuse Transitional Facility Providers must provide SUD treatment services through a licensed Substance Abuse Transitional Facility on a 24/7/365 basis. *See R9-10-1401 et seq.* Substance Abuse Transitional Facility Providers must verify appropriate clinical supervision to safely administer treatment services and verify availability of medical staff to provide appropriate medical consultation and supervision. To verify Members receive appropriate follow up care, providers must verify coordination of care. Substance Abuse Transitional Facility Providers must utilize Peer Support staff to maximize opportunities for Members to understand and embrace recovery. Immediate and ongoing detoxification and psychiatric crisis stabilization services must be provided in the least restrictive setting, consistent with individual and family need and community safety.

14.13.5 Continuing Care, Discharge Planning, Aftercare Planning

Designated staff at the treatment provider engages the member, family/guardian and natural supports to actively participate in discharge planning. Discharge planning begins at the time of admission and continues to be an active part of the treatment/service planning process. It is recommended that agencies create an individualized, medically and clinically comprehensive crisis plan as part of discharge planning.

At a minimum the discharge plan must:

- Include realistic/quantifiable/measurable goals and objectives to inform when the member is discharge ready;

- Identify specific skills and supports the member needs in order to be successful upon discharge from a specific level of care;
- Include referrals to community resources, including 12–step programs and/or SMART Recovery;
- Reflects active coordination of care with providers and all involved agencies; and
- Include arrangements for therapy and other applicable psychiatric services provided in a timely manner.

14.13.6 Developing a Relapse Prevention Plan

At a minimum the relapse prevention plan:

- Includes the member’s identification of what relapse would look like;
- Identifies possible stressful events and triggers;
- Describes signs and symptoms that a relapse is imminent;
- Describes recommended interventions and the persons responsible;
- Identifies resources or supports to contact if in crisis, including phone numbers;
- Identifies interventions to avoid; and
- Assesses for potential safety issues.

14.13.7 Program Requirements for Providers of IV Drug and Opioid Treatment Services

Providers must fully educate the Member about all treatment options and strategies to promote recovery from opiate abuse; including, health risks, relapse risks, and alternative treatments.

IV Drug and Opioid Treatment Providers (OTPs) must maintain current policies and procedures designed to verify adherence to The Health Plan Provider Manual, 42 CFR Par 8, SAMHSA_ Treatment Improvement Protocol 49, AHCCCS Practice Protocol - Buprenorphine Guidance, the American Psychiatric Association Practice Guideline - Treatment of Patients with Substance Use Disorders, the Drug Enforcement Administration (DEA) and any applicable accreditation requirements.

IV Drug and Opioid Treatment Providers must also ensure Members have access to any medically necessary lab or physical health screening as referenced in the SAMHSA Treatment Improvement Protocol 49.

All Opioid Treatment Providers must have in place written policies and procedures describing their agency’s Diversion Control Program.

All OTPs must have information on the Dangers of Street Drugs posted in their clinic lobbies.

14.13.8 Promotion of Recovery

Treatment must promote recovery, minimizing the impact of substances on the Member's life and assisting the Member in reaching the maximum level of functioning in life appropriate for the Member.

14.14 Program Requirements for Providers of Services to Adolescents Who Act Out Sexually

Assessment and treatment for adolescents that act out sexually must be supervised by qualified clinicians using acceptable treatment modalities based on Evidenced Based Practices for the treatment of adolescents who act out sexually and in accordance with State and Federal laws. Treatment teams must include Licensed Clinicians, Health Care Coordinators, and in-home family support staff. Providers of services to adolescents who act out sexually must verify Treatment and Discharge Planning is developed through Child and Family Team Practice.

Providers of services to adolescents who act out sexually must develop an effective Safety Plan that safeguards the Member and community from re-offending. Providers of services to adolescents who act out sexually must place the adolescent in a treatment program with adolescents of similar age and developmental maturity level, when group treatment is prescribed by the treatment provider.

Providers of services to adolescents who act out sexually must comply with the professional Code of Ethics of the Association for the Treatment of Sexual Abusers. Reference: www.atsa.com.

14.15 Program Requirements for Providers of Services to Adults Who Act Out Sexually

Providers of services to adults who act out sexually must provide treatment services geared toward preventing further offenses and safeguarding the community from harm. Services must include assessments related to inappropriate sexual behavior, treatment planning, family support services, address family reunification and visitation, collaborate with probation/parole or other supervision or multidisciplinary professionals, engage community supports, include transition services and continuity of care.

Treatment must be supervised by qualified clinicians using acceptable treatment modalities based on Evidenced Based Practices for the treatment of adults who act out sexually and in accordance with State and Federal laws. Providers of services to adults who act out sexually must verify treatment teams include Licensed Clinicians, Health Care Coordinators, and in home family support staff. Treatment and Discharge Planning must be provided through Integrated Team Meetings.

Providers of services to adults who act out sexually must develop an effective Safety Plan that addresses risk management and safeguards the Member and community from re-offenses. Providers of services to adults who act out sexually must place the adult in a treatment program with adults of similar age and developmental maturity level, when group treatment is prescribed by the treatment provider.

14.16 Community Observation Centers

14.16.1 Purpose Of Program

To provide crisis intervention services to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode, or behavior. These intensive and time limited services are designed to prevent, reduce, or eliminate a crisis situation and are provided 24 hours a day, 7 days a week, 365 days a year.

14.16.2 Services To Be Provided

14.16.2.1 *Health, Risk and Acuity Assessments for Triage*

All individuals entering the facility (based on Arizona Division of Licensing approval to accept members) shall have a basic health, risk and acuity screening completed by a qualified behavioral health staff member as defined by ACC R9-10-114. Triage assessments shall be completed within fifteen (15) minutes of an individual's entrance into the facility. Any individual demonstrating an elevated health risk shall be seen by appropriate staff to meet the member's needs.

14.16.2.2 *Comprehensive Screening and Assessment*

Comprehensive screenings and assessments shall be completed on all individuals presenting at the facility to determine the individual's behavioral health needs and immediate medical needs. Assessments are required to be completed by a qualified behavioral health professional as defined by ARS Title 32 and ACC R9-10-101. Screening and assessment services may result in a referral to community services, enrollment in The Health Plan system of care, admittance to crisis stabilization services, or admittance to inpatient services. At minimum, a psychiatric and psychosocial evaluation, diagnosis and treatment for the immediate behavioral crisis shall be provided. Breathalyzer analysis of Blood Alcohol Level and/or specimen collections for suspected drug use may be provided as clinically appropriate.

14.16.2.3 *Crisis Intervention Services*

Crisis intervention services (stabilization) is an immediate and unscheduled behavioral health service provided in response to an individual's behavioral health issue, to prevent imminent harm, to stabilize, or resolve an acute behavioral health issue. Crisis stabilization services are able to be provided for a maximum of 23 hours and designed to restore an individual's level of functioning so that the individual might be returned to the community with coordinated follow up services. Services provided include assessment, counseling, intake and enrollment, medical services, nursing services, medication and medication monitoring, and the development of a treatment plan. Discharge planning and coordination of care shall begin immediately upon admission and shall be developed through coordination with the Health Home, and the Adult Recovery Team (ART) or Child and Family Team (CFT) as appropriate.

14.16.2.4 *Provider Title 36 Emergency Petition*

If licensed to provide court ordered evaluation and treatment, the provider shall verify that services and examinations necessary to fulfill the requirements of ARS §36-524 through ARS §36-528 for emergency applications for admission for involuntary evaluation are provided in the least restrictive setting available and possible with the opportunity for the individual to

participate in evaluation and treatment on a voluntary basis. Prior to seeking an individual's admission to a Behavioral Health Inpatient facility for Court Ordered Evaluation (COE) Provider shall make all reasonable attempts to engage the individual in voluntary treatment and discontinue the use of the involuntary evaluation process.

Provider shall verify that staff members are available to provide testimony at Title 36 hearings upon the request of County courts.

14.16.3 Reporting Requirements

Provider shall submit all documents, reports and data in accordance with the Deliverable Schedule in **Section 16 – Deliverable Requirements**. All deliverables shall be submitted in the format prescribed by The Health Plan and within the time frames specified. Provider is required to submit any additional documents and/or ad hoc reports as requested by The Health Plan.

14.16.4 Community Observation Unit Capacity Requirements

14.16.4.1 *Pima County Banner UMC Crisis Response Center Community Observation Unit Capacity*

Provider shall have a capacity of 34 (chairs) for adults, 18 years or older, and eight (8) chairs for children, to provide accommodations for overnight stay as mandated by ADHS Division of Licensing Services in accordance with AAC Title 9, Chapter 10. Provider shall have capacity to provide facility-based 23-hour crisis observation/stabilization services for at least 34 adults and at least eight (8) children at any one time.

14.16.4.2 *Pima County CBI Center Community Observation Unit Capacity*

Provider shall have a capacity of 12 (chairs) for adults, 18 years or older, to provide accommodations for overnight stay as mandated by ADHS Division of Licensing Services in accordance with AAC Title 9, Chapter 10. Provider shall have capacity to provide facility-based. 23-hour crisis observation/stabilization services for at least 12 adults at any one time.

14.16.4.3 *Yuma County Horizon Health and Wellness Community Observation Unit Capacity*

Provider shall have a capacity of 14 (chairs) and one patient bedroom for adults, 18 years or older, to provide accommodations for overnight stay as mandated by ADHS Division of Licensing Services in accordance with AAC Title 9, Chapter 10. Provider shall have capacity to provide facility-based. 23-hour crisis observation/stabilization services for at least 15 adults at any one time.

14.16.4.4 *Pinal County Horizon Health and Wellness Community Observation Unit Capacity*

Provider shall have a capacity of 24 (chairs) and two patient bedrooms for adults, 18 years or older, to provide accommodations for overnight stay as mandated by ADHS Division of Licensing Services in accordance with AAC Title 9, Chapter 10. Provider shall have capacity to provide facility-based. 23-hour crisis observation/stabilization services for at least 26 adults at any one time.

14.16.4.5 ***Pinal County Community Bridges, Inc. Facility Capacity***

Provider shall have a capacity 16 beds for adults, 18 years or older, to provide accommodations for overnight stay as mandated by ADHS Division of Licensing Services in accordance with AAC Title 9, Chapter 10.

14.17 ACT (Assertive Community Treatment)

14.17.1 Program Requirements

Providers delivering ACT Team services are required to establish ACT teams that comply with the requirements outlined in the **SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices Kit**, <https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>, in communities approved by the Health Plan.

14.17.2 Fidelity to the Model

Providers delivering ACT Team services shall participate in SAMSHA EBP fidelity audits coordinated with the Health Plan on an annual basis at minimum.

14.17.3 Reporting Requirements

Provider shall submit all documents, reports and data in accordance with the Deliverable Schedule as indicated in **Section 16 – Deliverable Requirements**. All deliverables shall be submitted in the format prescribed by the Health Plan and within the time frames specified. Provider is required to submit any additional documents and/or ad hoc reports as requested by the Health Plan.

14.17.4 Other Requirements

ACT Team providers must participate in all trainings and meetings required or requested by AHCCCS and/or The Health Plan. ACT Team providers must coordinate for continuity of care between provider, member's Health Home, stakeholders (Adult Protective Services, Probation Officer, Department of Corrections, and other agencies), and other Specialty Providers (both physical and behavioral health) involved with the member.

14.18 Agencies Contracted to Employ Engagement Specialists

14.18.1 Program Requirements

Engagement Specialists are required to adhere to the parameters outlined in the Engagement Specialist Guide.

- Outcomes of the Engagement Program include:
 - Increase access to behavioral health and physical health services,
 - Reduce number of citizens without medical coverage, and
 - Increase engagement into services.

14.18.2 Staff Requirements

Agencies must verify that Engagement Specialists complete the following required trainings and credentials:

- Mental Health First Aid,
- Certified Application Counselor,
- Arizona Department of Insurance Certified Application Counselor License, and
- Veteran Navigator through the Arizona Coalition for Military Families.

14.18.3 Deliverables

Engagement Specialist Log must be completed by each provider – see Section 16 - Deliverables.

Section 15 - TRAINING AND PEER SUPPORT SUPERVISION REQUIREMENTS

In order to effectively meet the requirements of the Arizona Health Care Cost Containment System (AHCCCS), the Health Plan, Arizona Complete Health, must participate in development, implementation and support of trainings for contractors and subcontractors to ensure appropriate training, education, technical assistance, and workforce development opportunities. Specifically to:

- Promote a consistent practice philosophy, provide voice and empowerment to staff and members,
- Ensure a qualified, knowledgeable and culturally competent workforce,
- Provide timely information regarding initiatives and best practices, and
- Ensure that services are delivered in a manner that results in achievement of the Arizona System Principles, which include the Adult Service Delivery System-Nine Guiding Principles as outlined in Contract and Arizona Vision-Twelve Principles for Children Service Delivery as outlined in AMPM Policy 430.

15.1 Purpose

The purpose of this section is to provide information to contracted providers regarding the scope of required training topics, how training needs are identified for contracted providers and how contracted providers may request specific technical assistance from The Health Plan.

15.2 Training

- Contracted providers will ensure that before providing services to members each licensed and unlicensed staff person is qualified, knowledgeable and capable to provide services as required by AHCCCS policy and, as relevant to their job duties and responsibilities, and consistent with their contract with The Health Plan.
- Licensed and unlicensed personnel will attend and complete all pre-service, ongoing and or annual in-service training programs described and required by specific AHCCCS policies.
- Training in the content areas specified in ACOM policies will be completed within 90 days of the staff person's hire date, as relevant to each staff person's job duties and responsibilities and annually as applicable.
- 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 behavioral health system [e.g., the Balanced Budget Act (BBA), MMA, the Affordable Care Act (ACA) and Deficit Reduction Act (DRA)]. Additional trainings may be required, as determined by geographic service area identified needs.

15.3 Annual and Ongoing Training

The Health Plan's subcontracted providers are required to participate in ongoing training for the following content areas as prescribed by policy or as determined to be necessary:

- Trainings concerning procedures for submissions of encounters when determined to be needed by AHCCCS;
- Cultural competency and linguistically appropriate training updates for staff at all levels and across all disciplines respective to underrepresented/ underserved populations – annually;
- Identification and reporting of Quality of Care Concerns and the Quality of Care Concerns investigations process when determined to be needed by AHCCCS ,
- American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-2R) – when determined to be needed by the Contractor;
- Child and Adolescent Service Intensity Instrument (CASII) – when determined to be needed by AHCCCS or the Contractor;
- Disability Benefits 101, (DB-101) including Work Incentives – annually.
- Peer, family member, peer-run, family-run and parent-support training and coaching – as required by AMPM 961-A and 961-B;
- Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring involvement of persons providing Special Assistance (see AMPM 320-R) as determined to be necessary by AHCCCS;
- Workforce Development trainings specific to hiring, support, continuing education and professional development;
- Peer, family member, peer-run, family-run and parent-support training and coaching – as required by AMPM 961-A and 961-B;
- Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring involvement of persons providing Special Assistance (see AMPM 320-R) as determined to be necessary by AHCCCS;
- Workforce Development trainings specific to hiring, support, continuing education and professional development;
- 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 behavioral health system (e.g., the BBA, MMA, ACA, and DRA). Additional trainings may be required, as determined by geographic service area identified needs.

ADHS Public Health Licensing required training must be completed and documented in accordance with Public Health Licensing requirements (see applicable provisions of A.A.C. Title 9, Chapter 10. And the ADHS Public Health licensing website).

15.4 Required Training Specific to Professional Foster Homes Providing HCTC Services

15.4.1 Children

Medicaid reimbursable HCTC services for children are provided in professional foster homes licensed by the DES/Office of Licensing, Certification and Regulation which must comply with training requirements as listed in A.A.C. R6-5-5850. All agencies that recruit and license professional foster home providers must provide and credibly document the following training to each contracted provider:

- CPR and First Aid Training; and
- 18 hours of pre-service training utilizing the HCTC to Client Service Curriculum.

The provider delivering HCTC services must complete the above training prior to delivering services. In addition, the provider delivering HCTC services for children must complete and credibly document annual training as outlined in A.A.C. R6-5-5850, Special Provisions for a Professional Foster Home.

15.4.2 Adults

Medicaid reimbursable HCTC services for adults are provided in Adult Therapeutic Foster Homes licensed by ADHS Public Health Licensing, and must comply with training requirements as listed in applicable sections of A.A.C. Title 9, Chapter 10:

- Protecting the person's rights;
- Providing behavioral health services that the adult therapeutic foster home is authorized to provide and the provider delivering HCTC services is qualified to provide;
- Protecting and maintaining the confidentiality of clinical records;
- Recognizing and respecting cultural differences.

Recognizing, preventing or responding to a situation in which a person:

- May be a danger to self or a danger to others;
- Behaves in an aggressive or destructive manner;
- May be experiencing a crisis situation;
- May be experiencing a medical emergency;
- Reading and implementing a person's treatment plan; and
- Recognizing and responding to a fire, disaster, hazard or medical emergency.

In addition, providers delivering HCTC services to adults must complete and credibly document annual training as required by A.A.C. Title 9, Chapter 10

15.5 Required Training Specific to Community Service Agencies

Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA application 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 AMPM Policy 961, Peer, Family and CSA Training, Credentialing and Oversight Requirements.

15.6 Training Request

The Health Plan will make available to providers any policies, procedures, and contact information that identify how providers can access additional training and/or technical assistance specific to the trainings required by this policy and/or other types of applicable training resources.

15.7 Training Contact Person

The contracted providers will designate a training contact as key personnel and point of contact to implement and oversee compliance with the training requirements, and training plan.

- This person will attend the monthly Training Contact meeting held the 3rd Thursday of each month, 10:00 to 11:00 AM, hosted by The Health Plan.
- This person will monitor and maintain the Relias learning management system.

15.8 Workforce Development Plan and Implementation Progress Report

Contracted providers will develop, implement and submit an Annual Workforce Development and Training Plan that describes the training and workforce development priorities for the year. The training plan will be submitted on October 31st as specified in The Health Plan contract.

The Workforce Development Plan (WFD) will include the following:

- Short- and long-term strategic WFD capacity and capability requirements (e.g. addressing health professional shortage areas, and integrated care);
- Forecast of anticipated workforce capacity (size, job types, etc.) and capability (skills and workforce support) needs;
- Specific WFD goals;
- Description of the actions to be taken to implement WFD initiatives, such as programs to recruit ACC Members to seek employment in various roles within the ACC health care system; and
- Description of how stakeholders, Members, families, and the general public will be involved in the development and implementation of the WFD plan.

15.9 Monitor Provider Workforce Development Activities

Contracted providers will ensure:

- All ACC required training content or competency descriptions are incorporated into the appropriate orientation, education, or training program, and evaluation processes and are made available to provider personnel,

Providers have processes for documenting training, verifying the qualifications, skills, and knowledge of personnel, and retaining required training, and competency transcripts and records

15.10 Peer Support/Recovery Support Training, Certification and Supervision Requirements

The State has developed training requirements and certification standards for Peer Support Specialists/Recovery Support Specialists providing Peer Support Services, as described in the AHCCCS Covered Behavioral Health Services Guide. Peers serve an important role as providers, and AHCCCS and The Health Plan expects consistency and quality in peer-delivered services and support for peer-delivered services statewide.

15.10.1 Additional Information

People who have achieved and sustained recovery can be a powerful influence for individuals seeking their own path to recovery. By sharing personal experiences, peers help build a sense of self-worth, community connectedness, and an improved quality of life.

Peer services are supported on a statewide and national level. The Centers for Medicare and Medicaid Services (CMS) issued a letter to states recognizing the importance of peer support services as a viable component in the treatment of mental health and substance abuse issues. In the letter, CMS provides guidance to states for establishing criteria for peer support services, including supervision, care-coordination and training/credentialing.

15.10.2 Peer Support Specialist/Recovery Support Specialist Qualifications

Individuals seeking to be certified and employed as Peer Support Specialists/Recovery Support Specialists must:

- Be, or have been, a recipient of behavioral health services or substance abuse services and has an experience of recovery to share, and;
- Meet the requirements to function as a behavioral health paraprofessional, behavioral health technician, or behavioral health professional.

Individuals meeting the above criteria may be certified as a Peer Support Specialist/Recovery Support Specialist by completing training and passing a competency test through an AHCCCS/Office of Individual and Family Affairs (OIFA) approved Peer Support Employment Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA approved Peer Support Employment Training Program is applicable statewide.

Some agencies may wish to employ individuals prior to the completion of certification through a Peer Support Employment Training Program. However, required trainings must be completed prior to delivering services. An individual must be certified as a Peer Support Specialist/Recovery Support Specialist or currently enrolled in a AHCCCS/OIFA-approved Peer Support Training Program under the supervision of a qualified individual (see **Section 15.10**) prior to billing Peer Support Services.

15.10.3 Peer Support Employment Training Program Approval Process

A Peer Support Employment Training Program must submit their program curriculum, competency exam, and exam-scoring methodology (including an explanation of

accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA, and AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam and exam scoring methodology in accordance with **Section 15.10**.

Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit its curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to its curriculum or if there is an addition to required elements (see **Section 15.10.5**) during this three-year period, the program must submit the updated curriculum to AHCCCS/OIFA for review and approval.

AHCCCS/OIFA will base approval of the curriculum, competency exam and exam-scoring methodology only on the elements included in [AHCCCS AMPM Policy 961](#). If a Peer Support Employment Training Program requires regional or culturally specific training exclusive to a GSA or tribal community, the specific training cannot prevent employment or transfer of Peer Support Specialist/Recovery Support Specialist certification based on the additional elements or standards.

15.10.4 Competency Exam

Individuals seeking certification and employment as a Peer Support Specialist/Recovery Support Specialist must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Peer Support Employment Training Program has the authority to develop a unique competency exam. However, all exams must include at least one question related to each of the curriculum core elements listed in **Section 15.10.4**. Individuals credentialed in another state must submit their credential to AHCCCS/Office of Individual and Family Affairs. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential.

15.10.5 Peer Support Employment Training Curriculum Standards

A Peer Support Employment Training Program curriculum must include, at a minimum, the following core elements:

- **Concepts of Hope and Recovery:**
 - Instilling the belief that recovery is real and possible;
 - The history of the recovery movement and the varied ways that behavioral health issues have been viewed and treated over time and in the present;
 - Knowing and sharing one's story of a recovery journey and how one's story can assist others in many ways;
 - Mind- Body-Spirit connection and holistic approach to recovery; and
 - Overview of the Individual Service Plan (ISP) and its purpose.
- **Advocacy and Systems Perspective:**
 - Overview of State and national behavioral health system infrastructure and the history of Arizona's behavioral health system;
 - Stigma and effective stigma reduction strategies: countering self-stigma; role modeling recovery and valuing the lived experience;

- Introduction to organizational change- how to utilize person-first language and energize one's agency around recovery, hope, and the value of peer support;
- Creating a sense of community; the role of culture in recovery;
- Forms of advocacy and effective strategies – consumer rights and navigating behavioral health system; and
- Introduction to the Americans with Disabilities Act (ADA).
- **Psychiatric Rehabilitation Skills and Service Delivery:**
 - Strengths based approach; identifying one's own strengths and helping others identify theirs; building resilience;
 - Distinguishing between sympathy and empathy; emotional intelligence;
 - Understanding learned helplessness; what it is, how it is taught and how to assist others in overcoming its effects;
 - Introduction to motivational interviewing; communication skills and active listening;
 - Healing relationships – building trust and creating mutual responsibility;
 - Combating negative self-talk; noticing patterns and replacing negative statements about one's self, using mindfulness to gain self-confidence and relieve stress;
 - Group facilitation skills; and
 - Introduction to Culturally & Linguistically Appropriate Services (CLAS) Standards; creating a safe and supportive environment
- **Professional Responsibilities of the Peer Support Employee and Self Care in the Workplace:**
 - Qualified individuals must receive training on the following elements prior to delivering any covered services:
 - Professional boundaries & ethics- the varied roles of the helping professional; Collaborative supervision and the unique features of the Peer Support Specialist/Recovery Support Specialist;
 - Confidentiality laws and information sharing – understanding the Health Insurance Portability and Accountability Act (HIPAA)
 - Mandatory reporting requirements; what to report and when;
 - Understanding common signs and experiences of mental illness, substance abuse, addiction and trauma; orientation to commonly used medications and potential side effects;
 - Guidance on proper service documentation; billing and using recovery language throughout documentation; and
 - Self-care skills and coping practices for helping professionals; the importance of ongoing supports for overcoming stress in the workplace; resources to promote personal resilience; and, understanding burnout and using self-awareness to prevent compassion fatigue, vicarious trauma and secondary traumatic stress.

Some curriculum elements include concepts included in required training. Peer Support Employment Training Programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA)⁶. Training elements in this section must be specific to the Peer Support Specialist/Recovery Support Specialist's role in the public behavioral health system and instructional for peer support interactions.

Supervision is intended to provide support to Peer Support Specialists/Recovery Support Specialists in meeting treatment needs of Members receiving care from Peer Support Specialists/Recovery Support Specialists. Supervision provides an opportunity for growth within the agency and encouragement of recovery efforts.

Agencies employing Peer Support Specialists/Recovery Support Specialists must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the Peer Support Specialist/Recovery Support Specialist's qualifications as a Behavioral Health Technician, Behavioral Health Professional or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of Evidenced Based Practices in providing supervision to Peer Support Specialist/Recovery Support Specialists.

15.10.6 Process for Submitting Evidence of Certification

Agencies employing Peer Support Specialists/Recovery Support Specialists who are providing peer support services are responsible for keeping records of required qualifications and certification. The Health Plan will ensure through audits that Peer Support Specialists/Recovery Support Specialists meet qualifications and have certification, as described in this provider manual.

15.11 Parent/Family Support Training, Certification and Supervision Requirements

AHCCCS/Office of Individual and Family Affairs has developed training requirements and certification standards for Family Support roles providing Family Support Services, as described in the AHCCCS Covered Behavioral Health Services Guide. AHCCCS and The Health Plan recognizes the importance of the Certified Family Support role as a viable component in the delivery of integrated services and expects statewide support for these roles. AHCCCS and The Health Plan expect consistency and quality in parent/family delivered support of integrated services in both the Children's and Adult Systems statewide.

⁶ While peer support employment training programs must not duplicate training required of licensed agencies or CSAs, it is possible that licensed agencies and/or CSAs may consider training completed as part of the peer support employment training program as meeting the agencies' training requirements.

15.11.1 Parent/Family Support Provider and Trainer Qualifications

15.11.1.1 Children's System

Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the children's system must:

- Be a parent or primary caregiver with lived experience who has raised or is currently raising a child with emotional, behavioral, mental health or substance abuse needs; and
- Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

15.11.1.2 Adult System

Individuals seeking certification and employment as a Parent/Family Support Provider or Trainer in the adult system must:

- Have lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance abuse needs; and
- Meet the requirements to function as a behavioral health professional, behavioral health technician, or behavioral health paraprofessional.

Individuals meeting the above criteria may be certified as a Parent/Family Support Specialist by completing training and passing a competency test through an AHCCCS/OIFA approved Parent/Family Support Training Program. AHCCCS/OIFA will oversee the approval of all certification materials including curriculum and testing tools. Certification through AHCCCS/OIFA approved Parent/Family Support Employment Training Program is applicable statewide.

15.11.2 Parent/Family Support Provider Training Program Approval Process

- A Parent/Family Support Provider Training Program must submit their program curriculum, competency exam, and exam-scoring methodology (including an explanation of accommodations or alternative formats of program materials available to individuals who have special needs) to AHCCCS/OIFA. AHCCCS/OIFA will issue feedback or approval of the curriculum, competency exam, and exam-scoring methodology.
- Approval of curriculum is binding for no longer than three years. Three years after initial approval and thereafter, the program must resubmit their curriculum for review and re-approval. If a program makes substantial changes (meaning change to content, classroom time, etc.) to their curriculum or if there is an addition to required elements during this three-year period, the program must submit the updated content to AHCCCS/OIFA for review and approval no less than 60 days before the changed or updated curriculum is to be utilized.
- AHCCCS/OIFA will base approval of the curriculum, competency exam, and exam-scoring methodology only on the elements included in this policy. If a Parent/Family Support Provider Training Program requires regional or culturally specific training exclusive to a GSA or specific population, the specific training cannot prevent employment or transfer of family support certification based on the additional elements or standards.

15.11.3 Competency Exam

- Individuals seeking certification and employment as a Parent/Family Support Provider must complete and pass a competency exam with a minimum score of 80% upon completion of required training. Each Parent/Family Support Provider Training Program has the authority to develop a unique competency exam. However, all exams must include questions related to each of the curriculum core elements listed in subsection 15.11. Agencies employing Parent/Family Support Providers who are providing family support services are required to ensure that their employees are competently trained to work with their population.
- Individuals certified or credentialed in another state must submit their credential to AHCCCS/OIFA. The individual must demonstrate their state's credentialing standards meet those of AHCCCS prior to recognition of their credential. If that individual's credential/certification doesn't meet Arizona's standard the individual may obtain certification after passing a competency exam. If an individual does not pass the competency exam, the Parent/Family Support Provider Training Program shall require that the individual complete additional training prior to taking the competency exam again.

15.11.4 Parent/Family Support Provider Training Curriculum Standards

A Parent/Family Support Provider Employment Training Program curriculum must include the following core elements for persons working with both children and adults:

- **Communication Techniques:**
 - Person first, strengths-based language; using respectful communication; demonstrating care and commitment;
 - Active listening skills: The ability to demonstrate empathy, provide empathetic responses and differentiate between sympathy and empathy; listening non-judgmentally;
 - Using self-disclosure effectively; sharing one's story when appropriate.
- **System Knowledge:**
 - Overview and history of the Arizona Behavioral Health System: Jason K., Arizona Vision and 12 Principles and the Child and Family Team (CFT) process; Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, Adult Recovery Team (ART), and Arnold v. Sarn; Introduction to the Americans with Disabilities Act (ADA); funding sources for behavioral health systems,
 - Overview and history of the family and peer movements; the role of advocacy in systems transformation,
 - Rights of the caregiver/enrolled member
 - Transition Aged Youth: Role changes when bridging the Adult System of Care (ASOC) and Children's System of Care (CSOC) at transition for an enrolled member, family and Team.
- **Building Collaborative Partnerships and Relationships:**
 - Engagement; Identifies and utilizes strengths;

- Utilize and model conflict resolution skills, and problem solving skills,
- Understanding individual and family culture; biases; perceptions; system's cultures;
- The ability to identify, build and connect individuals and families, including families of choice to natural, community and informal supports;
- **Empowerment:**
 - Empower family members and other supports to identify their needs, and promote self-reliance,
 - Identify and understand stages of change and
 - Be able to identify unmet needs.
- **Wellness:**
 - Understanding the stages of grief and loss; and
 - Understanding self-care and stress management;
 - Understanding compassion fatigue, burnout, and trauma;
 - Resiliency and recovery;
 - Healthy personal and professional boundaries.

Some curriculum elements may include concepts that are part of AHCCCS required training, as described in AHCCCS AMPM Policy 1060 and the Behavioral Health Practice Tool on Unique Needs of Children, Youth and Families Involved with Department of Children's Services. Credentialed Parent/Family Support Provider training programs must not duplicate training required of individuals for employment with a licensed agency or Community Service Agency (CSA). Training elements in this section must be specific to the Family Support role in the public behavioral health system and instructional for family support interactions.

15.11.5 Supervision of Certified Parent/Family Support Providers

Agencies employing Parent/Family Support Providers must provide supervision by individuals qualified as Behavioral Health Technicians or Behavioral Health Professionals. Supervision must be appropriate to the services being delivered and the qualifications of the Parent/Family Support Provider as a Behavioral Health Technician, Behavioral Health Professional, or Behavioral Health Paraprofessional. Supervision must be documented and inclusive of both clinical and administrative supervision.

Individuals providing supervision must receive training and guidance to ensure current knowledge of best practices in providing supervision to Parent/Family Support Providers.

15.11.6 Process of Certification

Agencies employing Certified Parent/Family Support Providers who are providing family support services are responsible for keeping records of required qualifications and certification.

Section 16 - DELIVERABLE REQUIREMENTS

The following table is a summary of the periodic reporting requirements and is subject to change at any time during the term of the contract. The table is presented for convenience only and should not be construed to limit provider's responsibilities in any manner. Content for all deliverables is subject to ongoing review. All contractual obligations apply. Reports are to be submitted to AzCHdeliverables@azcompletehealth.com, unless otherwise noted, in the following format: DELIVERABLE #, DUE DATE, PROVIDER NAME -example: ND601_120115_ABCCOUNSELING.

"Days" means calendar days unless otherwise specified. If the due day is a weekend or a State of Arizona holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday

Templates will be provided upon request.

Report #	Deliverable Name	Providers Required to Submit	Due Date
AMPM-1020-1	Psychiatric Security Review Board/GEI Conditional Release Monthly Report	Health Home Providers with Psychiatric Security Review Board (PSRB) Members	2 nd day of the month for the previous months date
CA-905	RSS Inventory Utilization Committee Referral Report – PFRO	Specialty Behavioral Health Providers & CSA Providers that employ Peer and/or Family Supports	5th calendar day after quarter end
CA-906	RSS Inventory Utilization Committee Referral Report - Health Home	Health Homes	5th calendar day after quarter end
CA-907	Persons Receiving Special Assistance	Health Home Providers that receive CA-907 form from The Health Plan	28th day of each month via secure email
CA-908	Special Assistance Form Deliverable	Health Home Providers with active Special Assistance members	5 th day of the month for the previous months data
CA-910	Monthly Warm Line Report	HOPE, Inc.	5 th calendar day of each month
CD-502	Department of Economic Security - Professional Foster Care Home License	HCTC & BH Therapeutic Homes	Within 15 calendar days prior to expiration of each license
CO-115	Justice Services Report	Community Health Associates	5th calendar day of the Month
EC-301-1	Emergency Room Wait Times Report	NurseWise	3rd calendar day of month for previous month's data

Report #	Deliverable Name	Providers Required to Submit	Due Date
EC-301-1b	Daily Pending Inpatient Placement Report	NurseWise	Daily by 10am for previous day. Send to Email Distribution List as agreed upon by parties
EC-301-2	Mobile Team Timeliness Report	NurseWise	21 st calendar day of month for previous month
EC-301-5	Urgent Response Report	NurseWise	15 th calendar day of month for previous month
EC-301-6	Acute Health Plan & Provider Inquiry Log and Detail	NurseWise	20 th calendar day of month for previous month
EC-301-7	Crisis Call Report	NurseWise	5 th calendar day of month for previous month
EC-301-8	Client Activity Report	NurseWise	5 th calendar day of month for previous month
EC-301-11	The Health Plan Customer Service Phone Reporting	NurseWise	5 th calendar day of month for previous month
EC-301-11b	The Health Plan Customer Service Phone Reporting	NurseWise	Daily by 10am for previous day to Email Distribution as agreed upon
EC-301-17	Secondary Responder Activation Report	Devereux, La Frontera EMPACT, LifeShare, Hope, Inc., Old Pueblo & TLCR	10 th of month for previous month
EC-301-19	Report for Pima County-COE detail	NurseWise	20 th calendar day of month for previous month
EC-301-20	Pima County Crisis Line Report	NurseWise	20 th calendar day of month for previous month
EC-301-22	Crisis Notifications to Providers	NurseWise	Daily by 10am to individual/applicable providers
EC-301-23	Crisis Notification to Health Plan	NurseWise	Daily by 10am to all acute plans
EC-301-25	Foster Care Hotline Call Report	NurseWise	10 th calendar of the month for the previous month
EC-301-26	Tribal Crisis Call Template	NurseWise	7 th calendar day of the month for the previous month
EC-302	COT Title 36 Reporting	Health Home Providers that have	2 nd Business day of the month. All COT

Report #	Deliverable Name	Providers Required to Submit	Due Date
		members on COT	portal entries not yet entered for the current reporting month and all required documents that have not yet been submitted for the current reporting month.
EC-304	Prevention Report	Prevention Providers (except COPE & SAAF)	15th calendar day after month end
EC-305	Annual Prevention Report	Prevention Providers	Submission by September 15, 2017
EC-306	Prevention Program Description/Logic Model	Prevention Providers	Submission by April 1 st
EC-310	Annual Heat Plan Update	Health Home Providers	April 15th
EC-313	Coalition Detailed Implementation Plan	Prevention Providers	Submission online September 15 th or 30 days after approved program changes
EC-314	HIV Early Intervention Monthly Report	HIV Early Intervention Providers COPE SAAF	5 th calendar day after month end
EC-317	ACT Team Program Reporting	Telecare and CPCC/Community Partners Integrated healthcare	10 th calendar day after month end
EC-319	Evidence Based Prevention Assessment	Prevention Providers	15 th of July
EC-320	Urgent Transportation Report	AMT, Saguaro, & TLC-R	10 th calendar day after month end
EC-321	T36 Pre-Petition Data	CBI	Last day of the month for previous month's data
EC-322	Scorecard	CRC, HHW, CBI	29 th calendar day after month end

Report #	Deliverable Name	Providers Required to Submit	Due Date
EC-323	Crisis Mobile Team Activity Log	ACTS, CBI, CHA, HHW	5 th calendar day after month end
EC-324	Integration Performance Measures Outreach Monitoring Tool	Health Home Providers	5 th calendar day after quarter end
EC-325	Living Room Center Admission Report	CHA	10 th day of the month for previous month
EC-326	Quarterly SABG Prevention Activity Report	Prevention Providers (except COPE & SAAF)	45-days after quarter end
EC-327	Prevention Performance Measure Tables 31 & 32	Prevention Providers (except COPE & SAAF)	45-days after quarter end
FN-101	Month End Financial Statements (including supplemental schedules & liquidity and profit percentage)	Health Home Providers on PMPM payment method or Block Payment	30th calendar day after month end 40th calendar day after month end for SEC registered providers
FN-401	Quarterly Financial Statements (including liquidity and profit percentage)	All Specialty Providers paid via Block Payment. Or Crisis Providers paid via Block Purchase Excludes specialty providers that are ONLY paid Block Purchase	30th calendar day after quarter end
FN-402	*Final Audited Financial Statements *Final Audited Financial Statements for All Related Parties Earning Revenue under this Contract *Final Supplemental Reports to the Audited Financial Statements*Liquidity Ratios and Profit	All Providers receiving \$3,000,000 or more in annual revenue from The Health Plan	Includes -Health Home -Crisis Providers -Specialty Block Payment -Specialty FFS -Health Home / ICCA FFS -Hospitals FFS -Transportation FFS Due 120 days after

Report #	Deliverable Name	Providers Required to Submit	Due Date
	Percentage		provider's fiscal year end
FN-403	Non-Title Funding Expenditure Report	Providers that received Supported Housing funds, SABG, MHBG, NT SMI – Fee for Service or Block	30th calendar day after quarter end
FN-405	OMB Single Audit	Providers that received over \$750,000 federal grant funds for their agency (SABG and MHBG funds are sub-awards and included in providers Schedule of Federal Awards)	150 days after provider's fiscal year end Banner Healthcare Only - 210 days after provider's fiscal year end
FN-408	SABG and MHBG Policies	Providers receiving SABG and MHBG Block Grant Funds – Fee for Service or Block Payment or Block Purchase	By November 1 of each contract year
IT-702	7 Day Access to Care	Health Home Providers	as requested
OI-201	Child Dedicated Health Care Coordinator Inventory	Health Home Providers (except Banner, CBI, COPE, CPR, CRM, Desert Senita, & El Rio)	2nd calendar day of the Month
OI-206	Housing Roster Report	Achieve, Horizon Health and Wellness, SEABHS, Marana Health , CODAC, COPE, La Frontera, CPI/ Community Partners Integrated Healthcare, Old Pueblo Community Services, CBI, Wellness Connections, TLCR, Pinal Hispanic Council	2nd calendar day of the Month
OI-214	Quarterly Rehab	Health Home	2nd calendar day

Report #	Deliverable Name	Providers Required to Submit	Due Date
	Progress Report	Providers except CRP	after quarter end
OI-217	Tohono O'odham Nation Quarterly Report	Community Partnership Integrated Health Care PSA Art Awakenings I-Hope Transportation Intermountain Centers for Human Development, Horizon Health & Wellness 101 Wall Services, LLC Community Bridges Community Health Associates Native American Advancement Foundation	5 th calendar day after quarter end
OI-218	Tribal Warm Line Outreach Report	NurseWise	5 th calendar day after month end
OI-230	Monthly CCCT/CCI Program Report	Casa De Los Niños, CPES, Intermountain & Pathways	5 th calendar day after month end
OI-235	Employment Services Monthly Report	All Health Homes and Employment Specialty Providers	5 th calendar day of the month following
OI-236	MAT Census Report	CBI, La Frontera, COPE , CODAC, CMS, HHW, New Hope BH, Wellbeing	5 th calendar day after month end
RF-101	Weekly BIP Report	CBI, Cope, CODAC, CPCC, Devereux, ICHD & Park Place	Every Friday
RF-1002	Engagement Specialist Tracking Log	CHA, Coyote, Hope, PPEP, CCS, Old Pueblo, NAMI, CBI, Wellness, NazCare, HHW, PHC, TLCR	5 th calendar day after month end

Report #	Deliverable Name	Providers Required to Submit	Due Date
RF-1005	Incidents, Accidents, and Death Report	All Providers	Within (2) two business days of the incident and the IAD must be entered into the AHCCCS QMS Portal https://qmportal.azahcccs.gov/WF_Public_Default.aspx
RF-1008	Notification of Persons in Need of Special Assistance	Health Home Providers (except CPR)	Due to OHR within (5) five business days of identifying need for special assistance, copy to The Health Plan
RF-1009	Notification of Persons No Longer in Need of Special Assistance	Health Home Providers	Due to OHR within (10) days of identifying individual is no longer in need of special assistance, copy to The Health Plan via secure email
RF-1010	Complaint Resolution Confirmation Response	All Providers	Within two (2) business days of the request
RF-1013	PASRR Level II Evaluations completed by a Psychiatrist	Health Home Providers	When requested by AHCCCS or The Health Plan, complete evaluation within (3) three business days for hospitalized individuals and within 5 business days for all others.
RF-1015	Notification by email or letter of an unexpected material facility change that could impact the Provider Network	All Providers	Within one (1) business day of becoming aware of the unexpected change.
RF-1016	Notification of Change Form	All Providers	At least (30) thirty calendar days prior to the anticipated change that could impact the Provider Network.
RF-1018	Ad Hoc Reports not listed	All Providers	as requested

Report #	Deliverable Name	Providers Required to Submit	Due Date
RF-1021	System of Care Practice Review (SOCPR) Practice Improvement Plan Updates	Children's Health Home Providers participating in annual practice review process	Initial Plan due: upon request. Plan Updates due upon request
RF-1022	Medicare Advantage D-SNP Member Pre-Service Appeals Report	Banner	10 th calendar day of the month
TR-001	Call Stats - Service Level	Transportation Provider - Veyo	15 th of the month for previous month
TR-002	Complaints & Grievances	Transportation Provider - Veyo	15 th of the month for previous month
TR-003	Executive Summary	Transportation Provider - Veyo	15 th of the month for previous month
TR-004	Detail and Summary Trip Report	Transportation Provider - Veyo	15 th of the month for previous month
TR-005	Quarterly Executive Summary	Transportation Provider - Veyo	15 th of the month following quarter end for previous quarter

Section 17 - REFERENCES

17.1 Statutory And Regulatory References

17.1.1 Federal Statutes and Regulations

[American Recovery and Reinvestment Act of 2009 \(HITECH Act\), Title XIII, Subtitle D](#)

[ADA Accessibility Guidelines](#)

[Affordable Care Act \(P.L. 111-148\)](#)

[Age Discrimination in Employment Act \(ADEA\)](#)

[Americans with Disabilities Act](#)

[Balanced Budget Act of 1997](#)

Centers for Medicare & Medicaid Services ([42 CFR § 400, et seq.](#))

[Confidentiality of Drug and Alcohol Abuse Patient Records \(42 CFR Part 2\)](#)

Civil Rights Act, [Title VI](#) and [Title VII](#)

[Equal Pay Act \(EPA\)](#)

Federal Block Grants

[Mental Health Block Grant](#) pursuant to Division B, Title XXXII, Section 3204 of the Children's Health Act of 2000 (MHBG).

[Substance Abuse Block Grant](#) pursuant to Division B, Title XXXIII, Section 3303 of the Children's Health Act of 2000 and pursuant to Section 1921-1954 of the Public Health Service Act and (45 CFR Part 96) Interim Final Rules (SABG)

[Project for Assistance in Transition from Homelessness Grant \(PATH\)](#)

[Federal Health Insurance Marketplace](#)

[Health Insurance Portability and Accountability Act \(HIPAA\) Privacy, Security, and Enforcement Rules \(45 CFR §§ 160 and 164\)](#)

[Social Security Act, Sections 1903 and 1877 \(42 U.S.C. §§ 1395nn and 1396b\)](#)

17.1.2 [State Administrative Rules](#)

A.A.C. R2-19 Administrative Hearing Rules

A.A.C. R9-20 Behavioral Health Service Agencies: Licensure

A.A.C. R9-21 Behavioral Health Services for Persons with Serious Mental Illness

A.A.C. R9-22 AHCCCS Rules for the Title XIX/XXI acute program

A.A.C. R9-28 AHCCCS Rules for the Title XIX/XXI DDD ALTCS Program

A.A.C. R9-31 AHCCCS Rules for the Title XXI program

A.A.C. R9-34 AHCCCS Rules for the Grievance System

17.2 Reference Documents

[AHCCCS Guide and Manuals](#)

[AHCCCS Contracts](#)

17.3 Clinical Guidance Documents

[AHCCCS Behavioral Health System Practice Tools](#)

Section 18 - PROVIDER MANUAL FORMS & ATTACHMENTS

18.1 FORMS

ALL PROVIDERS: Please call the Provider Services Call Center at 1-866-796-0542 for a copy of any Forms or Attachments listed below.

2.3 Maternity Services

- 2.3.2 Notification of Pregnancy (NOP)
- 2.3.2 Notification of Pregnancy (NOP)-Spanish

2.10 Housing for ADULTS with a Serious Mental Illness

- Provider Manual Form 2.10.1 AHCCCS Property Acquisition Rehab Application
- Provider Manual Form 2.10.1 AHCCCS Property Acquisition Rehab Form Instructions

3.1 Medicare Part D Prescription Drug Coverage

- Provider Manual Form 3.1.1 Tracking of Medicare Part D Enrollment

3.3 Specialty Provider Requirement

- Provider Manual Form 3.3.3 Specialty Agency Monthly Summary

3.4 Outreach, Engagement, Re-Engagement, and Closure

- Provider Manual Form 3.4.1 Engagement and Re-Engagement Review

3.7 General and Informed Consent to Treatment

- Provider Manual Form 3.7.1 Consent for Treatment
- Provider Manual Form 3.7.1 Consent for Treatment - Spanish

3.13 Out-of-State Placements for Children and Young Adults

- Provider Manual Form 3.13.1 Out-of-State Placement, Initial Notice and 30 day Update

3.17 Health Home Provider Requirements

- Provider Manual Form 3.17.3, Birth through Five High Needs Screening Tool

4.1 Transition of Persons

- Provider Manual Form 4.1.1 Inter-Agency Transfer & Transition Checklist

4.2 Inter-RBHA Coordination of Care

- Provider Manual Form 4.2.1 AzCH Inter- Transfer and Coordination of Services Request Form
- Provider Manual Form 4.2.3 AZ Complete Health Authorization for Release-Generic

- Provider Manual Form 4.2.4 AZ Complete Health Consent for Release Confidential Information for Coordination of Care with Re-Disclosure

4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers

- Provider Manual Form 4.3.1 Request for Information from PCP or Medicare Provider
- Provider Manual Form 4.3.2 Communications Document

6.1 Urgent Response Disposition

- Provider Manual Form 6.1.1 Urgent Response Disposition

9.9 Seclusion and Restraint Reporting

- Provider Manual Form 9.9.1 Seclusion and Restraint Reporting-Behavioral Health Inpatient Facilities

10.1 Securing Services and Prior Authorization/Retrospective Authorization

- Provider Manual Form 10.1.1 Certification of Need (CON)
- Provider Manual Form 10.1.2 Recertification of Need (RON)
- Provider Manual Form 10.1.3 Notice of Admission to ALL LEVELS OF CARE
- Provider Manual Form 10.1.6 Out-of-Home Admission
- Provider Manual Form 10.1.8 Out-of-Home Concurrent Review Form
- Provider Manual Form 10.1.10 Inpatient Discharge Summary
- Provider Manual Form 10.1.11 Request for Expedited Authorization
- Provider Manual Form 10.1.12 Outpatient Medicare Prior Authorization Fax Form
- Provider Manual Form 10.1.13 Inpatient Medicare Prior Authorization Fax Form
- Provider Manual Form 10.1.14 Intensive Staff
- Provider Manual Form 10.1.15 Out-of-Network Request
- Provider Manual Form 10.1.16 Notice of Temporary Placement MASTER
- Provider Manual Form 10.1.17 Notice of Transfer Out of Home Facilities MASTER

15.3. Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX)

- Provider Manual Form 15.3.1 Notice of Decision and Right to Appeal
- Formulario Policy 15.3.1 Aviso de Decisión y Derecho de Apelación – Spanish

15.4 Conduct of Investigations Concerning Persons with Serious Mental Illness

- Provider Manual Form 15.4.1 Appeal or SMI Grievance
- Provider Manual Form 15.4.1 Appeal or SMI Grievance-Spanish

18.2 ATTACHMENTS

3.2 Appointment Standards and Timeliness of Service

- Provider Manual Attachment 3.2.1 DCS Child Welfare Timelines

3.5 Assessment and Service Planning

- Provider Manual Attachment 3.5.1 Service Plan Rights Acknowledgement Template
- Provider Manual Attachment 3.5.8 Functional Behavioral Assessment Guidance Document

3.8 Psychotropic Medication: Prescribing and Monitoring

- Provider Manual Attachment 3.8.5 Minimum Laboratory Monitoring for Psychotropic Medications

3.11 Special Assistance for Persons Determined to Have Serious Mental Illness

- Provider Manual Attachment 3.11.1 Special Assistance Guidance Document

4.4 Coordination of Care with Other Governmental Entities

- Provider Manual Attachment 4.4.2 Consultation & Clinical Intervention (CCI) Program Requirements

6.2 Rapid Response Guidance

- Provider Manual Attachment 6.1.1 Rapid Response Guidance Manual

9.9 Seclusion and Restraint Reporting

- 9.9.1 Seclusion and Restraint Reporting Form

10.1 Securing Services and Prior Authorization/Retrospective Authorization

- Provider Manual Attachment 10.1.1 Admission Psychiatric Acute Hospital & Sub-Acute Criteria,
- Provider Manual Attachment 10.1.2 Continued Psychiatric Acute or Sub-Acute Facilities Authorization Criteria,
- Provider Manual Attachment 10.1.3 Prior Authorization Criteria for Admission and Continued Stay for Behavioral Health Residential Facilities,
- Provider Manual Attachment 10.1.3a BHRF Substance Abuse Treatment Placement FAQs,
- Provider Manual Attachment 10.1.4 Prior Authorization Criteria for Admission and Continued Stay for Behavioral Health Supportive Homes,
- Provider Manual Attachment 10.1.5 Prior Authorization Criteria for Continued Stay for HTC
- Provider Manual Attachment 10.1.6 Authorization Criteria for Behavioral Health Inpatient Facilities

- Provider Manual Attachment 10.1.15 Prior Authorization Criteria for HCTC

12.2 Verification of U.S. Citizenship or Lawful Presence for Public Behavioral Health Benefits

- Provider Manual Attachment 12.2.1, Documents Accepted by AHCCCS to Verify Citizenship and Identity
- Provider Manual Attachment 12.2.2, Citizenship/Lawful Presence Verification Process Through Health-e-Arizona PLUS
- Provider Manual Attachment 12.2.3, Persons Who Are Exempt From Verification of Citizenship During the Prescreening and Application Process
- Provider Manual Attachment 12.2.4, Non-Citizen/Lawful Presence Verification Documents

13.1 Enrollment, Disenrollment and Other Data Submission

- Provider Manual Attachment 13.1.1 834 Transaction Data Requirements

15.3 Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX)

- Provider Manual Attachment 15.3.1 Notice of SMI Grievance and Appeal Procedure
- Provider Manual Attachment 15.3.1 Notice of SMI Grievance and Appeal Procedure – Spanish

Section 19 - DEFINITIONS & ACRONYMS

19.1 PART I: Definitions Pertaining to All AHCCCS Contracts

The definitions specified in Part 1 below refer to terms found in all AHCCCS Contracts. The definitions specified in Part 2 below refer to terms that exist in one or more Contracts but do not appear in all Contracts.

PART 1

638 TRIBAL FACILITY

A facility that is owned and/or operated by a Federally recognized American Indian/Alaskan Native Tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended. Also referred to as: tribally owned and/or operated 638 facility, tribally owned and/or operated facility, 638 tribal facility, and tribally-operated 638 health program.

ACTUARY

An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. An actuary develops and certifies the capitation rates. [42 CFR 438.2]

ADJUDICATED CLAIM

A claim that has been received and processed by the Contractor which resulted in a payment or denial of payment.

ADMINISTRATIVE SERVICES SUBCONTRACTS

An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:

1. Claims processing, including pharmacy claims,
2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization),
3. Management Service Agreements,
4. Service Level Agreements with any Division or Subsidiary of a corporate parent owner,
5. DDD acute care subcontractors.

Providers are not Administrative Services Subcontractors.

ADULT

A person 18 years of age or older, unless the term is given a different definition by statute, rule, or policies adopted by AHCCCS.

AGENT

Any person who has been delegated the authority to obligate or act on behalf of a provider [42 CFR 455.101].

AHCCCS COMPLETE CARE CONTRACTOR

A contracted Managed Care Organization (also known as a health plan) that, except in limited circumstances, is responsible for the provision of both physical and behavioral health services to eligible Title XIX/XXI persons enrolled by the administration.

AHCCCS CONTRACTOR OPERATIONS MANUAL (ACOM)

The ACOM provides information related to AHCCCS Contractor operations and is available on the AHCCCS website at www.azahcccs.gov.

AHCCCS ELIGIBILITY DETERMINATION

The process of determining, through an application and required verification, whether an applicant meets the criteria for Title XIX/XXI funded services.

AHCCCS MEDICAL POLICY MANUAL (AMPM)

The AMPM provides information regarding covered health care services and is available on the AHCCCS website at www.azahcccs.gov.

AHCCCS MEMBER

See "MEMBER."

AHCCCS RULES

See "ARIZONA ADMINISTRATIVE CODE."

AMBULATORY CARE

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

AMERICAN INDIAN HEALTH PROGRAM (AIHP)

An acute care Fee-For-Service program administered by AHCCCS for eligible American Indians which reimburses for physical and behavioral health services provided by and through the Indian Health Service (IHS), tribal health programs operated under 638 or any other AHCCCS registered provider.

AMERICANS with DISABILITIES ACT (ADA)

The ADA prohibits discrimination on the basis of disability and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications. Refer to the Americans with Disabilities Act of 1990, as amended, in 42 U.S.C. 126 and 47 U.S.C. 5.

APPEAL

The request for review of an adverse benefit determination.

APPEAL RESOLUTION

The written determination by the Contractor concerning an appeal.

ARIZONA ADMINISTRATIVE CODE (A.A.C.)

State regulations established pursuant to relevant statutes. Referred to in Contract as “Rules.” AHCCCS Rules are State regulations which have been promulgated by the AHCCCS Administration and published by the Arizona Secretary of State.

ARIZONA DEPARTMENT OF HEALTH SERVICES (ADHS)

The State agency that has the powers and duties set forth in A.R.S. §36-104 and A.R.S. Title 36, Chapters 5 and 34.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

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

ARIZONA LONG TERM CARE SYSTEM (ALTCS)

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

ARIZONA REVISED STATUTES (A.R.S.)

Laws of the State of Arizona.

BALANCED BUDGET ACT (BBA)

See “MEDICAID MANAGED CARE REGULATIONS.”

BEHAVIORAL HEALTH (BH)

Mental health and substance use collectively.

BEHAVIORAL HEALTH DISORDER

Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of International Classification of Disorders (DSM) excluding those diagnoses such as intellectual disability, learning disorders and dementia, which are not typically responsive to mental health or substance use treatment.

BEHAVIORAL HEALTH PROFESSIONAL

- a. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:
 - i. Independently engage in the practice of behavioral health as defined in A.R.S. §32-3251, or
 - ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. §32-3251 under direct supervision as defined in A.A.C. R4-6-101;
- b. A psychiatrist as defined in A.R.S. §36-501;
- c. A psychologist as defined in A.R.S. §32-2061;
- d. A physician;
- e. A behavior analyst as defined in A.R.S. §32-2091;

- f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse; or
- f. A registered nurse.

BEHAVIORAL HEALTH SERVICES

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

BOARD CERTIFIED

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

BORDER COMMUNITIES

Cities, towns or municipalities located in Arizona and within a designated geographic service area whose residents typically receive primary or emergency care in adjacent Geographic Service Areas (GSA) or neighboring states, excluding neighboring countries, due to service availability or distance.

CAPITATION

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

CENTER OF EXCELLENCE

A facility and/or program that is recognized as providing the highest levels of leadership, quality, and service. Centers of Excellence align physicians and other providers to achieve higher value through greater focus on appropriateness of care, clinical excellence, and patient satisfaction.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

An organization within the United States Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program.

CHILD

A person under the age of 18, unless the term is given a different definition by statute, rule or policies adopted by AHCCCS.

CHILD AND FAMILY TEAM (CFT)

A defined group of individuals that includes, at a minimum, the child and their family, a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like (DCS) Department of

Child Safety or the Division of Developmental Disabilities (DDD). The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and Contract as necessary to be successful on behalf of the child.

CLAIM DISPUTE

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

CLEAN CLAIM

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

CLIENT INFORMATION SYSTEM (CIS)

The centralized processing system for files from each TRBHA/RBHA to AHCCCS as well as an informational repository for a variety of BH related reporting. The CIS system includes Member Enrollment and Eligibility, Encounter processing data, and SMI determination processes.

CODE OF FEDERAL REGULATIONS (CFR)

The general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

COMPREHENSIVE RISK CONTRACT

A risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services [42 CFR 438.2]:

1. Outpatient hospital services
2. Rural health clinic services
3. Federally Qualified Health Center (FQHC) services
4. Other laboratory and X-ray services
5. Nursing facility (NF) services
6. Early and periodic screening, Diagnostic, and Treatment (EPSDT) services
7. Family planning services
8. Physician services
9. Home health services

CONTRACT SERVICES

See "COVERED SERVICES."

CONTRACTOR

An organization or entity that has a prepaid capitated Contract with AHCCCS pursuant to A.R.S. §36-2904, A.R.S. §36-2940, or A.R.S. §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.

CONVICTED

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

COPAYMENT

A monetary amount that a member pays directly to a provider at the time a covered service is rendered (R9-22-711).

CORRECTIVE ACTION PLAN (CAP)

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

COST AVOIDANCE

The process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Contractor.

COVERED SERVICES

The health and medical services to be delivered by the Contractor as described in Section D, Program Requirements or the Scope of Work Section.

CREDENTIALING

The process of obtaining, verifying and evaluating information regarding applicable licensure, accreditation, certification, educational and practice requirements to determine whether a provider has the required credentials to deliver specific covered services to members.

DAY

A day means a calendar day unless otherwise specified.

DAY – BUSINESS/WORKING

A business day means a Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

DELEGATED AGREEMENT

A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the Contractor pursuant to this Contract.

DIVISION OF BEHAVIORAL HEALTH SERVICES (DBHS)

The State agency that formerly had the duties set forth by the legislature to provide BH services within Arizona.

DEPARTMENT OF ECONOMIC SECURITY/DIVISION OF DEVELOPMENTAL DISABILITIES (DES/DDD)

The Division of a State agency, as defined in A.R.S. Title 36, Chapter 5.1, which is responsible for serving eligible Arizona residents with a developmental/intellectual disability. AHCCCS contracts with DES/DDD to serve Medicaid eligible individuals with a developmental/intellectual disability.

DISENROLLMENT

The discontinuance of a member's eligibility to receive covered services through a Contractor.

DIVISION OF HEALTH CARE MANAGEMENT (DHCM)

The division responsible for Contractor oversight regarding AHCCCS Contractor operations, quality, maternal and child health, behavioral health, medical management, case management, rate setting, encounters, and financial/operational oversight.

DUAL ELIGIBLE

A member who is eligible for both Medicare and Medicaid.

DURABLE MEDICAL EQUIPMENT (DME)

Equipment that provides therapeutic benefits; is designed primarily for a medical purpose; is ordered by a physician/provider; is able to withstand repeated use; and is appropriate for use in the home. See also Medical Equipment and Appliances.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

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

EMERGENCY MEDICAL CONDITION

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

EMERGENCY MEDICAL SERVICE

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

EMERGENCY SERVICES

Medical or behavioral health services provided for the treatment of an emergency medical condition.

ENCOUNTER

A record of a health care-related service rendered by a provider or providers registered with AHCCCS to a member who is enrolled with a Contractor on the date of service.

ENROLLEE

A Medicaid recipient who is currently enrolled with a Contractor [42 CFR 438.2].

ENROLLMENT

The process by which an eligible person becomes a member of a Contractor's plan.

EVIDENCE-BASED PRACTICE

An intervention that is recognized as effective in treating a specific health-related condition based on scientific research; the skill and judgment of care health professionals; and the unique needs, concerns and preferences of the person receiving services.

EXHIBITS

All items attached as part of the original Solicitation.

EXCLUDED

Services not covered under the State Plan or the 1115 Waiver, including but not limited to, services that are above a prescribed limit, experimental services, or services that are not medically necessary.

FEDERAL FINANCIAL PARTICIPATION (FFP)

FFP refers to the contribution that the Federal government makes to the Title XIX and Title XXI program portions of AHCCCS, as defined in 42 CFR 400.203.

FEE-FOR-SERVICE (FFS)

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

FEE-FOR-SERVICE MEMBER

A Title XIX or Title XXI eligible individual who is not enrolled with an AHCCCS Contractor.

FISCAL AGENT

A Contractor that processes or pays vendor claims on behalf of the Medicaid agency, 42 CFR 455.101.

FRAUD

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.

GEOGRAPHIC SERVICE AREA (GSA)

An area designated by AHCCCS within which a Contractor of record provides, directly or through subcontract, covered health care service to a member enrolled with that Contractor of record, as defined in 9 A.A.C. 22, Article 1.

GRIEVANCE

A member's expression of dissatisfaction with any matter, other than an adverse benefit determination.

GRIEVANCE AND APPEAL SYSTEM

A system that includes a process for member grievances and appeals including, SMI grievances and appeals, provider claim disputes. The Grievance and Appeal system provides access to the State fair hearing process.

HEALTH CARE PROFESSIONAL

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

HEALTH INSURANCE

Coverage against expenses incurred through illness or injury of the person whose life or physical well-being is the subject of coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

HEALTH PLAN

See "CONTRACTOR."

HOME HEALTH CARE

See "HOME HEALTH SERVICES".

HOME HEALTH SERVICES

Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70 when provided to a member at his place of residence and on their physician's orders as part of a written plan of care [42 CFR 440.70].

HOSPICE SERVICES

Palliative and support care for members who are certified by a physician as being terminally ill and having six months or less to live.

HOSPITALIZATION

Admission to, or period of stay in, a health care institution that is licensed as a hospital as defined in R9-22-101.

IN-NETWORK PROVIDER

A person or entity which has signed a provider agreement as specified in ARS §36-2904 and that has a subcontract with an AHCCCS Contractor to provide services prescribed in A.R.S. §36-2901 et seq.

INSTITUTION FOR MENTAL DISEASE (IMD)

A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases [42 CFR 435.1010].

INCURRED BUT NOT REPORTED (IBNR)

Liability for services rendered for which claims have not been received.

INDIVIDUAL RECOVERY PLAN (FORMERLY KNOWN AS THE INDIVIDUAL SERVICE PLAN)

See "SERVICE PLAN"

INDIAN HEALTH SERVICES (IHS)

The operating division within the U.S. Department of Health and Human Services, responsible for providing medical and public health services to members of federally recognized Tribes and Alaska Natives as outlined in 25 U.S.C. 1661.

INFORMATION SYSTEMS

The component of the Contractor's organization which supports the Information Systems, whether the systems themselves are internal to the organization (full spectrum of systems staffing), or externally contracted (internal oversight and support).

INTERGOVERNMENTAL AGREEMENT (IGA)

When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct Contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into

agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to Contract for or perform some or all of the services specified in the Contract or agreement or exercise those powers jointly held by the contracting parties. A.R.S. Title 11, Chapter 7, Article 3 (A.R.S. §11-952.A).

LIABLE PARTY

An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease or disability of an AHCCCS applicant or member as defined in A.A.C. R9-22-1001.

LIEN

A legal claim, filed with the County Recorder's office in which a member resides and in the county an injury was sustained for the purpose of ensuring that AHCCCS receives reimbursement for medical services paid. The lien is attached to any settlement the member may receive as a result of an injury.

LONG -TERM SERVICES AND SUPPORTS (LTSS)

Services and supports provided to members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the member to live or work in the setting of their choice, which may include the individual's home, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting [42 CFR 438.2].

MAJOR UPGRADE

Any systems upgrade or change to a major business component that may result in a disruption to the following: loading of contracts, providers or members, issuing prior authorizations or the adjudication of claims.

MANAGED CARE

Systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to members; establish explicit criteria for the selection of health care providers; have financial incentives for members to use providers and procedures associated with the plan; and have formal programs for quality, medical management and the coordination of care.

MANAGED CARE ORGANIZATION

An entity that has, or is seeking to qualify for, a comprehensive risk Contract under 42 CFR Part 438 and that is [42 CFR 438.2]:

1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR Part 489, or
2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
 - a. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
 - b. Meets the solvency standards of 42 CFR 438.116.

MANAGED CARE PROGRAM

A managed care delivery system operated by a State as authorized under section 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act [42 CFR 438.2].

MANAGEMENT SERVICES AGREEMENT

A type of subcontract with an entity in which the owner of the Contractor delegates all or substantially all management and administrative services necessary for the operation of the Contractor.

MATERIAL CHANGE TO BUSINESS OPERATIONS

Any change in overall operations that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance standards as required in Contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific GSA.

MATERIAL CHANGE TO PROVIDER NETWORK

Any change that affects, or can reasonably be foreseen to affect, the Contractor's ability to meet the performance and/or provider network standards as described in Contract including, but not limited to, any change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.

MANAGING EMPLOYEE

A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency [42 CFR 455.101].

MATERIAL OMISSION

A fact, data or other information excluded from a report, Contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, Contract, etc.

MEDICAID

A Federal/State program authorized by Title XIX of the Social Security Act, as amended.

MEDICAID MANAGED CARE REGULATIONS

The Federal law mandating, in part, that States ensure the accessibility and delivery of quality health care by their managed care Contractors. These regulations were promulgated pursuant to the Balanced Budget Act (BBA) of 1997.

MEDICARE

A Federal program authorized by Title XVIII of the Social Security Act, as amended.

MEDICAL EQUIPMENT AND APPLIANCES

Any item, appliance, or piece of equipment (pursuant to 42 CFR 440.70) that is not a prosthetic or orthotic; and

1. Is customarily used to serve a medical purpose, and is generally not useful to a person in the absence of an illness, disability, or injury,

2. Can withstand repeated use, and
 3. Can be reusable by others or removable.
- Medical equipment and appliances may also be referred to as Durable Medical Equipment (DME).

MEDICAL MANAGEMENT (MM)

An integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to hospice).

MEDICAL SUPPLIES

Health care related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury [42 CFR 440.70].

MEDICAL RECORDS

A chronological written account of a patient's examination and treatment that includes the patient's medical history and complaints, the provider's physical findings, behavioral health findings, the results of diagnostic tests and procedures, medications and therapeutic procedures, referrals and treatment plans.

MEDICAL SERVICES

Medical care and treatment provided by a Primary Care Provider (PCP), attending physician or dentist or by a nurse or other health related professional and technical personnel at the direction/order of a licensed physician or dentist.

MEDICALLY NECESSARY

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

MEDICALLY NECESSARY SERVICES

Those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability and other adverse health conditions or their progression or to prolong life.

MEDICATION ASSISTED TREATMENT

The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.

MEMBER

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

MEMBER INFORMATION MATERIALS

Any materials given to the Contractor's membership. This includes, but is not limited to: member handbooks, member newsletters, provider directories, surveys, on hold

messages and health related brochures/reminders and videos, form letter templates, and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member's phone.

NATIONAL PROVIDER IDENTIFIER (NPI)

A unique identification number for covered health care providers, assigned by the CMS contracted national enumerator.

NETWORK

A list of doctors, or other health care providers, and hospitals that a Contractor contracts with directly, or employs through a subcontractor, to provide medical care to its members.

NON-CONTRACTING PROVIDER

A person or entity that provides services as prescribed in A.R.S. §36-2901 who does not have a subcontract with an AHCCCS Contractor.

OUT OF NETWORK PROVIDER

A person or entity that has a provider agreement with the AHCCCS Administration pursuant to ARS 36-2904 which does not have a subcontract with an AHCCCS Contractor and which provides services specified in A.R.S. §36-2901 et seq.

PARENT

A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction.

PERFORMANCE IMPROVEMENT PROJECT (PIP)

A planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. Formerly referred to as Quality Improvement Projects (QIP).

PERFORMANCE STANDARDS

A set of standardized measures designed to assist AHCCCS in evaluating, comparing and improving the performance of its Contractors.

PHYSICIAN SERVICES

Medical assessment, treatments and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.

PLAN

See "SERVICE PLAN".

POSTSTABILIZATION CARE SERVICES

Medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized in order to maintain, improve or resolve

the member's condition so that the member could alternatively be safely discharged or transferred to another location [42 CFR 438.114(a)].

POTENTIAL ENROLLEE

A Medicaid-eligible recipient who is not yet enrolled with a Contractor [42 CFR 438.10(a)].

PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS)

An integrated information infrastructure that supports AHCCCS operations, administrative activities and reporting requirements.

PREMIUM

The amount an individual pays for health insurance every month. In addition to the premium, an individual usually has to pay other costs for their health care, including a deductible, copayments, and coinsurance.

PREMIUM TAX

The premium tax is equal to the tax imposed pursuant to A.R.S. §36-2905 and A.R.S. §36-2944.01 for all payments made to Contractors for the Contract Year.

PRESCRIPTION DRUGS

Any prescription medication as defined in A.R.S. §32-1901 is prescribed by a health care professional to a subscriber to treat the subscriber's condition.

PRIMARY CARE

All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them [42 CFR 438.2].

PRIMARY CARE PHYSICIAN

A physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17 and who otherwise meets the definition of Primary Care Provider (PCP).

PRIMARY CARE PROVIDER (PCP)

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

PRIMARY PREVENTION

The focus on methods to reduce, control, eliminate and prevent the incidence or onset of physical or mental health disease through the application of interventions before there is any evidence of disease or injury.

PRIOR AUTHORIZATION

Process by which the Administration or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior authorization is not a guarantee of payment (A.A.C. R9-22-101).

PRIOR PERIOD

See "PRIOR PERIOD COVERAGE."

PRIOR PERIOD COVERAGE (PPC)

The period of time prior to the member's enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the Contractor. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service and the member will be enrolled with the Contractor only on a prospective basis. HPE does not apply to ALTCS members. The time period for prior period coverage does not include the time period for prior quarter coverage.

PRIOR QUARTER COVERAGE

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

1. Received one or more covered services described in 9 A.A.C. 22, Article 2 and Article 12, and 9 A.A.C. 28, Article 2 during the month, and
2. Would have qualified for Medicaid at the time services were received if the person had applied regardless of whether the person is alive when the application is made. Refer to A.A.C. R9-22-303.

AHCCCS Contractors are not responsible for payment for covered services received during the prior quarter.

PROGRAM CONTRACTOR

See "CONTRACTOR"

PROVIDER

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

PROVIDER GROUP

Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

PRUDENT LAYPERSON (for purposes of determining whether an emergency medical condition exists)

A person without medical training who relies on the experience, knowledge and judgment of a reasonable person to make a decision regarding whether or not the absence of immediate medical attention will result in: 1) placing the health of the individual in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of a bodily part or organ.

QUALIFIED MEDICARE BENEFICIARY DUAL ELIGIBLE (QMB DUAL)

A person determined eligible under A.A.C. R9-29-101 et seq. for Qualified Medicare Beneficiary (QMB) and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB Dual receives both Medicare and Medicaid services and cost sharing assistance.

REFERRAL

A verbal, written, telephonic, electronic or in-person request for health services.

REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA)

A contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible persons assigned by the administration and provision of comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration.

REHABILITATION

Physical, occupational, and speech therapies, and items to assist in improving or restoring a person's functional level (A.A.C. R9-22-101).

REINSURANCE

A risk-sharing program provided by AHCCCS to Contractors for the reimbursement of certain Contract service costs incurred for a member beyond a predetermined monetary threshold.

RELATED PARTY

A party that has, or may have, the ability to control or significantly influence a Contractor, or a party that is, or may be, controlled or significantly influenced by a Contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the Contractor and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

REQUEST FOR PROPOSAL (RFP)

A RFP includes all documents, whether attached or incorporated by references that are used by the Administration for soliciting a Proposal under 9 A.A.C. 22 Article 6 and 9 A.A.C. 28 Article 6.

RISK CONTRACT

A Contract between the State and MCO, under which the Contractor:

1. Assumes risk for the cost of the services covered under the Contract; and
2. Incurs loss if the cost of furnishing the services exceeds the payments under the Contract. [42 CFR 438.2]

ROOM AND BOARD (or ROOM)

The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when a person lives in an institutional setting (e.g. NF, ICF). Medicaid funds cannot be expended for room and board when a member resides in an Alternative HCBS Setting (e.g. Assisted Living Home, Behavioral Health Residential Facilities) or an apartment like setting that may provide meals.

SCOPE OF SERVICES

See "COVERED SERVICES."

SERVICE LEVEL AGREEMENT

A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract.

SERVICE PLAN

A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

SPECIALIST

A Board-eligible or certified physician who declares themselves as a specialist and practices a specific medical specialty. For the purposes of this definition, Board-eligible means a physician who meets all the requirements for certification but has not tested for or has not been issued certification.

SPECIAL HEALTH CARE NEEDS (SHCN)

Serious and chronic physical, developmental, or behavioral conditions requiring medically necessary health and related services of a type or amount beyond that required by members generally; that lasts or is expected to last one year or longer and may require ongoing care not generally provided by a primary care provider.

SPECIALTY PHYSICIAN

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

STATE

The State of Arizona.

STATEWIDE

Of sufficient scope and breadth to address the health care service needs of members throughout the State of Arizona.

STATE FISCAL YEAR

The budget year-State fiscal year: July 1 through June 30.

STATE PLAN

The written agreements between the State and CMS, which describes how the AHCCCS program meets CMS requirements for participation in the Medicaid program and the State Children's Health Insurance Program.

SUBCONTRACT

An agreement entered into by the Contractor with any of the following: a provider of health care services who agrees to furnish covered services to member; or with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to AHCCCS under the terms of this Contract, as defined in 9 A.A.C. 22 Article 1.

SUBCONTRACTOR

1. A provider of health care who agrees to furnish covered services to members.
2. A person, agency or organization with which the Contractor has contracted or delegated some of its management/administrative functions or responsibilities.
3. A person, agency or organization with which a fiscal agent has entered into a Contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the AHCCCS agreement.

SUBSIDIARY

An entity owned or controlled by the Contractor.

SUBSTANCE USE DISORDERS

A range of conditions that vary in severity over time, from problematic, short-term use/abuse of substances to severe and chronic disorders requiring long-term and sustained treatment and recovery management.

SUPPLEMENTAL SECURITY INCOME (SSI) AND SSI RELATED GROUPS

Eligible individuals receiving income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or have a disability and have household income levels at or below 100% of the FPL.

THIRD PARTY LIABILITY (TPL)

See "LIABLE PARTY."

TITLE XIX

Known as Medicaid, Title XIX of the Social Security Act provides for Federal grants to the states for medical assistance programs. Title XIX enables states to furnish medical assistance to those who have insufficient income and resources to meet the costs of necessary medical services, rehabilitation and other services, to help those families and

individuals become or remain independent and able to care for themselves. Title XIX members include but are not limited to those eligible under Section 1931 of the Social Security Act, Supplemental Security Income (SSI), SSI-related groups, Medicare cost sharing groups, Breast and Cervical Cancer Treatment Program and Freedom to Work Program. Which includes those populations described in 42 U.S.C. 1396 a(a)(10)(A).

TITLE XIX MEMBER

Title XIX members include those eligible under Section 1931 provisions of the Social Security Act (previously AFDC), Sixth Omnibus Budget Reconciliation Act (SOBRA), Supplemental Security Income (SSI) or SSI-related groups, Medicare Cost Sharing groups, Adult Group at or below 106% Federal Poverty Level (Adults \leq 106%), Adult Group above 106% Federal Poverty Level (Adults $>$ 106%), Breast and Cervical Cancer Treatment program, Title IV-E Foster Care and Adoption Subsidy, Young Adult Transitional Insurance, and Freedom to Work.

TREATMENT

A procedure or method to cure, improve, or palliate an individual's medical condition or behavioral health issue. Refer to A.A.C. R9-10-101.

TRIBAL REGIONAL BEHAVIORAL HEALTH AUTHORITY (TRBHA)

A tribal entity that has an intergovernmental agreement with the administration, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health services to all eligible persons assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401 and A.R.S. §36-3407.

19.2 Part 2: Definitions Pertaining to One or More AHCCCS Contracts

The definitions specified in Part 1 below refer to terms found in all AHCCCS contracts.

1931 (ALSO REFERRED TO AS TANF RELATED)

Eligible individuals and families under Section 1931 of the Social Security Act, with household income levels at or below 100% of the Federal Poverty Level (FPL). See also “TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF).”

ABUSE (OF MEMBER)

Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. §46-451 and A.R.S. §13-3623.

ABUSE (BY PROVIDER)

Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.

ACTIVE TREATMENT

Active treatment means there is a current need for treatment. The treatment is identified on the member’s service plan to treat a serious and chronic physical, developmental or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider

ACUTE CARE ONLY (ACO)

The enrollment status of a member who is otherwise financially and medically eligible for ALTCS but who 1) refuses HCBS offered by the case manager; 2) has made an uncompensated transfer that makes him or her ineligible; 3) resides in a setting in which Long Term Care Services and Supports (LTSS) cannot be provided; or 4) has equity value in a home that exceeds \$552,000. These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive LTC institutional, alternative residential or HCBS.

ADMINISTRATIVE OFFICE OF THE COURTS (AOC)

The Arizona Constitution authorizes an administrative director and staff to assist the Chief Justice with administrative duties. Under the direction of the Chief Justice, the administrative director and the staff of the Administrative Office of the Courts (AOC) provide the necessary support for the supervision and administration of all State courts.

ADULT GROUP ABOVE 106% FEDERAL POVERTY LEVEL (ADULTS > 106%)

Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (FPL).

ADULT GROUP AT OR BELOW 106% FEDERAL POVERTY LEVEL (ADULTS \leq 106%)

Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (FPL).

AGENT

Any person who has been delegated the authority to obligate or act on behalf of another person or entity.

AFFILIATED ORGANIZATION

A party that, directly or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with an entity.

AID FOR FAMILIES WITH DEPENDENT CHILDREN (AFDC)

See "TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)."

ANNIVERSARY DATE

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

ANNUAL ENROLLMENT CHOICE (AEC)

The opportunity for a person to change Contractors every 12 months.

ARIZONA DEPARTMENT OF CHILD SAFETY (DCS)

The department established pursuant to A.R.S. §8-451 to protect children and to perform the following:

1. Investigate reports of abuse and neglect.
2. Assess, promote and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.
3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.
4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention and treatment services pursuant to this chapter.

ARIZONA DEPARTMENT OF JUVENILE CORRECTION (ADJC)

The State agency responsible for all juveniles adjudicated as delinquent and committed to its jurisdiction by the county juvenile courts.

BED HOLD

A 24 hour per day unit of service that is authorized by an ALTCS member's case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and therapeutic leave. Refer to the Arizona Medicaid State Plan, 42 CFR 447.40 and 42 CFR 483.12, 9 A.A.C. 28 and AMPM Chapter 100.

BEHAVIORAL HEALTH PARAPROFESSIONAL

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

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

BEHAVIORAL HEALTH RESIDENTIAL FACILITY

As specified in A.A.C. R9-10-101, health care institution that provides treatment to an individual experiencing a behavioral health issue that:

1. Limits the individual's ability to be independent, or
2. Causes the individual to require treatment to maintain or enhance independence.

BEHAVIORAL HEALTH TECHNICIAN

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

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

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP)

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

CARE MANAGEMENT PROGRAM (CMP)

Activities to identify the top tier of high need/high cost Title XIX members receiving services within an AHCCCS contracted health plan; including the design of clinical interventions or alternative treatments to reduce risk, cost, and help members achieve better health care outcomes. Care management is an administrative function performed by the health plan. Distinct from case management, Care Managers should not perform the day-to-day duties of service delivery.

CARE MANAGEMENT

A group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.

CASE MANAGEMENT

A collaborative process which assess, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Contractor Case management for DES/DDD is referred to as Support Coordination.

CASH MANAGEMENT IMPROVEMENT ACT (CMIA)

Cash Management Improvement Act of 1990 [31 CFR Part 205]. Provides guidelines for the drawdown and transfer of Federal funds.

CLIENT ASSESSMENT AND TRACKING SYSTEM (CATS)

A component of AHCCCS' data management information system that supports ALTCS and that is designed to provide key information to, and receive key information from ALTCS Contractors.

COMPREHENSIVE MEDICAL AND DENTAL PROGRAM (CMDP)

A Contractor that is responsible for the provision of covered, medically necessary AHCCCS services for foster children in Arizona. Refer to A.R.S. §8-512.

COMPETITIVE BID PROCESS

A State procurement system used to select Contractors to provide covered services on a geographic basis.

COUNTY OF FISCAL RESPONSIBILITY

The county of fiscal responsibility is the Arizona county that is responsible for paying the State's funding match for the member's ALTCS Service Package. The county of physical presence (the county in which the member physically resides) and the county of fiscal responsibility may be the same county or different counties.

DEVELOPMENTAL DISABILITY (DD)

As defined in A.R.S. §36-551, a strongly demonstrated potential that a child under six years of age has a developmental disability or will become a child with a developmental disability, as determined by a test performed pursuant to section 36-694 or by other appropriate tests, or a severe, chronic disability that:

1. Is attributable to cognitive disability, cerebral palsy, epilepsy or autism.
2. Is manifested before age eighteen.
3. Is likely to continue indefinitely.
4. Results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care.
 - b. Receptive and expressive language.
 - c. Learning.
 - d. Mobility.
 - e. Self-direction.
 - f. Capacity for independent living.
 - g. Economic self-sufficiency.
5. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration.

EQUITY PARTNERS

The sponsoring organizations or parent companies of the managed care organization that share in the returns generated by the organization, both profits and liabilities.

FAMILY-CENTERED

Care that recognizes and respects the pivotal role of the family in the lives of members. It supports families in their natural care-giving roles, promotes normal patterns of living, and ensures family collaboration and choice in the provision of services to the member. When appropriate the member directs the involvement of the family to ensure person centered care.

FAMILY OR FAMILY MEMBER

A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may also include siblings, grandparents, aunts and uncles.

FAMILY-RUN ORGANIZATION

An entity that has a board of directors made up of more than 50% family members who have primary responsibility for the raising of a child, youth, adolescent or young adult with a Serious Emotional Disturbance, (SED) or have the lived experience as a primary natural support for an adult with emotional, behavioral, mental health or substance use needs.

FEDERAL EMERGENCY SERVICES (FES)

A program delineated in A.A.C. R9-22-217, to treat an emergency condition for a member who is determined eligible under A.R.S. §36-2903.03(D).

FEDERALLY QUALIFIED HEALTH CENTER (FQHC)

A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting criteria under Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act.

FEDERALLY QUALIFIED HEALTH CENTER LOOK-ALIKE

A public or private non-profit health care organization that has been identified by the HRSA and certified by CMS as meeting the definition of “health center” under Section 330 of the Public Health Service Act, but does not receive grant funding under Section 330.

FIELD CLINIC

A “clinic” consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

FREEDOM OF CHOICE (FC)

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

GENERAL MENTAL HEALTH/SUBSTANCE USE (GMH/SU)

Behavioral health services provided to adult members age 18 and older who have not been determined to have a Serious Mental Illness.

GENERALIST SUPPORT AND REHABILITATION SERVICES PROVIDERS

Configure their program operations to the needs of the Child and Family Team without arbitrary limits on frequency, duration, type of service, age, gender, population or other factors associated with the delivery of Support and Rehabilitation Services.

HABILITATION

The process by which a person is assisted to acquire and maintain those life skills that enable the person to cope more effectively with personal and environmental demands and to raise the level of the person's physical, mental and social efficiency (A.R.S. §36-551 (18)).

HOME

A residential dwelling that is owned, rented, leased, or occupied at no cost to the member, including a house, a mobile home, an apartment or other similar shelter. A home is not a facility, a setting or an institution, or a portion and any of these, licensed or certified by a regulatory agency of the State as defined in A.A.C. R9-28-101.

HOME AND COMMUNITY BASED SERVICES (HCBS)

Home and community-based services, as defined in A.R.S. §36-2931 and A.R.S. §36-2939.

INTEGRATED MEDICAL RECORD

A single document in which all of the medical information listed in Chapter 900 of the AMPM is recorded to facilitate the coordination and quality of care delivered by multiple providers serving a single patient in multiple locations and at varying times.

INTERDISCIPLINARY CARE

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

INTERMEDIATE CARE FACILITY FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF/IID)

A placement setting for persons with intellectual disabilities.

JUVENILE PROBATION OFFICE (JPO)

An officer within the Arizona Department of Juvenile Corrections assigned to a juvenile upon release from a secure facility. Having close supervision and observation over juvenile's who are ordered to participate in the intensive probation program including visual contact at least four times per week and weekly contact with the school, employer, community restitution agency or treatment program. (A.R.S. §8-353)

KIDSCARE

Federal and State Children's Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL).

MEDICAL PRACTITIONER

A physician, physician assistant or registered nurse practitioner.

MEDICARE MANAGED CARE PLAN

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

MULTI-SPECIALTY INTERDISCIPLINARY CLINIC (MSIC)

An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

PEER-RUN ORGANIZATION

Peer-Operated Services that are:

1. Independent - Owned, administratively controlled, and managed by peers,
2. Autonomous - All decisions are made by the program,
3. Accountable - Responsibility for decisions rests with the program, and
4. Peer – controlled - Governance board is at least 51% peers.

PERSON-CENTERED

An approach to planning designed to assist the member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.

PERSON WITH A DEVELOPMENTAL/ INTELLECTUAL DISABILITY

An individual who meets the Arizona definition as outlined in A.R.S. §36-551 and is determined eligible for services through the DES Division of Developmental Disabilities (DDD). Services for AHCCCS-enrolled acute and long term care members with developmental/intellectual disabilities are managed through the DES Division of Developmental Disabilities.

PRE-ADMISSION SCREENING (PAS)

A process of determining an individual's risk of institutionalization at a NF or ICF level of care as specified in 9 A.A.C. 28 Article 1.

PRESCRIPTION DRUG COVERAGE

Prescription medications prescribed by an AHCCCS registered qualified practitioner as a pharmacy benefit, based on medical necessity, and in compliance with Federal and state law including 42 U.S.C 1396r-8 and A.A.C. R9-22-209.

RATE CODE

Eligibility classification for capitation payment purposes.

RISK GROUP

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

ROSTER BILLING

Any claim that does not meet the standardized claim requirements of 9 A.A.C. 22, Article 7 is considered roster billing.

RURAL HEALTH CLINIC (RHC)

A clinic located in an area designated by the Bureau of Census as rural, and by the Secretary of the DHHS as medically underserved or having an insufficient number of physicians, which meets the requirements under 42 CFR 491.

SERIOUS MENTAL ILLNESS (SMI)

A condition as defined in A.R.S. §36-550 and determined in a person 18 years of age or older.

SIXTH OMNIBUS BUDGET AND RECONCILIATION ACT (SOBRA)

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

SMI ELIGIBILITY DETERMINATION

The process, after assessment and submission of required documentation to determine, whether a member meets the criteria for Serious Mental Illness.

SPECIALIST SUPPORT AND REHABILITATION SERVICES PROVIDERS

Provide either a limited scope of Support and Rehabilitation Services (such as primarily specializing in respite services or skills training services) and/or services that may be designed for a specific population, age, gender, frequency, duration or some other factor (such as a service specializing in working with teenagers or those with a history of displaying harmful sexual behaviors).

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

State Children's Health Insurance Program under Title XXI of the Social Security Act (Also known as CHIP). The Arizona version of CHIP is referred to as "KidsCare." See also "KIDSCARE."

STATE ONLY TRANSPLANT MEMBERS

Individuals who are eligible under one of the Title XIX eligibility categories and found eligible for a transplant, but subsequently lose Title XIX eligibility due to excess income become eligible for one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11.

SUBSTANCE ABUSE

As specified in A.A.C. R9-10-101, an individual's misuse of alcohol or other drug or chemical that:

1. Alters the individual's behavior or mental functioning;
2. Has the potential to cause the individual to be psychologically or physiologically dependent on alcohol or other drug or chemical; and
3. Impairs, reduces, or destroys the individual's social or economic functioning.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF)

A Federal cash assistance program under Title IV of the Social Security Act established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). It replaced Aid To Families With Dependent Children (AFDC).

TITLE XXI

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

TITLE XXI MEMBER

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

TREATMENT PLAN

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

VIRTUAL CLINICS

Integrated services provided in community settings through the use of innovative strategies for care coordination such as Telemedicine, integrated medical records and virtual interdisciplinary treatment team meetings.

19.3 The Health Plan Definitions

24 HOUR URGENT REFERRAL.

A referral that results in an intake that must be completed in a community setting within 24 hours of the request. It includes care coordination, discharge planning services and an SMI screening when appropriate. The 24 Hour Mobile Team Urgent Referral services are provided in hospitals, nursing homes, foster homes, detention facilities and other community settings.

72 HOUR DCS RAPID RESPONSE

A mobile response that includes an intake in a community setting within 72 hours of the request. It includes care coordination services and coordination with DCS and the courts. The 72 Hour Mobile Team Rapid Response services are provided in hospitals, homes, shelters and other community settings.

834 TRANSACTION ENROLLMENT/DISENROLLMENT

AHIPAA compliant transmission, by a health care provider to a T/RBHA and by a T/RBHA to AHCCCS that contains information to establish or terminate a person's enrollment in the AHCCCS service delivery system.

AHCCCS – AzCH - Arizona Complete Care Contract

Contract entered into between AHCCCS and AzCH - Arizona Complete Care, including all attachments and exhibits thereto, as such contract may be amended or supplemented from time to time.

ADMINISTRATIVE COSTS

Administrative expenses incurred to manage the health system, including, but not limited to provider relations and contracting; provider billing; provider sub-capitation administration provision; non-encounterable PBM fees (e.g., pharmacy network management, pharmacy discount negotiating, drug utilization review, coordination of specialty drugs, pharmacy claims processing, pharmacy call center operations, etc.); quality improvement activities; accounting; information technology services; processing and investigating grievances and appeals; legal services, which includes legal representation of the Contractor at administrative hearings; planning; program development; program evaluation; personnel management; staff development and training; provider auditing and monitoring; utilization review and quality assurance. Administrative costs do not include expenses incurred for the direct provision of health care services, including case management, or integrated health care services.

ADULT RECOVERY TEAM ("ART")

A defined group of individuals that includes, at a minimum, the member, their family, a behavioral health representative, and any individuals important in the member's life that are identified and invited to participate by the member. This may include system partners such as extended family members, friends, family support partners, healthcare providers, community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like the Department of Developmental Disabilities (DDD), Probation, or the Administrative Office of the Courts (AOC). The size, scope and intensity of involvement of the team members are determined by the objectives established for the adult, the needs of the family in providing for the adult, and by which individuals are needed to develop an effective service plan, and can therefore expand and contract as necessary to be successful on behalf of the adult should this be needed or required.

ADVERSE BENEFIT DETERMINATION

(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

- (2) The reduction, suspension, or termination of a previously authorized service;
- (3) The denial, in whole or in part, of payment for a service;
- (4) The failure to provide services in a timely manner;
- (5) The failure of the Health Plan to act within the established timeframes regarding the standard resolution of grievances and appeals;
- (6) The denial of a member's request to obtain services outside the network; and/or
- (7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

AFFILIATE

A person or entity controlling, controlled by, or under common control with AzCH - Arizona Complete Care.

AHCCCS REGISTERED PROVIDER

A provider that enters into an agreement with AHCCCS under A.A.C. R9-22-703(A), and meets licensing or certification requirements to provide covered services.

AMENDMENT

A written document that is issued for the purpose of making changes to a document.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY ("ADES")

The State agency that has the powers and duties set forth in A.R.S. § 41-1951, et seq.

ASSESSMENT INTERVENTION CENTER ("AIC")

A time limited, intensive program serving children and families that delivers services in an ADHS-licensed BHRF (Provider Type B8). The program's focus is on thorough psychiatric, psychological, and family systems evaluations, a comprehensive behavioral analysis; and development of targeted interventions individualized for each member and family. The program is designed for up to a thirty (30) day treatment period. The initial fourteen (14) days of service do not require prior authorization. Additional services require a concurrent authorization on or before the fourteenth (14th) day of service. The maximum length of stay is thirty (30) days. The goal of the program is to answer the question "What supports and interventions are needed for this member to live successfully in the community?"

ATTACHMENT

Any attachment, amendment, exhibit and/or schedule to a document.

BEST PRACTICES

Evidence-based practices, promising practices, or emerging practices.

BOARD ELIGIBLE PSYCHIATRY

A physician with documentation of completion of an accredited psychiatry residency program approved by the American College of Graduate Medical Education, or the American Osteopathic Association. Documentation would include either a certificate of residency training including exact dates, or a letter of verification of residency training from the training director including the exact dates of training.

BRIEF INTERVENTION PROGRAM (BIP)

Is a time-limited, intensive crisis intervention program that delivers services in an ADHS licensed BHRF (Provider Type B8) to help persons live successfully in the community. The program includes crisis, supportive and treatment services. No prior authorization is needed for the first 5 days.

A CFT or ART meeting must be conducted within three (3) business days of a member's admission to the program.

If an extension in the stay is needed to further stabilize after the initial 5 days, an authorization is required for an extension of 5 additional days. The clinical documentation must be submitted to support medical necessity. The maximum length of stay is ten (10) days.

There are limited beds in the community designed as discharge BIP beds for members who do not qualify for medical necessity in a behavioral health level 1 facility but the member needs stabilization prior to returning to their previous living arrangements.

AzCH – ARIZONA COMPLETE CARE PROVIDER MANUAL

Provider Manual including any amendments, appendices, modifications, supplements, bulletins, or notices related to the AzCH - Arizona Complete Care Provider Manual that may be made from time to time and available on AzCH - Complete Health Plan's website. AzCH - Complete Health Plan shall use its reasonable efforts to give Subcontractor advance notice of any amendment or modification of the AzCH – Complete Health Plan Provider Manual that materially affects Subcontractor's

CLAIM

A service billed under a fee-for-service arrangement.

COMMUNITY SERVICE AGENCY ("CSA")

An agency that is contracted directly by AzCH - Arizona Complete Care and registered with AHCCCS to provide rehabilitation and support services consistent with the staff qualifications and training. Refer to the AHCCCS Covered Behavioral Health Services Guide for details.

COMPLEX NEEDS

The presence of significant behavioral challenges that impact the safety of a member, facility personnel, and/or other members for which additional staff support is needed to address and successfully treat the member's behavioral challenges in the facility.

CONFLICT OF INTEREST ("COI")

Any situation in which the Subcontractor or an individual employed or retained by the Subcontractor is in a position to exploit a contractual, professional, or official capacity in some way for personal or organizational benefit that otherwise would not exist.

CONTRACT YEAR ("CY")

The time period that corresponds to the federal fiscal year, October 1 through September 30 used for financial reporting purposes.

CULTURAL COMPETENCY

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals which enables that system, agency, or those professionals to work effectively 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.

DEDICATED HEALTH CARE COORDINATOR

The job title used by AzCH - Arizona Complete Care to describe the role Subcontractor employees perform related to assisting a High Needs Member and family in achieving recovery. These duties include all duties formerly assigned to the role of the Case Manager and include intensive case management services, management of care, coordination of services, employment support, health promotion, motivational interviewing, assisting with service planning and other similar services to support recovery.

DELIVERABLES

The reports and other deliverables the Subcontractor is required to provide to AzCH - Arizona Complete Care pursuant to the AzCH - Arizona Complete Care Provider Manual.

DIRECT CARE STAFF

In the case where a Subcontractor is a health care entity, a person or entity who is employed by or otherwise engaged by Subcontractor to provide Covered Services to Members.

NATIONAL CLAS STANDARDS

The U.S. Department of Health and Human Services Office of Minority Health standards for Culturally and Linguistically Appropriate Services ("CLAS"), which may be amended or supplemented from time to time and is are included as Exhibit F. The National CLAS Standards aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.

FISCAL YEAR ("FY")

The State budget year: July 1 through June 30. This is to be distinguished from the Contract Year, as defined above.

FORMULARY

A list of covered medications available for treatment of Members.

FREEDOM TO WORK (also referred to as TICKET TO WORK)

Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after

allowable deductions is at or below 250% of the FPL, and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.

GENERAL MENTAL HEALTH/SUBSTANCE ABUSE (GMH/SA)

Behavioral health services provided to adult members age 18 and older who have not been determined to have a serious mental illness.

HEALTH CARE COORDINATOR

Health Care Coordinator is the job title used by AzCH - Arizona Complete Care to describe the required duties performed by Subcontractor (Provider) employees related to coordinating physical health, behavioral health and social services in a member-focused manner with the goals of improving whole person health outcomes, and more effective and efficient use of resources. Health Care Coordinators, often referred to as Health Care Coordinators, Case Managers, Integrated Care Managers, or Care Coordinators; provide accessible, comprehensive, and continuous coordination of care based on effective working relationships with members and accumulated knowledge over time of members' health care challenges and strengths. Health Care Coordinators build on members' strengths to promote wellness, recovery, and resiliency.

HIGH NEED CASE MANAGEMENT

An intensive level of case management services provided to high need Members.

HIGH NEED RECOVERY MANAGEMENT ("HNRM")

Specially designed programs, care management services, treatment services and dedicated staff responsible to meet the care management and treatment needs of High Need Members. HNRM is required to be available 24/7/365 to monitor and facilitate the safety of High Need Members, the safety of communities, and assist High Need Members to live successfully in the community.

INTERAGENCY SERVICE AGREEMENT ("ISA")

An agreement between two or more agencies of the State wherein an agency is reimbursed for services provided to another agency or is advanced funds for services provided to another agency. (A.R.S. § 35-148(A))

LEVEL I BEHAVIORAL HEALTH FACILITY

An inpatient treatment program or behavioral health treatment facility that is licensed under A.A.C. Title 9, Chapter 10 and includes a psychiatric acute hospital, a residential treatment center for individuals under the age of twenty-one (21), or a sub-acute facility.

LEVEL IV BEHAVIORAL HEALTH FACILITY

A behavioral health agency as defined in A.A.C. Title 9, Chapter 10.

LOW AND MODERATE NEED RECOVERY CENTER

A set of specially designed programs and services and designated staff responsible to meet the needs of Members with low to moderate needs. LMNR Centers are required to

screen Members for "High Needs" and refer High Need Members to High Need Recovery Centers.

MATERIAL GAP

A temporary change in a provider network that may reasonably be foreseen to jeopardize the delivery of covered health services to an identifiable segment of the Member population.

MATERIAL OMISSION

Facts, data or other information excluded from a report, contract, the absence of which could lead to erroneous conclusions following reasonable review of such report or contract.

MAY

Something is permissive.

MEDICAL EXPENSE DEDUCTION

Title XIX waiver Member whose family income exceeds the limits of all other Title XIX categories (except ALTCS) and has family medical expenses that reduce income to or below 40% of the Federal Poverty Level. Medical Expense Deduction members may or may not have a categorical link to Title XIX.

MEDICAL INSTITUTION

An acute care hospital, psychiatric hospital—Non IMD, psychiatric hospital – IMD—, Residential Treatment Center—Non IMD, psychiatric hospital – IMD—, Skilled Nursing Facility, or Intermediate Care Facility for persons with intellectual disabilities.

MEDICARE MODERNIZATION IMPROVEMENT ACT OF 2003 ("MMA")

The federal law that created a prescription drug benefit called Medicare Part D for individuals who are eligible for Medicare Part A and/or enrolled in Medicare Part B.

MEDICARE PART D EXCLUDED DRUGS

Medicaid does not pay for Medicare Part D covered drugs for members eligible for Medicare Part D including Dual Eligible Members. Exceptions include behavioral health medications on the behavioral health drug list for members with a serious mental illness. Certain drugs that are excluded from coverage by Medicare continue to be covered by AHCCCS. Those medications include over-the-counter medications as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D health plan's formulary are not considered excluded drugs and are not covered by AHCCCS.

MEDICATIONS LIST

The same meaning as "Formulary" or "Preferred Drug List" (PDL).

MENTAL HEALTH BLOCK GRANT ("MHBG")

An annual formula grant from The Substance Abuse and Mental Health Services Administration (SAMHSA) that provides funds to establish or expand an organized

community-based system of care for providing non-Title XIX mental health services to children with serious emotional disturbances (SED) and adults with serious mental illness (SMI). These funds are used to: (1) carry out the State plan contained in the application; (2) evaluate programs and services, and; (3) conduct planning, administration, and educational activities related to the provision of services.

MUST

Denotes the imperative.

NON-TITLE XIX/XXI FUNDING

Fixed, non-capitated funds, including funds from MHBG and SABG, County, and other funds, and State appropriations (excluding State appropriations for state match to support the Title XIX and Title XXI program), which are used for services to Non-Title XIX/XXI eligible persons and for medically necessary services not covered by Title XIX or Title XXI programs.

NON-TITLE XIX/XXI MEMBER OR NON-TITLE XIX/XXI PERSON

An individual who needs or may be at risk of needing covered health-related services, but does not meet federal and state requirements for Title XIX or Title XXI eligibility.

NON-TITLE XIX/XXI SMI MEMBER

A Non-Title XIX/XXI Member who has met the criteria to be designated as Seriously Mentally Ill.

OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS (OIFA)

An AHCCCS bureau that builds partnerships with individuals, families of choice, youth, communities, organizations to promote recovery, resiliency and wellness. OIFA collaborates with key leadership and community members in the decision making process at all levels of the behavioral health system. In partnership with the community, OIFA advocates for the development of culturally inclusive environments that are welcoming to individuals and families. establishes structures to promote diverse youth, family and individual voices in leadership positions throughout Arizona, delivers training, technical assistance and instructional materials for individuals and their families, ensure peers support and family support are available to all persons receiving services and their families, and monitors contractor performance and measure outcomes.

OUTREACH

Activities to identify and encourage Members or potential Members, who may be in need of, but not yet receiving physical or behavioral health services.

PAYOR

AzCH – Arizona Complete Care or another entity that is responsible for funding Covered Services to Members.

PAYOR CONTRACT

AzCH – Arizona Complete Care's contract with any Payor that governs provision of Covered Services to Members. When AzCH – Arizona Complete Care is the Payor, "PAYOR CONTRACT" AzCH – Arizona Complete Care's contract with the State or federal

agency or other entity that has contracted with AzCH - Arizona Complete Care to arrange for the provision of Covered Services to eligible individuals of such agency or other entity.

PRIVILEGING

The process used to determine if credentialed clinicians are competent to perform certain treatment interventions, based on training, supervised practice, and/or competency testing.

PROFIT

The excess of revenues over expenditures, in accordance with Generally Accepted Accounting Principles, regardless of whether Subcontractor is a for-profit or a not-for-profit entity.

PROVIDER NETWORK

The agencies, facilities, professional groups, and professionals or other persons under subcontract to AzCH – Complete Care Plan to provide Covered Services to Members, including the Subcontractor to the extent the Subcontractor directly provides Covered Services to Members.

PSYCHIATRIST

A person who is a licensed physician as defined in A.R.S. Title 32, Chapter 13 or Chapter 17 and who holds psychiatric board certification from the American Board of Psychiatry and Neurology, the American College of Osteopathic Neurologists and Psychiatrists, or the American Osteopathic Board of Neurology and Psychiatry; or is board eligible.

REHABILITATION SERVICES ADMINISTRATION ("RSA")

The Division within Arizona Department of Economic Security.

SAMHSA

The Substance Abuse and Mental Health Services Administration, which is a part of the U.S. Public Health Service leads public health efforts to advance the behavioral health of the nation.

SHALL

Something is mandatory.

SHOULD

Denotes a preference.

SMI GRIEVANCE INVESTIGATION

A grievance or request for investigation that is filed by or on behalf of a person with Serious Mental Illness alleging a violation of the member's rights or asserting that a condition requiring investigation exists.

SMI MEMBER

A member who meets the criteria and has been enrolled with a Serious Mental Illness as defined in A.R.S. 36-550.

SMI MEMBER RECEIVING PHYSICAL HEALTH CARE SERVICES

A Title XIX eligible adult who is eligible to receive both behavioral and physical health care services through AzCH - Arizona Complete Care's provider network.

SPECIALTY ASSESSMENT

A specialized assessment written by a Specialty Provider to determine an eligible individual's level of functioning and medical necessity for the specialty services provided by the Specialty Provider. All persons being served in the public health system must have an assessment upon an initial request for services with updates occurring at least annually. The Specialty Assessment must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the individual for the medical condition being treated. AzCH - Arizona Complete Care does not have a mandated Specialty Assessment template but all Behavioral Health Assessments must include all elements outlined in Policy 105, Assessment and Service Planning and be in accordance to all state and federal regulations.

SPECIALTY/SUB-SPECIALTY PROVIDER

A contracted provider type requiring full execution of specialty/sub-specialty services. Specialty/Sub-specialty Providers are required to deliver specialized programs and treatment services in treatment facilities, the community, Member homes, or specified offices to meet the unique needs of special populations. Specialty Providers include ADHS Division of Licensing Services licensed facilities, CSAs, MDs, DOs, Licensed Psychologists, NPs, LPCs, LISACs, and LCSWs.

SPECIALTY SERVICE PLAN

A written plan for services written by the Specialty Provider upon an eligible individual's request for services. Specialty Service Plans require periodic updates to the plan to meet the changing health needs for persons who continue to meet medical necessity for requested services. AzCH - Arizona Complete Care does not mandate a specific service plan template. All Specialty Service Plans must be written in accordance to all state and federal regulations.

STEP THERAPY

The practice of initiating drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails.

SUBSTANCE ABUSE BLOCK GRANT ("SABG")

An annual formula grant from The Substance Abuse and Mental Health Services Administration (SAMHSA) that supports primary prevention services and treatment services for persons with substance use disorders. It is used to plan, implement and evaluate activities to prevent and treat substance abuse. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance abusers.

SUPPORT SERVICES

Covered Services as defined in the AHCCCS Covered Behavioral Health Services Guide.

TICKET TO WORK

Has the same meaning as "Freedom to Work."

TITLE XIX COVERED SERVICES

The covered services identified in the AHCCCS Covered Behavioral Health Services Guide and the physical health care covered services described in Solicitation No. ADHS 15-00004276, Scope of Work Section 4.7, Physical Health Care Covered Services.

TITLE XIX WAIVER GROUP – AHCCCS CARE (NON-MED)

Eligible individuals and couples whose income is at or below one hundred percent (100%) of the FPL and who are not categorically linked to another Title XIX program.

TRAUMA-INFORMED CARE ("TIC")

An approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in the lives of people who receive services and people who provide services (SAMHSA Center for Trauma Informed Care).

VITAL MATERIALS

Written materials that are critical to obtaining services which include, at a minimum, the following:

1. Member Handbooks
2. Provider Directories
3. Consent Forms
4. Appeal and Grievance Notices,
5. Denial and Termination Notices

YOUNG ADULT TRANSITION INSURANCE ("YATI")

Transitional medical care for individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday.

19.4 Acronyms

A.A.C.	Arizona Administrative Code
AAR	Arizona Administrative Register
ACOM	Arizona Healthcare Cost Containment System Contractor Operational Manual
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADOE	Arizona Department of Education
ADES or DES	Arizona Department of Economic Security
ADES/DDD or DDD	Arizona Department of Economic Security, Division of Developmental Disabilities

ADES/RSA or RSA	Arizona Department of Economic Security, Rehabilitation Services Administration
ADHS	Arizona Department of Health Services
ADJC	Arizona Department of Juvenile Correction
ADOC	Arizona Department of Corrections
ADOH	Arizona Department of Housing
AHCCCS	Arizona Healthcare Cost Containment System
AIHP	American Indian Health Program
ALTCS	Arizona Long Term Care System
AMPM	Arizona Healthcare Cost Containment System Medical Policy Manual
AOC	Administrative Office of the Courts of the Supreme Court
A.R.S.	Arizona Revised Statutes
ASAM	American Society of Addiction Medicine
ASAM PPC	American Society of Addiction Medicine Patient Placement Criteria
ASDB	Arizona State Schools for the Deaf and Blind
AzSH	Arizona State Hospital
ASIIS	Arizona State Immunization Information System
AzEIP	Arizona Early Intervention Program
BHP	Behavioral Health Professional
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CFT	Child and Family Team
CLAS	National Culturally Linguistically and Appropriate Service Standards
CLIA	Clinical Laboratory Improvement Amendments
CMDP	Comprehensive Medical and Dental Plan
CMS	Centers for Medicare and Medicaid Services
CPHQ	Certified Professional in Healthcare Quality
CRS	Children's Rehabilitative Services
DASIS	Drug and Alcohol Services Information System
DBHS	Division of Behavioral Health Services
DCS	Department of Child Safety
DHHS or HHS	U.S. Department of Health and Human Services
DME	Durable Medical Equipment
DSM	Diagnostic and Statistical Manual of International Classification of Disorders
EHR	Electronic Health Records
EPLS	Excluded Provider List System
EPSDT	Early Periodic Screening Diagnostic and Treatment Service
F.I.R.S.T.	Families in Recovery Succeeding Together
FQHC	Federally Qualified Health Centers

FTP	File Transfer Protocol
GME	Graduate Medical Education
GMH	General Mental Health Adults
GSA	Geographical Service Area
HCAC	Health Care Acquired Condition
HCTC	Home Care Training to Home Care Client
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
HMIS	Homeless Management Information System
HRC	Human Rights Committee
HUD	Housing and Urban Development
IAD	Incident, Accident, and Death
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
IGA	Intergovernmental Agreement
IHS	Indian Health Services
IMD	Institution for Mental Disease
ISA	Interagency Service Agreement
ISP	Individual Service Plan
IVR	Interactive Voice Response
LEIE	List of Excluded Individuals/Entities
LEP	Limited English Proficiency
MAP	Medicare Advantage Plan
MAPDP	Medicare Advantage Prescription Drug Plan
MCO	Managed Care Organization
MHBG	Mental Health Block Grant
MIS	Management Information System
MM/UM	Medical Management/Utilization Management
MPS	Minimum Performance Standard
MRPDL	AHCCCS Minimum Required Prescription Drug List
NOMS	National Outcome Measures
NPI	National Provider Identifier
OHR	Office of Human Rights
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPI	Office Program Integrity
OPPC	Other Provider-Provider Condition
NON-MED	Non-Medical Expense Deduction Member

PASRR	Pre-Admission Screening and Resident Review
PATH	Project for Assistance in Transition from Homelessness
PCP	Primary Care Provider
PDSA	Plan Do Study Act
PHA	Public Housing Authorities
PIP	Performance Improvement Plan, Process or Projects
PMMIS	AHCCCS Prepaid Medical Management Information System
PPS	Prospective Payment System
QIO	Quality Improvement Organizations
QM	Quality Management
QOC	Quality of Care Concern
RBHA/MCO/Health Plan	Regional Behavioral Health Authority/Managed Care Organization/Health Plan
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SABG	Substance Abuse Block Grant
SCHIP	State Children's Health Insurance Program
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOBRA	Sixth Omnibus Budget and Reconciliation Act of 1986, amended by the Medicare Catastrophic Coverage Act of 1988
SSI	Supplemental Security Income
SSI-MAO	Social Security Income Management Administration Office
TANF	Temporary Assistance to Needy Families
TDD	Telecommunications Device for the Deaf
TRBHA	Tribal Regional Behavioral Health Authority
VFC	Vaccine for Children
ZIP	Zone Improvement Plan