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CHAPTER 1 - INTRODUCTION TO THE DIVISION OF DEVELOPMENTAL DISABILITIES

REVISION DATE: 4/16/2014

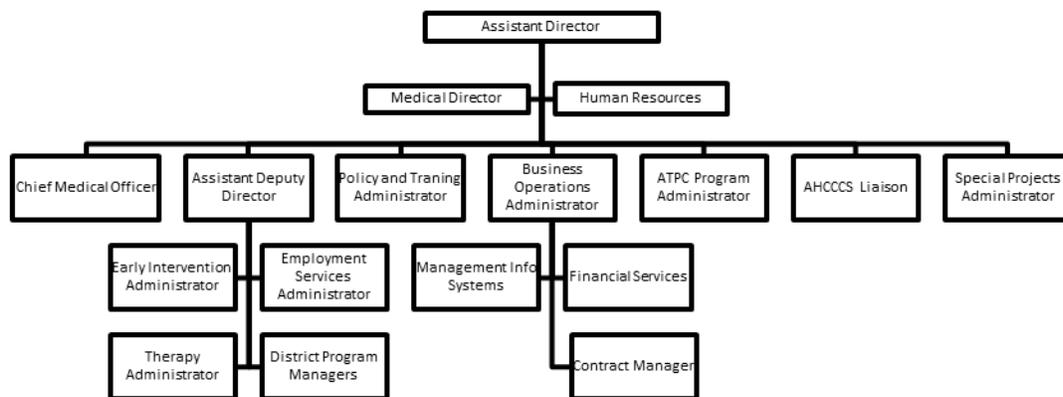
EFFECTIVE DATE: March 29, 2013

REFERENCES: [A.R.S. § 36-554\(A\)\(10\)](#)

Program Description

The Division of Developmental Disabilities within the Arizona Department of Economic Security (Department or ADES) provides services and programs to people with developmental disabilities and their families. The Division believes that people can best be supported in integrated community settings and the majority of the Division's programs and services are tailored to meet the individual needs of people with developmental disabilities and their families at home and in community-based settings.

The Division coordinates services and resources through central administrative offices, five district offices and local offices located in communities throughout Arizona. While some services are delivered directly by the State, almost all services and supports are delivered through a network of individual and agency providers throughout Arizona.



The Division contracts with Acute Care Health Plans that together provide medical care to ALTCS members with developmental disabilities residing in every Arizona County. The health plans are responsible for assigning or allowing each person who is enrolled the choice of a primary care provider. The current contracted health plans are Arizona Physicians Independent Physician Association, Mercy Care Plan, and Care 1st Health Plan Arizona.

American Indian Health Program (AIHP) is selected as the primary provider by many Native American members. When AIHP makes a referral for service(s) outside their facilities, the Division is responsible for these services on a fee-for-service basis.

Division Credo and Value Statement

The Division, in partnership with consumers with developmental disabilities, their families, advocates, community members and service providers, will develop, enhance, and support environments which will enable consumers with developmental disabilities to achieve and maintain physical well-being, personal and professional satisfaction, and participation as family and community members, and safety from abuse and exploitation.

The following value statements reflect the Division's philosophy:

We value:

- A. The development and fostering of personal relationships with family and friends.
- B. Consumer and family initiative in making choices and expressing preferences.
- C. Equal access to quality services and supports for all individuals.
- D. Consumers as welcomed, participating, and contributing members in all aspects of family and community life.
- E. The rights of all individuals and the preservation of their worth, value and dignity.
- F. Healthy relationships with people.
- G. Individual and family priorities and choices.
- H. Equal access to quality services and supports for all individuals and families.
- I. Partnerships and ongoing communication with individuals, family members, advocates, providers, and community members.
- J. Developmental approaches – changing conditions that affect people rather than changing people who are affected by conditions.
- K. Individual freedom from abuse, neglect and exploitation with a balance between the right to make choices and experience life and individual safety.
- L. A diverse workforce that is motivated, skilled and knowledgeable of and uses the most effective practices known.
- M. An environment rich in diversity in which each person is respected and has the opportunity to reach their optimal potential.
- N. An individual's right to choose to participate in and contribute to all aspects of home and community life.
- O. A system of services and supports which are:

1. Responsive – timely and flexible responses to internal and external customers
2. Strength based – recognizing people’s strengths, promoting self-reliance, enhancing confidence and building on community assets
1. Effective – ongoing identification of effective methods and practices and incorporation of those practices into operations
2. Accountable to our customers and to the taxpayers.

Therefore:

- A. Programs and services will be offered in a manner which supports and enhances independence, self-esteem, mutual respect, value and dignity.
- B. Within available resources, programs and services will be offered to support consumer and family preferences and choices regarding opportunities for consumers to learn/gain, exercise personal and professional competence and shape personal futures.
- C. Opportunities, programs and services will be designed and developed in partnership with consumers, families, advocates, community members and service providers.
- D. Families and friends will be recognized as the primary providers of support, nurturing, and training, and as capable of determining their own needs.
- E. Programs and services will be provided through a comprehensive, home and community-based system which recognizes and supports cultural diversity.
- F. Programs and services will be designed and offered to promote optimum physical, mental and emotional well-being.
- G. The Division will work cooperatively with community and business leaders to develop information and access to community programs and supports for consumers. It will participate in community education programs regarding developmental disabilities.
- H. Programs and services will be offered in a manner which exhibits effective, efficient and appropriate management and public accountability.
- I. Decisions, actions, and program development will be guided by the Division philosophy, values, and imperatives.

Behavioral Health Services Network

The majority of behavioral health services are provided through the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS). The ADHS/DBHS receives a capitation for these services that is appropriated directly by the Arizona Legislature. The Division administers the service delivery through an Interagency Service Agreement (ISA) with the ADHS/DBHS. Ultimately, the Division is responsible for ensuring

that the delivery of behavioral health services is meeting the needs of the members being served.

In addition to behavioral health services provided through ADHS/DBHS, the Division provides other home and community based for members using behavioral health services. These services are part of and contained in the Home and Community Based Services (HCBS) information.

Home and Community Based Services (HCBS) Network

HCBS are supports to promote independence and inclusion within the community for eligible members with developmental disabilities and their families, in the least restrictive home and community-based settings. These services include, but are not limited to: in-home services (e.g., attendant care, habilitation, respite); habilitative therapies; day programs; employment programs; and residential services. The Division contracts with over 600 Qualified Vendors and 1,800 Independent Providers to provide this array of home and community-based services.

Chapter 2 - PROVIDER RESPONSIBILITIES AND EXPECTATIONS

REVISION DATE: 8/12/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: A.A.C R6-6-1001; A.A.C R6-6-1101; [Service Specifications](#); [DDD Rules](#); [ALTCS Rules](#)

All providers must have a valid AHCCCS identification number. If applicable, the provider must also have a National Provider Identifier (NPI), proper licensure according to state and federal regulations, and documentation indicating compliance with local fire and sanitation codes and regulations.

All providers must ensure each member's privacy is protected, in accordance with the privacy requirements in 45 CFR parts 160 and 164.

Qualified Vendors and Independent Providers will:

- A. Provide services in a manner that supports and enhances the member's independence, self-esteem, mutual respect, value, and dignity.
- B. Actively participate in the member's Planning Team meeting at the date, time, and location determined by the Division.
- C. Meet with the member and, if applicable, the primary caregiver prior to initiating service and obtain necessary information.
- D. Administer first aid and appropriate attention to injury or illness.
- E. Report incidents in accordance with the Division's Policy Manual.
- F. As required, submit progress reports and teaching strategies (including measurable data to validate the effectiveness of the service) to aid the Support Coordinator in assessing the continued need for the service.
- G. Notify the Support Coordinator to request a Planning Team meeting whenever there is a significant change in the member's status.
- H. Complete other assignments as determined by the Planning Team.
- I. Provide services as authorized by the Division.

Referrals for Potential Applicants for Developmental Home Licensure

A Qualified Vendor contracted by the Division for the recruitment of Developmental Home providers must inform a potential applicant for Developmental Home licensure of the requirements for licensure under A.A.C. R6-6-1001 or A.A.C. R6-6-1101 *Application for License*. The Qualified Vendor may not "counsel out" or in any way dissuade an applicant who wishes to apply to the Department for a developmental home license.

If the Qualified Vendor determines it is not able to work with an applicant who wishes to apply for a license, the determination may not be based on race, religion, national origin, sex, sexual orientation, gender identity or a similar protected class.

A Qualified Vendor must assist any applicant with whom they decline to work to find an alternative vendor or, if no alternative vendor is available, refer the applicant to the Division. The Qualified Vendor must transfer any application information to the alternative vendor or Division, as applicable.

CHAPTER 3 - PROVIDER SERVICE DEPARTMENTS

REVISION DATE: 5/27/2016, 1/29/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

The Division offers a variety of assistance for its providers. For inquiries regarding billing/claims, contracts, and health care services, or to initiate a complaint, providers may contact Provider Relations at 602-542-6863 or e-mail DDDProviderRelations@azdes.gov.

Medical providers providing services for members enrolled with an acute care contractor should contact the appropriate Health Plan:

United Community Health Plan: 1-800-445-1638

Care1st: 602-778-1800

Mercy Care: 1-800-624-3879

CHAPTER 4 – COVERED AND NON-COVERED SERVICES

REVISION DATE: 10/14/2016, 5/27/2016, 4/1/2015, 8/1/2014, 4/16/2014

EFFECTIVE DATE: March 29, 2013

Covered Services

The Division follows AHCCCS guidelines pertaining to the services that are covered under the ALTCS program as set forth in the AHCCCS Medical Policy Manual (AMPM). Services cannot be denied based on moral and religious grounds. You are encouraged to view the AMPM on the AHCCCS website for further information about covered services.

- A. Examples of covered services for members under the age of 21 years include, but are not limited to:
 - 1. Emergency room services
 - 2. Dental
 - 3. Podiatry
 - 4. Vision
 - 5. Doctor's office visits
 - 6. Urgent care
 - 7. Transplants
 - 8. Family planning services
 - 9. Medications
 - 10. Behavioral health services
 - 11. Therapies
 - 12. Respite
 - 13. Habilitation
 - 14. Attendant care services.

- B. Examples of covered services for members age 21 years and over include, but are not limited to:
 - 1. Emergency room services
 - 2. Dental
 - 3. Podiatry

4. Doctor's office visits
5. Urgent care
6. Family planning services
7. Medications
8. Behavioral health services
9. Respite
10. Habilitation
11. Attendant care services
12. Residential.

Non-Covered Services

A. Examples of non-covered services for members age 21 years and over:

1. Percussive vest
2. Certain transplants.

B. Examples of non-covered services for members of all ages:

1. Vehicle modification
2. Vehicle lift
3. Day care
4. Additions to homes
5. Pill crusher
6. Service animal
7. Life coach
8. Home repairs
9. Rent.

C. Examples of covered Behavioral Health Services:

1. Behavior Management (behavioral health personal assistance, family support/homecare training, self-help/peer support)
2. Behavioral Health Case Management Services

3. Behavioral Health Nursing Services
4. Behavioral Health Therapeutic Home Care Services (formerly known as Therapeutic Foster Care)
5. Emergency/Crisis Behavioral Health Care
6. Emergency and Non-Emergency Transportation
7. Evaluation and Assessment
8. Individual, Group and Family Therapy and Counseling
9. Inpatient Hospital Services
10. Institutions for Mental Disease (with limitations)
11. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis
12. Non-Hospital Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)
13. Opioid Agonist Treatment
14. Partial Care (supervised day program, therapeutic day program and medical day program)
15. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)
16. Psychotropic Medication Adjustment and Monitoring
17. Respite Care
18. Rural Substance Abuse Transitional Agency Services
19. Screening.

CHAPTER 5 – EMERGENCY ROOM UTILIZATION

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

Emergency services are covered for all Division ALTCS members. The Division views the member's Primary Care Provider (PCP) as the gatekeeper for medical services. Given this, non-emergency services should be addressed by the PCP. Urgent care centers are also available, as appropriate.

The Division encourages its providers to educate members on appropriate utilization of emergency room and urgent care centers.

CHAPTER 6 - EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

REVISION DATE: 5/27/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [AHCCCS Manual](#), [A.A.C. R9-22-205](#), [A.A.C. R9-22-213](#)

Members age 21 years and under who are eligible for AHCCCS are also eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT offers comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by screenings. This includes required health, developmental, and behavioral health screenings.

Services include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis, HIV/AIDS, breast cancer, cervical cancer, and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the nutritional needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic work-ups and medically necessary immunizations are also covered as specified in Arizona Administrative Code, R9-22-205. Comprehensive unclothed physical examination, laboratory tests, vision services, hearing services and dental services are covered as specified in Arizona Administrative Code, R9-22-213.

EPSDT providers must document immunizations into Arizona State Immunization Information System (ASIIS) and enroll annually in the Vaccine for Children Program.

CHAPTER 7 – DENTAL

REVISION DATE: 11/10/16, 4/15/15, 4/16/14

EFFECTIVE DATE: March 29, 2013

REFERENCES: AHCCCS Medical Policy Manual (AMPM) 310-D Covered Services Dental Services for Members 21 Years of Age and Older, 430 EPSDT Services

Dental Services for Members Age 20 and Younger

Members who are Medicaid eligible (ALTCS and TSC) and age 20 years and younger are covered for both preventative and restorative dental services. These services include, but are not limited to:

- A. Examinations
- B. Cleanings
- C. Extractions
- D. Sealants
- E. X-rays
- F. Amalgam or resin restorations
- G. Fluoride varnish

Dental Services for Members Age 21 and Over

Members who are Medicaid eligible (ALTCS and TSC) and age 21 years and over are covered for dental services when these services are related to the treatment of a medical condition, covered transplants, and in preparation for certain radiation treatments.

Examples of medical conditions that warrant dental services are infection or the fracture of the jaw. These services include, but are not limited to:

- A. Treatment of facial trauma
- B. Treatment of fractures
- C. X-rays
- D. Emergency examinations

Other dental services, including dentures, are covered for AHCCCS ALTCS members 21 years of age and older. Dental services are limited to a total benefit amount of \$1,000 per member for each 12-month period beginning October 1, 2016 through September 30, 2017.

Emergency Dental Care/Extractions for ALTCS Members of All Ages

Emergency dental care and extractions are covered for all members who are eligible for ALTCS, regardless of age.

CHAPTER 8 – FAMILY PLANNING

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [AHCCCS](#) – Medical Policy Manual

Family planning services are covered for members to delay or prevent pregnancy. Covered family planning services include medical, surgical, and pharmacological and laboratory services, as well as contraceptive devices, information and counseling services which allow members to make informed decisions regarding family planning methods.

Member requests for tubal ligation or vasectomy must receive prior authorization from the Division's Medical Director.

Elective sterilization by hysterectomy will not be authorized in accordance with the AMPM. Elective hysterectomy due to medical necessity requires prior authorization by the Division's Medical Director.

CHAPTER 9 - PCP ASSIGNMENTS

REVISION DATE: 4/16/14

EFFECTIVE DATE: March 29, 2013

REFERENCES: [Mercy Care Plan](#); [Care 1st](#); [Arizona Physicians, IPA](#)

The Division contracts with three Acute Care Health Plans to deliver acute health services for its members. The acute care health plan is responsible for assigning a PCP to enrolled members. Please refer to the health plan's website for information about the PCP assignment process.

Members who are of Native American descent may choose to receive acute care services through the American Indian Health Program (AIHP). The Division operates the acute care service delivery system for these members. When a member elects AIHP, the Division's Support Coordinator works with the member to select a PCP that provides geographically convenient and culturally appropriate services.

All Division members can change their PCP at any time. Members enrolled with an acute care contractor should contact the Division Liaison or the health plan's Member Services Unit to execute a PCP change.

CHAPTER 10 - REFERRALS TO SPECIALISTS

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

For DDD American Indian Health Program (AIHP) members, providers need to receive a prior authorization in order to see a specialist; however, they do not necessarily need to receive a referral from their PCP. A prescription is required for any medical service, including but not limited to, durable medical equipment, nutrition, and prescription medications.

The Division's Health Plans vary in their policy and procedures regarding referrals to a specialist. Providers are expected to follow these policies and procedures.

For AHCCCS eligible members, behavioral health services are available through the Regional Behavioral Health Authority (RBHA). No referral is required to initiate these services. The Division expects providers to assist members in initiating these services. The provider must notify the Support Coordinator when assistance to initiate these services has been provided.

CHAPTER 11 – ALTCS GRIEVANCES, CLAIM DISPUTES, AND APPEALS

REVISION DATE: 11/10/16, 4/16/14

EFFECTIVE DATE: March 29, 2013

Grievances

A grievance is an expression of dissatisfaction. Grievances may pertain to the quality of care or services provided or dissatisfaction with providers, direct care workers, or Division of Developmental Disabilities (Division) staff. A grievance is not a dispute involving the payment of a claim, denial of a claim, imposition of a sanction, or reinsurance.

To file a grievance, contact:

Division of Developmental Disabilities Customer Service Center
1-866-229-5553 (toll free)

Provider Claim Disputes

If you wish to file a claim dispute to maintain your rights, follow the instructions provided below. All providers of services to Division members may file a claim dispute based on a claim denial, dissatisfaction with a claim payment, or recoupment action by the Division. You may challenge the claim denial or adjudication by filing a formal claim dispute with the Office of Administrative Review.

Pursuant to Arizona Health Care Cost Containment System (AHCCCS) guidelines, all claim disputes challenging claim payments, denials, or recoupments must be filed in writing no later than 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 calendar days after the payment, denial or recoupment of a timely claim submission, whichever is later.

The claim dispute must state the factual and legal basis for the relief requested, along with all supporting documentation such as claims, remits, billing detail reports, explanation of benefits, time sheets, medical review sheets, medical records, and correspondence, etc. Incomplete submissions or those which do not meet the criteria for a claim dispute will be denied.

Mail or fax written claim disputes to:

OFFICE OF ADMINISTRATIVE REVIEW
9TH FLOOR SUITE 916
3443 N CENTRAL AVE
PHOENIX ARIZONA 85012

Fax: 602-277-0026

If you have questions, call 602-771-8163 or 1-855-888-3106.

The Division will send the claimant a Notice of Decision within 30 calendar days from the date the claim dispute is received. The Notice of Decision due date may be extended upon mutual agreement between the Division and the provider.

State Fair Hearings (Regarding Notice of Decision)

If you disagree with the Division's Notice of Decision, you may submit a written request for a State Fair Hearing within 30 calendar days of receipt of the Notice of Decision.

In your request for State Fair Hearing, reference the following information:

- Re: Request for State Fair Hearing
- DDD Claim Dispute Number
- Member Name and AHCCCS ID.

Mail or fax written requests for State Fair Hearing to:

OFFICE OF ADMINISTRATIVE REVIEW
9TH FLOOR SUITE 916
3443 N CENTRAL AVE
PHOENIX ARIZONA 85012

Fax: 602-277-0026

If you have questions, call 602-771-8163 or 1-855-888-3106.

Appeals

Providers may assist members in filing an appeal on their behalf with the member's written permission. The Division does not restrict or prohibit a provider from advocating on behalf of a member. The appeal may be filed verbally or in writing and must be received by the Division within 60 calendar days from the date of the Notice of Action letter.

If the member (or the provider on behalf of the member) believes that the member's health or ability to function will be harmed unless a decision is made in the next three days, the member (or the provider on behalf of the member) can ask for an expedited appeal. Expedited appeals are resolved within three business days.

If the Division does not agree that an expedited appeal is needed, the Division notifies the provider in writing (when the provider requested the expedited appeal on the member's behalf) and the member within two days; the Division also tries to contact the requesting party via telephone. The Division will then decide the appeal within 30 days.

Reasons for filing an appeal include:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previous authorization
- Denial, in whole or in part, of payment of a service
- Failure to provide service in a timely manner as defined by the State
- Failure to act within the timeframes provided in 42 CFP 438.408(b) required for standard and expedited resolution of appeals and standard disposition or grievances

- Failure of the health plan to act timely
- Denial of a rural enrollee's request to obtain services outside the Contractor's network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.

To file a written appeal, mail or fax the written appeal to:

OFFICE OF ADMINISTRATIVE REVIEW
9TH FLOOR SUITE 916
3443 N CENTRAL AVE
PHOENIX ARIZONA 85012

Fax: 602-277-0026

To file a telephonic appeal, or if you have questions, call 602-771-8163 or 1-855-888-3106.

State Fair Hearings (Regarding Notice of Appeal Resolution)

If you disagree with the Notice of Appeal Resolution, you may submit a written request for a State Fair Hearing within 30 calendar days of receipt of the Notice of Appeal Resolution.

In your request for State Fair Hearing, reference:

- Re: Request for State Fair Hearing
- DDD Appeal Number
- Member Name and AHCCCS ID.

Mail or fax written requests for State Fair Hearing to:

OFFICE OF ADMINISTRATIVE REVIEW
9TH FLOOR SUITE 916
3443 N CENTRAL AVE
PHOENIX ARIZONA 85012

Fax: 602-277-0026

If you have questions, call 602-771-8163 or 1-855-888-3106.

CHAPTER 12 – BILLING AND ENCOUNTER SUBMISSION

REVISION DATE: 6/17/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [AHCCCS](#); [Billing Information](#)

All providers who participate in the Arizona Health Care Cost Containment System (AHCCCS) program must be registered with AHCCCS and be assigned a Provider of Service (POS) number (i.e., a six-digit registration number). Additionally, providers are required to register their National Provider Identifier (NPI) with AHCCCS. Your current Federal Tax ID number associated with your Division contract and NPI are required on claims. Information about AHCCCS requirements and use of an NPI can be found on the AHCCCS website.

Acceptable Claim Forms

For HCBS services, the Division requires Qualified Vendors to submit claims using the Division's FOCUS system (the Division's automated service authorization and payment processing system). Please refer to the Division's Claims Submission Guide for more information.

For Acute Care Services, there are three different types of claim forms that must be used.

- A. CMS-1500 Form: For claims for professional services.
- B. UB-04 Form: For claims for hospital in-patient and out-patient services, dialysis, hospice, and skilled nursing facility services.
- C. ADA Claim Form: For claims for dental services.

A claim form cannot exceed 99 lines. The Division complies with all AHCCCS billing and payment requirements when processing claims. Acute claims processed through QNXT™ must be billed with Healthcare Common Procedure Coding System (HCPCS).

CHAPTER 13 - UTILIZATION MANAGEMENT

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

Utilization management is a function of prior authorization and concurrent review. The Division's Acute Care Health Plans have developed their own policies and procedures for both prior authorization and concurrent review standards. Providers are expected to follow the Division's policies and procedures.

For Division members enrolled with AIHP, prior authorization is required before rendering any service.

Prior authorization spreadsheet for Home and Community Based Services can be found on the Division's website. (<https://www.azdes.gov/main.aspx?menu=96&id=2470> Service Approval Matrix (Prior Authorization))

CHAPTER 14 – REIMBURSEMENT

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [42 CFR 438.106](#); [A.R.S. §36-2931](#); [A.A.C R9-22-711](#)

Pursuant to 42 CFR 438.106, Division ALTCS members (as defined by ARS §36-2931) are not subject to payment liability to providers who provide covered services. Further, Division ALTCS members are not required to make a copayment for any covered services pursuant to AAC R9-22-711.

The Division's Acute Care Health Plans have a mechanism for reimbursing members for their out-of-pocket expenses for covered services. Providers are responsible for billing any private insurance and/or Medicare before submitting a claim to the Division or one of its Health Plans. When a member does have private insurance or Medicare an Explanation of Benefits (EOB) must be attached to the claim submitted to the Division.

CHAPTER 15 - COST SHARING RESPONSIBILITY

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [42 CFR 438.106](#); [A.R.S § 36-2931](#); [A.A.C R9-22-711](#)

Pursuant to 42 CFR 438.106, Division ALTCS members (as defined by A.R.S §36-2931) are not subject to payment liability to providers who provided covered services. Further, Division ALTCS members are not required to make copayment for any covered service pursuant to A.A.C R9-22-711.

CHAPTER 16 – EXPLANATION OF REMITTANCE ADVICE

REVISION DATE: 6/17/16, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [Billing Information](#)

Refer to Claims Submission Guide on the Division's website.

CHAPTER 17 PRIOR AUTHORIZATION REQUIREMENTS

REVISION DATE: 6/17/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [AHCCCS Medical Policy Manual](#); [Mercy Care Plan](#); [Care 1st](#); [United Healthcare](#); [Prior Authorization for HCBS](#)

To receive prior authorization for acute care services for a Division member enrolled with an acute care health plan, providers should contact the Prior Authorization Department of the member's acute care Health Plan.

To receive prior authorization for acute care services for a Division member enrolled with American Indian Health Program (AIHP), providers should contact the Division's Health Care Services Prior Authorization Unit at the contact information below.

The Division adheres to the prior authorization guidelines and timelines available in the AHCCCS Medical Policy Manual. The Division will no longer process requests for prior authorization of medical services after the services have been rendered. Standard authorization requests will be processed within 14 calendar days of physician's order. Expedited authorization requests must be noted as such and will be processed within three working days of physician's order.

Health Care Services/Prior Authorization Unit
3443 North Central Avenue, Suite 600
Site Code 795M
Phoenix, Arizona 85005
(602) 771-8080 phone
(800) 624-4964 toll-free
(602) 238-9294 fax

Prior authorization (Service Approval Matrix) for Home and Community Based Services can be found on the Division's website. Provider claims cannot exceed the hours documented on the *ALTCS Member Service Plan* (DDD 1500). Providers shall deliver services/tasks based on the member's Planning Document including the Service Evaluation.

CHAPTER 18 - CLAIMS MEDICAL REVIEW

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [Mercy Care Plan](#); [Care 1st](#); [Arizona Physicians, IPA](#)

The Division reserves the right to review any and all claims for eligible members who were provided covered services for which a provider is requesting or has requested payment from the Division. The Division's acute care health plans may employ their own claims medical review processes. Providers may refer to the appropriate acute care health plan's website for further information.

CHAPTER 19 – CONCURRENT REVIEW

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

The Division has a team of medical professionals who perform concurrent and retrospective review for members enrolled with American Indian Health Program (AIHP) who experienced a stay in an inpatient or skilled nursing setting. The Division's acute care health plans perform their own utilization review and concurrent review for Division members enrolled with their health plan who experienced a stay in an inpatient or skilled nursing setting.

CHAPTER 20 – FRAUD, WASTE, AND ABUSE

REVISION DATE: 6/17/16, 4/16/14

EFFECTIVE DATE: March 29, 2013

REFERENCES: [42 CFR 455.2](#), [A.R.S. §§ 46-451](#) and [13-3623](#)

The Division is committed to the prevention and detection of fraud, waste and abuse. Providers are responsible to administer internal controls to guard against fraud, waste and abuse.

Abuse of the Program

Abuse is defined by Federal law ([42 CFR 455.2](#)) as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Abuse of a Member

Abuse of a member, as defined by Arizona law ([A.R.S. §§ 46-451](#) and [13-3623](#)), means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

Fraud

Fraud is defined by Federal law ([42 CFR 455.2](#)) as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Examples of fraud are:

- A. Falsifying Claims/Encounters: Alteration of a claim; incorrect coding; double-billing; or false data submitted.
- B. Falsifying Services: Billing for services/supplies not provided; misrepresentation of services/supplies; or substitution of services.
- C. Administrative/Financial: Kickbacks; falsifying credentials; fraudulent enrollment practices; fraudulent Third Party Liability (TPL) reporting; or fraudulent recoupment practices.
- D. Member Issues (Fraud) Eligibility Determination Issues: Resource misrepresentation (transfer/hiding); Residency; or household composition.

Waste

Waste is defined as overutilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary cost to a federally-funded or state-funded program.

Division Monitoring

The Division:

- A. Reviews all participating providers during the credentialing/certification process (including re-credentialing).
- B. Monitors providers for non-compliance with Division contracts, rules, policies and procedures, in addition to AHCCCS policies.
- C. Verifies as part of Prior Authorization:
 - 1. Member eligibility
 - 2. Medical necessity
 - 3. Appropriateness of service being authorized
 - 4. Service being requested is a covered service
 - 5. An appropriate provider referral.

The Division's electronic claims processing application executes over 150 pre-payment edits ensuring payment accuracy and guarding against fraud and abuse. Some of these edits include: member eligibility; covered services; prior authorization; appropriate services codes; dates of services; authorized units and units provided; duplicate claims; approved rates; and utilization.

The Division, with the support of the Department's Audit and Management Services Division, conducts post payment reviews. These reviews look retrospectively at a sample of paid claims to ensure provider internal controls are in place. These reviews include the review of provider files, such as timesheets, to ensure proper documentation.

Quality Management conducts regularly scheduled on-site reviews. Additional reviews may be conducted on an as needed basis.

If at any time during the above processes, an unusual incident is suspected or discovered, the matter is referred to the Department's Fraud Coordinator.

Provider Requirements

A. Training and Education

Providers must ensure all employees receive adequate training addressing fraud, waste, and abuse prevention, recognition and reporting, and encourage employees and Division members to report fraud, waste, and abuse without fear of retaliation.

B. Reporting Fraud, Waste and Abuse

When a provider becomes aware of an incident of potential/suspected fraud, waste or abuse, the provider must report the incident to the Division within one business day of becoming aware of the incident. To report suspected fraud, waste or abuse of the program, the provider performs one of the following:

1. Call the toll free DES/DDD Hotline at 877-822-5799
2. Report the incident by completing the [on-line referral form](#).

C. Reporting Abuse of a Member

Providers must:

1. Comply with mandatory reporting requirements in accordance with A.R.S. §13-3620 for children under age 18, and A.R.S. §46-454 for adults, as outlined in [Chapter 6000](#) of the Division's Policy Manual.
2. Report to the Division all incidents of suspected abuse of a member in accordance with the policy and procedures detailed in [Chapter 6000](#).

CHAPTER 21 - FALSE CLAIMS ACT

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

The Deficit Reduction Act of 2005 (DRA) was signed into law in early 2006. The DRA encourages states to have false claims legislation in place. The DRA also requires any entity, including providers, receiving annual Medicaid payments of \$5 million or more to provide written policies to all employees, contractors, and agents about the False Claims Act. Any state laws that pertain to civil or criminal penalties for making false claims and statements, and the whistleblower protection under such laws, including the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, should also be included in these policies.

Chapter 22 – FORMULARY INFORMATION

REVISION DATE: 6/17/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

AHCCCS has developed a minimum required drug list its contractors, including the Division and its subcontracted Health Plans are required to cover for members. Contractors can cover more drugs than are listed but not less. Formulary information can be found at: https://www.azahcccs.gov/PlansProviders/Downloads/PharmacyUpdates/AHCCCS_MRPDL.pdf

To receive Pharmacy updates directly from AHCCCS:

<http://listserv.azahcccs.gov/cgi-bin/wa.exe?SUBED1=PHARMACY-UPDATES&A=1>

A comprehensive list of medication by classification, brand/generic names can be found at:

<https://azahcccs.gov/Resources/Downloads/PharmacyUpdates/AHCCCSDrugListMay12016.pdf>

CHAPTER 23 - APPOINTMENT STANDARDS

REVISION DATE: 5/13/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: ACOM 417, ACOM 415; 42 CFR 438.206.

INTENDED USERS: Subcontracted Health Plans, Qualified Vendors, Non-Contracted Providers

The Division monitors and reports appointment accessibility and availability to ensure compliance with the Arizona Health Care Cost Containment System (AHCCCS) standards set forth in Section D, Appointment Standards of the contracts (ACOM 417) and [42 CFR 438.206].

- A. For PCP appointments, members will be provided:
 - 1. Emergency appointments the same day or within 24 hours of the member's phone call or other notification, or as medically appropriate.
 - 2. Urgent care appointments within two days.
 - 3. Routine care appointments within 21 days.
- B. For specialty provider appointments, members will be provided:
 - 1. Emergency appointments within 24 hours of referral.
 - 2. Urgent care appointments within three days of referral.
 - 3. Routine care appointments within 45 days of referral.
- C. For behavioral health services appointments, members will be provided:
 - 1. Emergency appointments within 24 hours of referral.
 - 2. Routine appointments within 30 days of referral.
- D. For dental appointments, members will be provided:
 - 1. Emergency appointments within 24 hours.
 - 2. Urgent appointments within three days of request.
 - 3. Routine care appointments within 45 days of request.
- E. For maternity care appointments, members will be provided initial prenatal care appointment:
 - 1. In the first trimester within 14 days of request.

2. In the second trimester within seven days of request.
3. In the third trimester within three days of request.
4. High risk pregnancies within three days of identification of high risk by the Division or maternity care provider, or immediately if an emergency exists.

The Division monitors and ensures that a member's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than 45 minutes, except when the provider is unavailable due to an emergency.

- A. For medically-necessary, non-emergent, transportation shall be scheduled so the member:
 1. Arrives on time but no sooner than one hour before the appointment,
 2. Is not picked up prior to the completion of the appointment, and
 3. Is not required to wait more than one hour after the conclusion of the appointment for transportation home.
- B. Qualified Vendors provide critical services:
 1. For existing members, within 14 calendar days following assignment of the authorization.
 2. For newly eligible members, within 30 calendar days following assignment of the authorization.

A gap in critical service is the difference between the number of hours of home care scheduled in each member's planning document and the hours of the scheduled type of critical service that are actually delivered to the member. Critical services are Attendant Care (ATC), Homemaker (HSK) and Respite (RSP).

CHAPTER 24 – AMERICAN WITH DISABILITIES ACT

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs receiving federal financial assistance. The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in employment, public services, public accommodations, and telecommunications. Providers contracted with the Division shall comply with the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act of 1964.

CHAPTER 25 – ENROLLMENT VERIFICATION

REVISION DATE: 6/17/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

AHCCCS Online for Health Plans and Providers: All registered AHCCCS providers are eligible to create an account at:

<https://azweb.statemedicaid.us/Account/Login.aspx?ReturnUrl=%2f>

This tool can be used to check eligibility/enrollment.

Providers are expected to verify member's enrollment by requesting the member to present the acute care health plan identification card. If the member is unable to present the acute care health plan identification card, providers may verify enrollment by calling the Division's Health Care Services Member Services Unit at 602-771-8080.

CHAPTER 26 – CULTURAL COMPETENCY

REVISION DATE: 6/10/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: Civil Rights Act of 1964 Public Law § 88-352

The Division promotes a culture of respect and dignity when working with individuals who have developmental disabilities and values a competent, diverse provider network capable of effectively addressing the needs and preferences of its culturally and linguistically diverse members. Cultural Competency refers to the ability of provider staff to acknowledge and understand the influence cultural history, life experiences, language differences; values and disability have on individuals and families.

Knowledge and use of “disability etiquette” are critical when establishing rapport and working with members with developmental disabilities. According to the National Center for Cultural Competence at Georgetown University, *“People first terminology is the standard that should govern all communication about this population (people with disabilities). Training and policy within health and mental health care organizations should require people first terminology such as individuals with developmental disabilities, a person with intellectual disabilities, and a patient with a physical disability or communication disorder.”*

The Division works with long term care contractors to provide services that are “culturally relevant and linguistically appropriate” to the population served. Requirements include an effective communication strategy when considering acceptance of a referral; reasonable steps to ensure meaningful access to Medicaid services for persons with limited English proficiency; written information available in the prevalent non-English languages in its particular service area; and interpreter services available at no charge for all non-English languages, not just those identified as prevalent.

For assistance in accessing non acute care interpreter services to support members who speak a language other than English or use sign language, contact 602-542-0419.

The Division acts in accordance with contractual obligations, state and federal codes and laws, including the Civil Rights Act of 1964 Public Law § 88-352 which prohibits discrimination in government agencies.

CHAPTER 27 – PEER REVIEW AND INTER-RATER RELIABILITY

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

For both acute and long term care services, the Division evaluates the necessity, quality, or utilization of care/service provided. For acute services, peer review is conducted by others from the same discipline, or with similar or essentially equal qualifications, who are not in direct economic competition with the health care professional under review. For long term care services, inter-rater reliability is conducted by Support Coordinators. The peer review process evaluates the consistency with which individuals involved in decision making apply standardized criteria in accordance with adopted practice guidelines.

CHAPTER 28 - MEMBER RIGHTS

REVISION DATE: 3/25/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [42 CFR 438.100](#); [A.R.S. § 36-551.01](#); Division Operations Manual: Chapter 1000, 1001-A

All members have the right to be treated with dignity and respect. The Division is concerned with protecting the rights of all individuals who are receiving supports and services operated by, supervised by, or financially supported by the Division. The provider must ensure all employees are familiar with the information in the references listed above.

CHAPTER 29 - ADVISING OR ADVOCATING ON BEHALF OF A CONSUMER

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [42 CFR 438.102](#)

Pursuant to 42 CFR 438.102, the Division may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a consumer who is authorized to receive services from the provider for the following:

- A. The member's health status, medical care, or treatment options including any alternative treatment that may be self-administered.
- B. Any information the member needs in order to decide among all relevant treatment options.
- C. The risks, benefits, and consequences of treatment or no treatment.
- D. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

CHAPTER 30 – CLINICAL PRACTICE GUIDELINES

REVISION DATE: 5/27/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

The Division has developed guidelines for its providers, members, and staff, to utilize. These guidelines are reviewed at least annually and are used when determining medical necessity. To obtain these guidelines, contact the Division's Prior Authorization Unit at 602-771-8080.

As determined appropriate by the Division, the Division may also use the clinical practice guidelines currently approved by the Agency for Healthcare Research and Quality (U.S. Department of Health and Human Services). These guidelines are available on-line at [National Guideline Clearinghouse](#) or via the link to the National Guideline Clearinghouse, located on the Division's [website](#).

Links to the clinical practice guidelines used by the Division's contracted health plans are also provided on the Division's website.

CHAPTER 31 - CHANGE OF CONTRACTOR

REVISION DATE: 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: [A.R.S. § 36-2944](#)

Pursuant to Arizona Revised Statute, the Department of Economic Security provides services either directly or through subcontract to members who have a developmental disability. The Division is the only AHCCCS program contractor for members who have a developmental disability.

During annual enrollment Division members have the opportunity to change Acute Care Health Plans, subject to the availability of other contracted Acute Care Health Plans in their area. Members must notify the Division's Member Services Unit of their wish to change Acute Care Health Plans during the annual enrollment choice period. If the member does not participate in annual enrollment choice, and their eligibility is maintained, members will remain with their current Acute Care Health Plan.

The Division reserves the right to conduct an open enrollment, if deemed necessary, by Division Administration. Members must notify the Division if they wish to change contractors during open enrollment.

Members may have extenuating circumstances that necessitate changing contractors outside of the member's annual enrollment choice. AHCCCS Policy 402 documents and delineates the rights, obligations and responsibilities of:

- A. The member,
- B. The member's current health plan,
- C. The requested health plan, and
- D. The AHCCCS Administration.

This includes facilitating continuity of care, quality of care, efficient and effective program operations, and in responding to administrative issues regarding member notification and errors in assignment.

CHAPTER 32 - SEPARATION OF CHILDREN AND ADULTS IN CENTER-BASED PROGRAMS

REVISION DATE: 3/25/2016, 8/1/2014

EFFECTIVE DATE: April 16, 2014

INTENDED USER(S): Network staff, Quality Assurance staff, and Qualified Vendors

PURPOSE: To outline the requirements for separation of children and adults in center-based programs that provide services to both populations. For the purpose of this chapter, a therapy clinic is not considered a center-based program.

Definitions

Children - any member 17 years of age or younger.

Adults - any member 18 years or older.

Requirements

- A. Separation of children and adults is required to ensure the health and safety of Division members at all times.
- B. Each site must have one area designated solely for children and one area designated solely for adults to prevent any interaction between the two age groups.
- C. Each site shall provide a physical and visual barrier separating the two areas. Separate areas shall include:
 1. Bathrooms, and
 2. Any interior space used for instruction, play, or similar activities.
- D. The site may have common areas (e.g., kitchens, hallways, storage areas, reception areas, building entrances) accessible by both children and adults.
- E. The Qualified Vendor shall provide the Division with written policies that include efforts to minimize contact between children and adults in a manner that will maintain the health and safety of all members.
- F. During the delivery of the service, transportation of children must be provided separately from transportation of adults.
- G. District Network and/or Quality Assurance staff will work collaboratively with Qualified Vendors to review service sites and offer technical assistance to meet these requirements.
- H. Qualified Vendors shall meet these requirements.

Requests for Change in Process or Policy

- A. A completed *Separation of Children and Adults in Center-Based Programs* form must be submitted to the District Quality Assurance Monitor for each site when a change in process or policy is needed in order to meet the requirement. The form is on the Division's website, located [here](https://www.azdes.gov/appforms.aspx?category=81&menu=96).
(<https://www.azdes.gov/appforms.aspx?category=81&menu=96>)

The request will include:

1. The reason(s) for the request; and,
 2. The proposed means by which the following will be met:
 - i. The health and safety of members and/or staff; and,
 - ii. The intent of the contract.
- B. Approval shall be made at the sole discretion of the Division and may include a site visit.
- C. Upon approval of the request, the Qualified Vendor will provide the Division a template "Letter of Notification" to be sent to all current and prospective members/legally responsible person(s) informing them of the change in process or policy regarding the separation of children and adults.
1. When substantial changes to the physical location or member participation occur which may affect an approved request, the Qualified Vendor shall provide written notification to the Division of anticipated changes within five business days.
 2. Qualified Vendors may exercise the remedy outlined in R6-6-2115 when in disagreement with a Division decision.

CHAPTER 33 - ASSESSMENT REQUIREMENTS FOR MEMBERS PLACED IN RESIDENTIAL SETTINGS

REVISION DATE: 10/9/2015, 4/1/2015

EFFECTIVE DATE: July 31, 1993

REFERENCES: A.A.C. R6-6-806(B)

Members residing in group home settings operated or financially supported by the Division must receive certain assessments. Residential staff is responsible for obtaining the following documentation:

A. Vital Information

1. The name, address, and telephone numbers of the health care provider for each resident;
2. The name and telephone numbers of the health plan and insurance carrier for each resident and the process for authorization of health care for each resident;
3. Guardianship status for each resident; and,
4. The name and telephone number of the responsible party and the person to be contacted in case of emergency for each resident.

B. Individualized Needs

1. Allergies including the signs and symptoms of allergic reactions specific to the individual
2. Nutritional needs or special diets with parameters
3. Special fluid intake needs
4. Seizure activity including the type or characteristics of the seizures, frequency and duration and instructions for staff response to seizure activity
5. Adaptive Equipment, Protective Devices and Facility Adaptations
6. Required Medical Monitoring (e.g., blood glucose testing, blood pressure checks, lab work)
7. Reference to the Behavior Treatment Plan or the ISP if healthcare related issues are addressed
8. Special instructions for carrying, lifting, positioning, bathing, feeding, or other aspects of personal care
9. Other individualized healthcare routines

- C. Complete Medical History
1. Physical examination
 2. Immunization record
 3. Tuberculosis screening
 4. Hepatitis B screening
 5. Type of developmental disability
 6. Medication history
 7. History of allergies
 8. Dental history
 9. Seizure history
 10. Developmental history
 11. Family medical history

In addition, the Planning Team (Individual Support Plan/Individualized Family Services Plan team) must ensure that additional evaluations and assessments are identified and obtained.

CHAPTER 34 – PROVIDER PUBLICATIONS

EFFECTIVE DATE: Effective upon signature of Amendment #1 RFQVA 710000

As specified in the Qualified Vendor Agreement, 6.3.5.2, the Qualified Vendor shall provide to the Division for review all reports or publications (written, visual, and/or audio communications) which are intended for Division members or applicants for services funded or partially funded by the Division. The preceding sentence does not apply to communications directed to the general public or persons who are not members or applicants for services funded or partially funded under the Qualified Vendor Agreement.

Qualified Vendor Responsibilities

- A. Reports or publications requiring review by the Division include but are not limited to:
 - 1. Newsletters
 - 2. Flyers referencing the Division or Division services
 - 3. Fact Sheets
 - 4. Website Content
 - 5. Radio or TV Presentations
- B. The following information does not require review by the Division:
 - 1. Changes to office locations, hours, or phone numbers
 - 2. Information regarding staff (Staff Profiles)
 - 3. Links to resources on website
 - 4. Daily/Weekly Emails
- C. All submitted reports or publications must be in:
 - 1. Compliance with AHCCCS policy, Division policy, state laws, Provider Manual, and the Qualified Vendor Agreement.
 - 2. An editable word document, not pdf; and,
 - 3. 6th grade or below reading level.
 - 4. Must include the following statement on printed material:

Under Titles VI and VII of the Civil Rights Act of 1964 (respectively "Title VI" and "Title VII") and the Americans with Disabilities Act of 1990 (ADA) Section

504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, (insert Qualified Vendor name here) prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. The (insert Qualified Vendor name here) must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means that if necessary, the (insert Qualified Vendor name here) must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the (insert Qualified Vendor name here) will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy please contact: (insert Qualified Vendor contact person and phone number here) Para obtener este documento en otro formato u obtener información adicional sobre esta política, (insert Qualified Vendor contact person and phone number here)".

- D. Audio materials must include the script.
- E. The Qualified Vendor shall submit each report or publication to (DDDProviderPublications@azdes.gov) a minimum of 30 calendar days prior to the anticipated date of delivery or publication. The submission will include the following:
 - 1. Email address and phone number for the employee from the Qualified Vendor who can best answer questions regarding the publication.
 - 2. The name of the Qualified Vendor agency as listed on its Qualified Vendor Agreement.
- F. If the Qualified Vendor does not receive a response by the 30th calendar day following submission to the Division, the Qualified Vendor may move forward with the publication.
- G. If the Division expresses concern(s) with the information provided on the submitted report or publication, the Division will explain the concern(s) and the Qualified Vendor shall not move forward with the report or publication until the Division and Qualified Vendor have agreed upon a resolution of the concern. If the Division and Qualified Vendor are unable to resolve the concern, the Qualified Vendor may pursue review as provided in A.A.C. R6-6-2117.

Division Responsibilities

- A. Upon receipt of the draft report or publication from the Qualified Vendor, the designated Division employee will initiate the review as described above.
- B. Failure of DDD to comment on any submitted report or publication does not waive any subsequent action or constitute approval of the report or publication.

CHAPTER 35 - PROGRESS REPORTING REQUIREMENT

REVISION DATE: Effective upon signature of Amendment #1 RFQVA 710000

EFFECTIVE DATE: July 1, 2013

Progress notes and other documentation are required based on the service being provided.

Elements of Progress Notes

- A. The Division does not have a required format to be used for progress reports (except as set forth below in "Section C of Schedule for Progress Reports) ; however, the following minimum elements must be included:
1. Overall progress specific to planning document outcomes;
 2. Performance data that identifies the member's progress toward achievement of the established outcomes;
 3. Current and potential barriers to achieving outcomes;
 4. Written summary describing specific service activities; and,
 5. Additional requirements as specified below.
- B. No periodic progress reports are required for the following services:
1. Attendant Care
 2. Housekeeping
 3. Respite
 4. Transportation
- C. Providers shall keep data that documents the provision of all services regardless of whether a progress report is required, and make this data available to the Division upon request.

Schedule for Progress Reports

The required due date for the progress reports by service are listed below. Reports must be submitted to the member's assigned Support Coordinator and can be submitted electronically, unless otherwise specified below.

- A. **Monthly** progress reports, due within 10 business days following each month, are required for the following services:
1. Day Treatment and Training, Child (Summer)

2. Habilitation, Consultation
 3. Habilitation, Group Home
 4. Habilitation, Nursing Supported Group Home
 5. Home Health Aide
 - a. Submit reports to Health Care Services with a copy to the Support Coordinator.
 6. Nursing
 - a. Submit written monthly progress reports to the member's PCP or physician of record, and the Division upon request, regarding the care provided to each assigned member.
- B. **Quarterly** progress reports, due July 15, October 15, January 15, April 15, are required for the following services:
1. Center Based Employment
 - a. In addition to the minimum requirements of the progress report, the reports shall also disclose any calendar month when the member is not engaged in paid work for at least 75% of the scheduled work hours for that member.
 2. Day Treatment and Training, Adult
 3. Day Treatment and Training, Child (After School)
 4. Employment Support Aide
 - a. In addition to the minimum requirements for the progress report, the reports shall also include:
 - i. Performance data that identifies the progress of the member toward achievement of the established objectives;
 - ii. A detailed record of each contact including hours of service with the member; and,
 - iii. Detailed information regarding specific employment support activities.
 5. Group Supported Employment
 6. Habilitation, Communication

7. Habilitation, Community Protection and Treatment Hourly
8. Habilitation, Early Childhood Autism Specialized
 - a. In addition to the minimum requirements of the progress report, the reports shall also include:
 - i. Progress reports shall include data from both the consultant and any hourly habilitation support service providers.
 - ii. The progress report shall be signed by the supervising licensed psychologist or licensed Behavior Analyst.
 - iii. Progress reports shall demonstrate parent/caregiver participation in training sessions and progress toward outcomes.
9. Habilitation, Individually Designed Living Arrangement
10. Habilitation, Music Therapy
11. Habilitation, Specialized Behavior
12. Habilitation, Hourly Support
13. Habilitation, Vendor Supported Developmental Home (Child and Adult)
14. Individual Supported Employment
 - a. In addition to the minimum requirements of the progress report the reports shall also include:
 - i. A detailed record of each contact with the member; and,
 - ii. Detailed information in regard to specific job search activities.
15. Nursing
 - a. Shall provide quarterly written progress reports to the Division's Health Care Services, including a copy of the current signed plan of treatment, the nursing care plan, and copies of all current physician orders.
16. Therapies (Occupational Therapy, Physical Therapy, Speech Therapy)
 - a. In addition to the minimum requirements of the progress report, the reports shall also include: the Division's therapy reporting requirements as identified on the Division's Quarterly Therapy Progress/Discharge Report form.

17. Transition to Employment
- C. **Semi-annual** reports, due January 31st and July 31st, are required for these services using Division forms:
1. Center Based Employment
 2. Employment Support Aide
 - a. In addition to the minimum requirements for the progress report, the reports shall also include:
 - i. Performance data that identifies the progress of the member toward achievement of the established objectives;
 - ii. A detailed record of each contact including hours of service with the member; and
 - iii. Detailed information regarding specific employment support activities.
 3. Group Supported Employment
 4. Individual Supported Employment

CHAPTER 36 - FIRE SAFETY

REVISION DATE: 10/9/2015, 7/3/2015, 10/30/2014

EFFECTIVE DATE: January 15, 1996

INTENDED USER(S): Group Home Qualified Vendor

REFERENCE: A.A.C. R9-33-201; A.A.C. R9-33-202

FORM: Fire Risk Profile (DD-254)

Fire Risk Profile

A Fire Risk Profile (FRP) shall be completed for each group home setting serving four or more members. The FRP is a Division instrument that yields a score for a facility based on the ability of members to evacuate the group home. The Fire Risk Profile shall be updated when a member enters or exits the residential program and when the needs of a member, in one or more of the seven categories outlined below, changes significantly. The FRP shall also be updated each time there is a structural change in the home. The FRP is required to be updated at least annually even if changes do not occur in the composition or structure of the setting. A copy of the FRP shall be maintained in each residential setting and must be made available upon request. The FRP will be routinely reviewed by the Division through program monitoring; if concerns are identified, the issue will be referred to Network and/or the Arizona Department of Health Services for resolution.

Instructions for Completing the Fire Risk Profile

The name of each member shall be listed in the designated section of the Fire Risk Profile (FRP). Each member shall be evaluated on the seven (7) factors identified on the FRP, using the rating that best describes the member. Place the appropriate rating values in columns to the right. Add the values for each member to determine the sum of their rating. If a member's rating exceeds 100, use only 100. To determine the facility rating, add together the ratings of all members.

The following guidelines shall be used in evaluating each member's abilities and needs for the seven factors on the FRP:

- A. Social Adaptation - This factor rates the member's willingness to assist others and to cooperate in the evacuation process.
 1. Positive - the member is generally willing to assist others as far as they are able and can participate in a "buddy system" - helping or alerting anyone close to them in a fire emergency that needs assistance to evacuate. The member's physical ability to help shall not be considered for this item because it will be addressed under other factors. (Rating of 0)
 2. None - the member does not usually interact with others in everyday situations and, therefore, could not be expected to assist or alert others in a fire emergency. (Rating of 8)
 3. Negative - the member does not interact well with others and exhibits frequent disruptive behavior. They are likely to be uncooperative. (Rating of 16)

- B. Mobility Locomotion- This factor rates the member's physical ability to initiate and complete an evacuation.
1. Within Normal Range - the member is physically able to initiate and complete an evacuation. (Rating of 0)
 2. Speed Impairment/Needs Some Assistance - the member may require some initial staff assistance, e.g., getting out of bed, getting into a wheelchair, but can continue an evacuation without further assistance and within the three (3) minute timeframe. (Rating of 50)
 3. Needs Full Assistance - the member may require the full attention/assistance of a staff throughout the evacuation. (Rating of 100)
- C. Response to Instruction - This factor concerns the extent to which a member can receive, comprehend and follow through with simple instructions from staff. Evaluate the amount of guidance required to be reasonably certain that members will follow through with instructions given during an evacuation. Consider only the member's abilities to follow instructions; behavior under stress and sensory impairment are rated as separate factors.
1. Follows Verbal Instructions - the member reliably comprehends, remembers and follows simple, brief instructions stated verbally or in sign language. (Rating of 0)
 2. Needs Physical Guidance - the member does not always understand and follow directions; therefore, the member may need to be guided, reminded, reassured or otherwise accompanied during the evacuation, but will not require the exclusive attention of a staff. (Rating of 12)
 3. Does Not Respond to Instructions - the member does not respond to instructions or general guidance. The member may require considerable assistance and most of the attention of a staff during the evacuation. (Rating of 24)
- D. Behavior Under Stress - This factor concerns the member's ability to cope with stress in an emergency.
1. No Significant Change - the member will probably experience a level of stress that will not markedly interfere with their ability to evacuate. (Rating of 0)
 2. Delayed Reaction - the member may react to a fire emergency with confusion, slowed reaction, poor adaptability to hazards or demonstrates a moderate risk for seizure activity that disables the member for no more than 30 seconds. (Rating of 8)
 3. Significant Risk - the member may react to a fire emergency with physical resistance, unresponsiveness to evacuation or demonstrates a high risk for seizure activity that disables the member for longer than 30 seconds. (Rating of 16)

- E. Fire Awareness - This factor concerns the member's ability to appropriately respond to fire related cues. Fire related cues include smoke, flames, fire alarms, and warnings from others. Evaluate how well the member is likely to perform in response to such cues, assuming that no one may be available to give them instructions at the time of the emergency.
1. Will Evacuate When Signal is Present - the member will probably initiate and complete an evacuation in response to signs of an actual fire, warnings from others or a fire alarm. Also, the member will probably avoid the hazards of a real fire such as flames and heavy smoke. (Rating of 0)
 2. Responds to Signals - Needs Assistance to Avoid Hazard - the member will probably respond to an actual fire, warnings from others or a fire alarm; however, the member may not satisfactorily avoid the hazards of a fire or probably cannot complete the evacuation without assistance. (Rating of 8)
 3. No Fire Awareness -Needs Assistance - the member does not respond to signs of an actual fire, warnings of others; or a fire alarm. The member should be closely attended by staff during an emergency evacuation. (Rating of 16)
- F. Hearing/Sight Impairment - This factor evaluates any sensory impairment which, without adaptations, limits the member's ability to evacuate.
1. Within Normal Limits/Impairment Doesn't Impact Evacuation - the member may have a severe hearing or sight loss but requires no assistance in case of fire evacuation. Consider special features in the home such as a strobe light or bed vibrator alerting systems. When special features are in the home, a member may be able to evacuate without assistance. (Rating of 0)
 2. Impairment Assistance Needed to Start Evacuation - the member has severe hearing and/or sight loss and needs to be alerted to the presence of the fire emergency, but otherwise could evacuate without assistance. (Rating of 10)
 3. Impairment Assistance Needed Throughout Evacuation - the member has severe hearing and/or sight loss and needs guidance or other assistance in order to evacuate. (Rating of 20)
- G. Medication - This factor evaluates the impact of any medication on a member's ability to evacuate.
1. None - the member does not take medication which can affect their ability to evacuate. (Rating of 0)
 2. Maintenance Medication - the member routinely takes medications which can have some effect on the central nervous system, e.g., seizure controlling, antihistamines, mild tranquilizers, stimulants. The primary purpose of these medications is not to induce sleep. The member may need some assistance to evacuate. (Rating of 4)
 3. Medication For Sleep - the member routinely takes medication for the primary purpose of inducing or maintaining sleep. (Rating of 8)

Fire Safety Requirements

All group home settings must comply with Level I requirements. Settings with an FRP which exceeds 300 must also comply with Level II requirements.

Level I Fire Safety Requirements

At a minimum, all group home settings shall meet the following:

- A. The facility's street address is painted or posted against a contrasting background so that the group home's address is visible from the street; and if posting is not possible, local emergency services have been notified of the location of the home on at least an annual basis.
- B. Smoke detectors are working and audible at a level of 75db from the location of each bed used by a resident in the facility and/or capable of alerting all residents in the facility, including a resident with a mobility or sensory impairment. Smoke detectors are located in at least the following areas:
 - 1. Each bedroom;
 - 2. Each room or hallway adjacent to a bedroom, except a bathroom or a laundry room; and,
 - 3. Each room or hallway adjacent to the kitchen, except a bathroom, a pantry, or a laundry room.
- C. A minimum of one working, portable, all-purpose fire extinguisher labeled as rated 2A-10-BC by Underwriters Laboratories, or two collocated working, portable, all-purpose fire extinguishers labeled as rated at least 1A-10-BC by Underwriters Laboratories installed and maintained in the facility as prescribed by the manufacturer or the fire authority having jurisdiction.
 - 1. The provider shall ensure that a fire extinguisher is either disposable and has a charge indicator showing green or 'ready' status; or has been serviced annually by a fire extinguisher technician certified by the National Fire Protection Agency, the International Code Council, or Compliance Services and Assessments.
 - 2. If serviced and tagged, the documentation must include date of purchase or the date of recharging, whichever is more recent and the name of the company or organization performing the service, if applicable.
- D. All stairways, hallways, walkways and other routes of evacuation are free from obstacles that prohibit exit in case of emergency.
- E. Each sleeping room has at least one operable window or door that opens onto a street, alley, yard or exit court for emergency exit.
- F. Locks, bars, grilles, grates or similar devices, installed on windows or doors which are used for emergency exit, are equipped with release mechanisms which are operable from the inside without the use of a key or special knowledge or effort.

- G. A floor plan of the setting is available which designates the routes of evacuation, location of firefighting equipment and location of evacuation devices.
- H. The setting has a working non-cellular telephone that is available and accessible to staff and each resident at all times.
- I. Emergency telephone numbers for fire, police and local emergency medical personnel, or 911, as appropriate for the local community, and the address and telephone number of the group home are posted near all telephones in the setting.
- J. Electrical outlet plates are in good condition and cover the receptacle box.
- K. Combustible and/or flammable materials are not stored within three feet of furnaces, heaters or water heaters.
- L. As applicable, each operable fireplace in the setting is protected at all times by a fire screen or metal curtain.
- M. The premises do not have an accumulation of litter, rubbish, or garbage that may be considered a fire hazard.

Level II Fire Safety Requirements

At a minimum, all group home settings with a Fire Risk Profile (FRP) which exceeds 300 shall meet the following:

- A. The setting is in full compliance with the Level I Fire Safety Standards.
- B. The setting is equipped with back-up lighting designed to illuminate a path to safety in case of power failure (independent of in-house electrical power) and that this system is inspected at least annually by the manufacturer or an entity that installs or repairs emergency lighting systems.
- C. The group home setting has one of the following:
 - 1. Sufficient staff on duty to evacuate all residents present at the facility within three minutes; or,
 - 2. An automatic sprinkler system installed according to the applicable standard by reference in A.A.C. R9-1-412 and installed according to NFPA 13, 13R, or 13D and that covers every room in the entire facility. The automatic sprinkler system is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs automatic sprinkler systems.
- D. The group home setting is equipped with an early warning fire detection system that:
 - 1. Is safety approved.
 - 2. Shall either be hard wired or connected wirelessly, with battery back-up, and shall sound every alarm in the setting when smoke is detected.

3. Is installed in each bedroom, each room, or each hallway adjacent to a bedroom, and each room or each hallway adjacent to a kitchen.
4. Is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs early warning fire detection systems.

Fire Inspection

At the time of initial or renewal licensure, the group home settings are directed to pass a fire inspection by state or local fire authorities, or an entity authorized by the Department. Any repair or correction stated in a fire inspection report is made or corrected according to the requirements and time in the fire inspection report.

The fire inspection report should document the setting's full compliance with Level I and, as applicable, Level II Fire Safety Requirements. Documentation of the current completed fire inspection report should be maintained in the group home.

Fire Drill Requirements

- A. An evacuation drill including all residents is conducted at least once every six months on each shift; and,
- B. Documentation of an evacuation drill is available for review at the facility for at least two years that includes the date and time, duration (should be completed within three minutes) and a summary of the evacuation drill.
- C. If a member of the group home setting has been identified as having a condition that could cause harm if the member participated in an evacuation drill, then:
 1. The risk shall be identified in the member's ISP and will be reviewed annually.
 2. The provider will not include the member in the drill and will simulate evacuation of the member.
 3. When this condition is identified, the simulation drill may be increased to five minutes.

CHAPTER 37 – RESPONSIBLE PERSON/CAREGIVER PARTICIPATION IN THERAPY SESSIONS

EFFECTIVE DATE: Effective upon signature of Amendment #1 RFQVA 710000

Qualified Vendors approved to provide therapy (i.e., Occupational, Physical, and Speech) must ensure a caregiver/responsible person is present and participates in all therapy sessions.

- A. Division policy requires a parent/family member or other caregiver (paid/unpaid) to be present and participate in all therapy sessions in order to:
 - 1. Maximize the benefit of therapy services including implementing a home program;
 - 2. Improve outcomes; and,
 - 3. Adhere to legal liability standards.
- B. The member's parent/family member and caregiver are expected to instruct all other caregivers regarding the therapeutic activities that comprise the home program.
- C. If the parent/family member /caregiver does not participate in a therapy session:
 - 1. The therapy session shall be cancelled;
 - 2. The therapist shall contact the Support Coordinator to discuss the lack of parent/family member/caregiver participation prior to the next therapy session; and,
 - 3. The therapist shall document the reason for the cancellation on quarterly progress notes.
- D. When the therapist recommends that the parent/family member/caregiver participate in the therapy session by observing the session outside the eyesight of the member, the therapist shall submit this recommendation via the evaluation or quarterly progress notes. When this type of participation is used:
 - 1. The parent/family member/caregiver shall observe (e.g., one way or two way glass) the therapy session.
 - 2. The therapist must consult with the parent/family member /caregiver prior to the end of the therapy session to discuss the home program.
- E. The reasons for the requirement set forth above include:
 - 1. Avoiding the risk of sexual abuse and molestation; and,

2. Ensuring consultation between the therapist and the parent/family member/caregiver to facilitate implementation of the home program.

CHAPTER 38 – EMERGENCY COMMUNICATION WHEN TRANSPORTING A MEMBER

EFFECTIVE DATE: Effective upon signature of Amendment #1 RFQVA 710000

For the health and safety of each member, the Qualified Vendor shall ensure that all methods of transportation allow for emergency communication at any time during the delivery of the service. The method of emergency communication shall be appropriate to the geographic area (e.g., two-way radio, a cellular phone, or satellite based communication system).

CHAPTER 39 - VALUE-BASED PURCHASING - RESPONSIBLE DRIVING

EFFECTIVE DATE: August 12, 2016

The Arizona Health Care Cost Containment System (AHCCCS) requires the Division, as an Arizona Long Term Care System (ALTCS) program contractor, to implement Value-Based Purchasing (VBP) initiatives that leverage managed care toward value-based health care systems in order to improve members' experience/health and limit *per-capita* health care cost to the rate of general inflation. Specifically, the Division is required to implement a VBP initiative focused on decreasing quality of care concerns related to transportation services.

To increase awareness about responsible driving and member safety, the Division launched a VBP initiative called *Responsible Driving...it's more than what's outside the vehicle* in June, 2015. The initiative focuses on:

- A. Understanding heat-related effects
- B. Ensuring safe seating in vans and other vehicles
- C. Knowing passengers' needs
- D. Completing regular safety checks, both inside and outside the vehicle.

Vendor Requirements

To execute the VBP initiative, the Division requires vendors to develop and implement policies and procedures, regarding responsible driving and transporting members, that ensure:

- A. Current registration, plates, and insurance for each vehicle
- B. Ongoing vehicle maintenance that includes the vehicle climate control systems (air conditioner/heater), and log maintenance for two years
- C. Periodic reviews of driving records of employees that drive vehicles to transport members
- D. Emergency communication (two-way radio or cell phone) is available for transport
- E. Preparedness for emergencies (e.g., first aid kit, flashlights, emergency numbers)
- F. Safe vehicle boarding and exiting of members
- G. Vehicle inspection to ensure passenger safety inside and outside the vehicle prior, during, and after transport
- H. Training of staff on transportation policies/procedures.

The Division's Program Monitoring Unit reviews vendors' policies and procedures to ensure that all components are included.

The Division encourages providers to use *Policy and Procedure Focused Review: Responsible Driving Tool/Transporting Members (DDD-1753A FORPDF)* to self-assess policies and procedures in advance of the Division monitoring visit.

Qualified Vendors should share *Responsible Driving Safety Information Fact Sheet #6 (DDD-1751AFLYPD)* with providers.

CHAPTER 40 - INSURANCE

EFFECTIVE DATE: November 10, 2016

REFERENCES: [RFQVA DDD-710000](#)

Insurance Requirements

Qualified Vendors (QV) are required to maintain continuous insurance coverage through the duration of the Agreement; failure to comply may result in enrollment suspense and termination. Insurance requirements are set forth in the Agreement under Section 6.7 DES/DDD Standard Terms and Conditions for QV:

https://des.az.gov/sites/default/files/qv2014.section_6_standard_terms_and_conditions.pdf

Reporting Requirements

Proof of continuous insurance must be provided to the Division:

- A. Prior to the expiration of the policy, and
- B. Through a Certificate of Insurance (COI) submitted on an ACORD form 25 (or an equivalent form that has been approved by the State of Arizona).

Certificate of Insurance Requirements

- A. The QV's insurance provider is responsible for completing the COI.
- B. The QV is responsible for informing the insurance provider of the following requirements:
 1. The "Insured" box of the COI must reflect the name of the QV on the agreement and the address must be the same as the vendor address listed in Section 2 of the Qualified Vendor Agreement (QVA).
 2. The description section of the COI must include the solicitation number "RFQVA DDD-710000", and your contract or QVA number.
 3. Each COI submitted must reflect the State of Arizona, Department of Economic Security as the "Certificate Holder". One of the following addresses must be present in the Certificate Holder section of the certificate:
 - a. State of Arizona
Department of Economic Security
Division of Developmental Disabilities
Contract Management Unit
Business Operations – Site Code 791A

- b. State of Arizona
Department of Economic Security
Division of Developmental Disabilities
P.O. Box 6123
Phoenix, AZ 85005-6123

 - c. State of Arizona
Department of Economic Security
Division of Developmental Disabilities
1789 West Jefferson St
Site Code 791-A
Phoenix, AZ 85007
4. The COI must include the policy number, effective date, and expiration date for each type of insurance.

CHAPTER 41 – TERMINATION OF THE QUALIFIED VENDOR AGREEMENT UPON REQUEST OF THE QUALIFIED VENDOR

REVISION DATE: 3/25/2016

EFFECTIVE DATE: April 1, 2015

INTENDED USER(S): Business Operations staff (Contract Unit and Fiscal Integrity), Network staff, Quality Assurance staff, Support Coordination, Qualified Vendors

REFERENCES: [A.A.C. 6-6-2100 et. seq.](#), [A.R.S. §36-2904.G](#), [Division Provider Manual Chapter 34 Provider Publications](#)

Section Six of the Qualified Vendor Agreement (Agreement) requires the following will be completed when a Qualified Vendor requests termination of its Agreement:

The Qualified Vendor shall:

- A. Provide a 60 day written notice to the Division's Contract Management Unit setting forth the reasons for requesting termination.
- B. Submit a draft of the written notice for members/families and subcontractors, if applicable, regarding the termination to the District's Network Manager/designee for review and approval. The written notification must:
 1. Be written in 6th grade or below reading level, as specified in Chapter 34 of the Division's Provider Manual; and,
 2. Include assurance that the Qualified Vendor will assist with transitioning members to alternate providers.
- C. Mail approved letter to members/families and subcontractors, if applicable, upon receipt approval of draft letter from the Network Manager/designee and of termination acceptance notification from the Contract Manager/designee.
- D. Continue to perform in accordance with the requirements of the Agreement up to or beyond the date of termination as directed in the termination acceptance notice provided by the Contract Manager/designee.
- E. Make provisions for continuing all management/administrative services until the transition of members is completed and all other requirements of the Agreement are satisfied.
- F. Facilitate any medically-necessary appointments for care and services for members.
- G. Assist in the training of personnel, at the Qualified Vendor's own expense, as required by the Division.
- H. Ensure distribution of Client Funds to appropriate parties.

- I. Complete and submit copies of all final progress reports and other data elements to the assigned Division Support Coordinator.
- J. Pay all outstanding obligations for care rendered to members.
- K. Provide the following financial reports to the Division's Business Operations Fiscal Integrity Unit:
 - 1. A monthly claims aging report by provider/creditor including *Incurred But Not Reported* (IBNR) amounts;
 - 2. A monthly summary of cash disbursements; and,
 - 3. Copies of all bank statements received by the Qualified Vendor in the preceding month for Qualified Vendor's bank accounts.

All reports in this section shall be due on the 15th day of each succeeding month for the prior month.

- L. Submit a final claim to the Division for payment, pursuant to A.R.S. §36-2904.G.
- M. Upon termination, all goods, materials, documents, data and reports prepared by the Qualified Vendor under the Agreement shall become the property of and be delivered to the State on demand.
- N. Retain records as specified in the Agreement.
- O. Be liable to the State for any excess costs incurred by the State in procuring materials or services in substitution for those due from the Qualified Vendor.

Division's Business Operations (Contract Management, Claims, and Fiscal Integrity)

- A. The Contract Management Unit will provide written notice of acceptance of such termination and the proposed termination date.
 - 1. The notification will be issued by the Contract Management Unit and will include information informing the Qualified Vendor of its responsibility to notify members/families and subcontractors in writing of its intent to terminate the Agreement and outlining the transition process.
 - 2. The Contract Management Unit will send a copy of the termination acceptance notification and the *Transition Roster* to the Division's Network Manager(s). The *Transition Roster* is for all services being provided by the Qualified Vendor and includes:

A list of open authorizations by service, timelines for Division Network notification to members and, timelines for transition of members to alternate providers.

- B. The Fiscal Integrity Unit will verify the following financial information from the Qualified Vendor:
1. A monthly claims aging report by provider/creditor including *Incurred But Not Reported* (IBNR) amounts.
 2. A monthly summary of cash disbursements.
 3. Copies of all bank statements received by the Qualified Vendor in the preceding month for Qualified Vendor's bank accounts.
 4. All reports in this section shall be due on the 15th day of each succeeding month for the prior month.

Division's District (Support Coordination, Network, and Client Funds)

The Division's District will:

- A. Review/approve the Qualified Vendor's written notice to members/families and subcontractors, if applicable, of the intent to terminate the Qualified Vendor Agreement.
- B. The Network Manager or designee will notify members in writing of the network change as outlined in the *Transition Roster*.
- C. Attend transition meetings with the Qualified Vendor to ensure the smooth transition of members to alternate providers.
- D. Update the *Transition Roster* and track the authorizations for each member.
- E. Coordinate the transition of authorizations to alternate provider.
- F. Ensure all ISP documentation reflects changes.
- G. Provide updates on the *Transition Roster* to the Contract Management Unit regarding the transition to its completion.
- H. Remove the Qualified Vendor from all Directories.
- I. Remove the Qualified Vendor from the Vendor Call Lists.
- J. Resolve/close any open issues in the Resolution System, as appropriate.
- K. Reconcile all Client Funds for which the Division is Representative Payee.

CHAPTER 42 – ELECTRONIC MONITORING/SURVEILLANCE SYSTEM IN PROGRAM SITES

REVISION DATE: 05/01/2015

EFFECTIVE DATE: April 1, 2015

REFERENCES: [A.R.S. §12-2297](#), [A.R.S. §36-551.01](#)

PURPOSE: To distinguish the circumstances under which on-site and/or remote electronic monitoring may be conducted in programs and services funded by the Division. This policy applies to day program services, employment services and residential services. Electronic monitoring is not prohibited in common areas of programs where there is an identified need to ensure the health and safety of the member(s) during the delivery of service.

The following requirements must be met:

- A. Prior to installing or using surveillance and monitoring equipment, the Qualified Vendor must notify the District Network Manager and provide a copy of the policy/procedures/notices that demonstrate there are no violations of the rights of any member as set forth in A.R.S §36-551.01.
- B. Electronic surveillance and monitoring equipment and/or service may be used in residential settings in which residing members and their legal representatives, if applicable, request or consent to such surveillance and monitoring.
- C. Electronic surveillance and monitoring equipment and/or service may be used in common public settings including but not limited to workshops and employment programs.
- D. A sign must be posted in a conspicuous place in each common area that is under surveillance.
- E. The sign must indicate the days and hours of surveillance.
- F. Surveillance may only be conducted in areas that do not extend to the member's private space (e.g., bathroom, bedroom).
- G. Surveillance records (e.g., tapes) will be maintained in accordance with A.R.S. §12-2297 (Retention of Records) and must be produced upon request of the member or responsible person, the Division, law enforcement, protective agencies, and to other persons and entities entitled to access to public records under the law.

CHAPTER 43 – RESPITE PROVIDED AT CAMP TO ALTCS MEMBERS

REVISION DATE: 3/25/2016

EFFECTIVE DATE: April 15, 2015

INTENDED USERS: Support Coordinators, Qualified Vendors, Network Staff, and Business Operations

PURPOSE: To clarify when Respite may be used for members to attend camp. The member must be eligible to receive Respite as determined by the Division.

Definitions

Camp - A Qualified Vendor service site used to provide Respite to a member's primary caregiver while concurrently providing recreational activities for the member. Camp may be daily or overnight.

Utilization of Respite for Camp

- A. Respite begins when the care and custody of the member is transferred to the Qualified Vendor from the primary caregiver.
- B. Respite ends when the care and custody is transferred from the Qualified Vendor to the primary caregiver.
- C. When the member is transported to camp by the Qualified Vendor, transportation is part of the Respite service.

Number of Units of Respite for Camp

- A. The service authorization is determined based on the number of hours the member is in the care and custody of the Qualified Vendor.
- B. When the member is receiving 12 or more hours of Respite in a calendar day, the service authorization reflects one unit of Respite Daily. One unit of Respite Daily equals 12 hours of Respite.

Example: Camp begins Friday at 1p.m. and the member returns to the care and custody of the responsible person on Monday morning at 10am. Respite will be:

Friday: 1p.m. – Midnight = 11 hours Respite Hourly

Saturday: All Day = One unit Respite Daily

Sunday: All day = One unit Respite Daily

Monday: Midnight to 10 a.m. = 10 hours Respite Hourly

The Qualified Vendor is authorized two units of Respite Daily and 21 hours of Respite Hourly. The Support Coordinator deducts 24 hours of Respite Hourly for the two units of Respite Daily from the member's annual Respite allotment.

Program Site Requirements for Camp

- A. Any site used to provide Respite services to ALTCS members must be inspected by the Division's Office of Licensing, Certification and Regulation (OLCR) as required by the Qualified Vendor Agreement (QVA), Section 7 Service Specification, Respite Service Requirements and Limitations and Title 6. Chapter 18. Article 7 of the Arizona Administrative Code (A.A.C.). http://www.azsos.gov/public_services/title_06/6-18.htm#Article_7
- B. Any direct care staff working with Division members must meet all training and background requirements as outlined in the Qualified Vendor Agreement and A.A.C. Title 6, Chapter 6, Article 15. http://www.azsos.gov/public_services/Title_06/6-06.htm
- C. Staff-to-member ratio must comply with and be billed in accordance with the Division's Rate Book.
- D. All members attending the program must be included in the calculation of staff-to-member ratio.

Camp Related Activity Fees

- A. The Qualified Vendor may request activity fees for special camp activities (e.g., horseback riding).
- B. Qualified Vendors must offer an alternative activity or may provide scholarships for members who cannot or do not want to pay an activity fee.
- C. Ability for a member to pay an activity fee cannot be used to determine program participation.

CHAPTER 44 – QUALIFIED VENDOR RESPONSIBILITIES FOR PLANNING TEAM MEETINGS

REVISION DATE: 9/15/2014, 8/1/2014

EFFECTIVE DATE: October 31, 1993

As a member of the Planning Team, Qualified Vendor responsibilities include, but are not limited to the following:

- A. Submit assessments, including recommendations, to the Support Coordinator at least five working days prior to the scheduled Planning Team meeting.
- B. Write plans of care or teaching strategies necessary to implement assigned outcomes and submit as required in the specific Service Specifications.
- C. Submit progress reports as required in the Provider Manual.
- D. Participate in the Planning Team meeting:
 - 1. In person at the location selected by the member;
 - 2. By phone; or,
 - 3. By submitting required documents prior to meeting.
- E. Complete action items as determined by the Planning Team.
- F. Contact the Support Coordinator to suggest a team meeting when the Qualified Vendor becomes aware of significant changes in the member's condition or status.

CHAPTER 46 – AGENCY WITH CHOICE

EFFECTIVE DATE: April 1, 2015

REFERENCES: [AHCCCS Chapter 1300 AMPM Member Directed Options](#)

FORMS: [Agency With Choice: Individual Representative](#) (DDD-1658A)

[Agency With Choice: Individual Representative](#) (Spanish) (DDD-1658S)

[Agency With Choice: Partnership Agreement](#) (DDD-1659A)

[Agency With Choice: Partnership Agreement](#) (Spanish) (DDD-1659S)

[ALTCS Service Model Options \(Decision Tree\)](#) (DDD-1626A)

[ALTCS Service Model Options \(Decision Tree\)](#) (Spanish) (DDD-1626S)

Agency with Choice (AWC) is a member-directed service delivery option available to Division members receiving Homemaker (HSK), Habilitation, Individually Designed Living-Hourly (HAI), Attendant Care (ATC), and/or Habilitation-Hourly Support (HAH). In this model, Qualified Vendors and members enter into a Partnership Agreement and share responsibilities for choosing, managing, and supervising direct care workers.

The *Appendix A QVADS Agency with Choice Selection* instructions provides guidance to “Opt-In” as an AWC vendor.

- A. Your agency may opt-in anytime for any or all AWC services.
- B. If your agency opts-in to AWC, the services you identified as AWC will be available to members who select the AWC service delivery option.
- C. Once your agency has opted-in to AWC, it may opt-out for any or all AWC services **ONLY** after closure of authorizations for members who selected AWC service delivery option.

The *Appendix B DDD Agency with Choice User Guide – FOCUS Vendor* instructions, provides guidance for billing as an AWC vendor.

- A. Once a new authorization has been received, the vendor **MUST** either acknowledge or deny the authorization within three (3) business days.
- B. Upon acknowledgement, you will be reminded to use a Healthcare Common Procedure Coding System (HCPCS) U-7 modifier when submitting claims for services provided under the AWC service delivery option.

Any authorization that is not acknowledged or denied within three (3) days of receipt will be automatically terminated and removed from the agency Focus screen. The Support Coordinator will contact the member to select an alternate agency.

For questions about Opting-In to AWC in QVADS please call (602) 771-1444 extension #3.

For questions about DDD Policy for AWC please contact DDDPolicy@azdes.gov.

For questions about AWC billing please contact DDDClaims@azdes.gov.



Chapter 57 Third Party Liability

57-A	Introduction
57-B	Statutory Requirements for Other Payor (Third Party Liability) Claims
57-C	Payments and Denials
57-D	Explanation of Benefits
57-E	DES/DDD Waiver Requests
57-F	Denial Code Explanation and Other Payor/Third Party Liability
57-G	Responsibilities
57-H	Process for Updating Insurance Changes in Focus
57-I	Other Payor (Third Party Liability) Billing Scenarios
57-J	Recommendations for Working with Insurance Companies
57	Frequently Asked Questions - Appendix

CHAPTER 57-A INTRODUCTION

EFFECTIVE DATE: August 5, 2016

This chapter applies to the following Division-specific service codes: Therapy Service Codes OTA, OEA, PTA, PEA, STA, SEA, PTI, OTI, and STI; Nursing Service Codes HN1, HNR, HNV, HN9, NF 1, NF 2, and NF 3.

“Other Payors/Third Party Liability (TPL)” refers to the resources available from a person or entity that is, or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a member eligible for Arizona Health Care Cost Containment System (AHCCCS) benefits. AHCCCS and the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD), as an AHCCCS program contractor, are the payor(s) of last resort. Excluded: Medical Savings Account (MSA), Health Flex Spending Arrangement (FTA), Health Savings Account (HSA).

“Coordination of benefits” refers to the activities involved in determining Medicaid benefits when a member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

“Cost avoidance” refers to the process of denying a claim and returning it to the provider for a determination of the amount of third-party liability.

CHAPTER 57-B STATUTORY REQUIREMENTS FOR OTHER PAYOR (THIRD PARTY LIABILITY) CLAIMS

EFFECTIVE DATE: August 5, 2016

REFERENCES: 42 CFR 433.138, 42 CFR 433.139, Deficit Reduction Act ("DRA") of 2005, A.R.S. § 36-2923, A.A.C. R9-22-1002, A.A.C. R9-22-1003, A.A.C. R9-22-1001, A.R.S. § 36-596, A.A.C. R6-6-1303, A.R.S. § 36 Chapter 5.1

- A. The Arizona Health Care Cost Containment System (AHCCCS) is, by Federal law, the "payor of last resort" in most instances. "Payor of last resort" means that AHCCCS only pays claims after all other forms of payment have been exhausted. According to 42 CFR 433.138, 42 CFR 433.139, and the Deficit Reduction Act (DRA) of 2005, AHCCCS is required to take measures to identify third party payers who are responsible for paying for services provided through AHCCCS and its program contractors.
- B. Arizona Revised Statutes (A.R.S.) § 36-2923 requires that private health insurers provide AHCCCS with the enrollment information and respond to AHCCCS requests for claims data necessary to ensure the time period in which the AHCCCS-eligible person or his/her spouse or dependents may or may not have been covered by the health care insurer and the nature of that coverage.
- C. Arizona Administrative Code (A.A.C.) R9-22-1002 requires AHCCCS to be the payor of last resort.
- D. A.A.C. R9-22-1003 requires AHCCCS to apply the principles of cost avoidance and coordination of benefits.
- E. According to A.A.C. R9-22-1001, "cost avoidance" is defined as "to deny a claim and return the claim to the provider for a determination of the amounts of first and third party liability."
- F. Pursuant to A.A.C. R9-22-1003(C), the responsibility to take reasonable measures to identify potentially legally liable first and third-party sources is bestowed upon AHCCCS or its program contractor, a provider, a non-contracting provider, and a member.
- G. A.R.S. § 36-596 requires ADES/DDD to act as the payor of last resort unless specifically prohibited by law, and to establish a benefit recovery program for state-funded services for individuals who receive services pursuant to Title 36, Chapter 5.1 of the Arizona Revised Statutes which are covered wholly or partly by a first party health insurance medical benefit.
- H. A.A.C. R6-6-1303 governs DD/non-Arizona Long Term Care System (ALTCS) Division-covered services and requires DDD to be the payor of last resort. It also requires service providers to submit Explanation of Benefits (EOB) for claim and payment processing in situations where a DDD member may have other medical benefits.

CHAPTER 57-C PAYMENTS AND DENIALS

EFFECTIVE DATE: August 5, 2016

REFERENCES: A.R.S. § 36-2904

Claims submitted on behalf of the Qualified Vendor can either be paid or denied. When submitting a claim to the Division, the Qualified Vendor must provide acceptable information, verifying the rejection or non-payment of the claim.

An Explanation of Benefits (EOB) is considered an acceptable document when the other payor/third party is an insurance company whose potential liability for the claim arises out of a contract of insurance. An EOB indicates how the payment was calculated and any reasons for non-payment. If there is more than one insurance company involved, the same process must be repeated for each insurance company.

The Qualified Vendor may submit a *COBV Waiver Request (DDD-1651A)* to the Division to indicate the member's Third Party Liability (TPL) payor was billed. Prior to submitting a *COBV Waiver Request*, the Qualified Vendor must receive a clean denial from the primary insurance company or companies (more information regarding waiver processing is available in Chapter 57-E DES/DDD Waiver Request). A request for additional or corrected information on behalf of the insurance company is not a clean denial.

According to A.R.S. § 36-2904, a "clean claim" means a claim that may be processed without obtaining additional information from the provider of service or from a third party. Clean claims do not include claims under investigation for fraud and abuse or claims under review for medical necessity. In order to be considered a clean claim, the EOB must contain, at minimum, the items listed under "Key Components of EOB" specified in Chapter 57-D Explanation of Benefits.

CHAPTER 57-D EXPLANATION OF BENEFITS

EFFECTIVE DATE: August 5, 2016

An Explanation of Benefits (EOB) is a statement provided by a health insurance company to covered individuals explaining what medical treatments and/or services were processed on their behalf.

Key Components of EOB

It is important to note that not all EOBs are the same. The format and content of the EOB depends on the benefit plan and the services provided by insurance companies. Deductible and copayment amounts may also vary.

The following are the most common and important parts of the EOB which, at a minimum, are needed for the Division's waiver review. If the EOB is missing the required information, the Qualified Vendor should contact the insurance company to obtain a corrected EOB and resubmit the corrected EOB to the Division.

- A. **Provider's Name:** Name of the Qualified Vendor.
- B. **Claim Information:** Includes the member/patient name, the member's group and identification numbers, and the claim number.
- C. **Service Information:** Identifies the health care facility or physician, dates of service and charges, and service or bill code for each specific service.
- D. **Coverage Information:** Shows what was paid to whom, what discounts and deductions were applied, and what part of the total expense was not covered.
- E. **Information About Amounts Not Covered:** Shows what benefit limitations or exclusions apply.
- F. **Information About Out-Of-Pocket Expenses:** Shows an amount when a claim applies toward the deductible or counts toward out-of-pocket expenses.
- G. **Summary:** Highlights the financial information and identifies the amount billed, total benefits approved, and the amount owed to the provider.
- H. **Reason Denial Codes/Remarks/Comments:** Most insurance companies generally use a numbering-based system to reflect the denial reason followed by comments or number-based explanation. Explanation of the denial codes is required for the Division's waiver process.

Important Considerations

- A. The billed service code reflected on the EOB must correspond to an AHCCCS-approved Current Procedural Terminology codes (CPT)/Healthcare Common Procedure Coding System (HCPCS) code. Usage of unapproved codes could be grounds for denial of the waiver. If the EOB does not contain the CPT/HCPCS codes, the CMS 1500 claim form must be included for the Division's review.

- B. If the EOB states "prior to the coverage effective date" or "termination of coverage," the Qualified Vendor must verify the eligibility information with the insurance company. All insurance updates must be provided to the Division TPL Benefits Coordinators at TPLBenefits@azdes.gov.

CHAPTER 57-E DES/DDD WAIVER REQUESTS

EFFECTIVE DATE: August 5, 2016

REFERENCES: *COBV Waiver Request (DDD-1651A)*, CMS 1500

Coordination of Benefits and Verification Waiver Request Form (COBV Waiver Request)

The waiver request form, *COBV Waiver Request (DDD-1651A)*, is initiated by the Qualified Vendor and used by the Division to meet the coordination of benefits requirement.

Location of the Waiver Request Form

The *COBV Waiver Request (DDD-1651A)* is available via the following link: <https://des.az.gov/services/disabilities/developmental-child-and-adult/help-providers>. In the resulting screen, under the "Billing" header, click on "Waiver Request Form."

The Division will not accept any older versions of the form.

Required Documents

The Qualified Vendor must submit waiver requests by e-mail to TPLWaiver@azdes.gov; requests must include:

- A. *COBV Waiver Request (DDD-1651A)* properly filled out (see below for more information), and
- B. Each corresponding Explanation of Benefits (EOB).

If the EOB does not contain the procedure codes (CPT/ HCPCS), include the CMS 1500 form (if applicable).

Key Components of the COBV Waiver Request Form

The following is information regarding the required fields.

Field	Explanation
1 Provider Name	Name of the billing agency
2 Provider ID Number	Tax ID or FEI Number, 9 digits
3 Four Digit Code	Four-letter alpha code assigned to the provider agency by the Division
4 Fax Number	Fax number of the agency
5 E-Mail Address	E-mail address of the assigned individual on behalf of the agency
6 Signature	Signature of the assigned individual on behalf of the agency
7 Date	Date of completion of the Waiver form
8 Member's Name	Legal name of the member
9 ASSIST ID	Unique 10 digit number
10 Insurance name/ MCID	Name of the Insurance Company in reference to EOB along with the Master Carrier ID (MCID)
11 Service Code	The Division-assigned service code for the approved services based on the ISP
12 Start Date	Start date of the service
13 End Date	End date of the service
14 Comments	Any comments that might be helpful in understanding the submitted documentation

When to Apply for DES/DDD Waiver

The Division may grant a waiver to the Qualified Vendor, based on the following conditions:

- A. When a Qualified Vendor obtains a denied EOB listing an approved service code and appropriate remarks codes and explanation.
- B. If a Qualified Vendor bills for services covered under Medicare Part B but is not Medicare certified.
 - 1. The Vendor must submit *COBV Waiver Request (DDD-1651A)* stating that the Qualified Vendor is not Medicare certified.
 - 2. The waiver requirement is only applicable for Medicare Part B. Billing pertaining to Medicare Parts A, C, and D does not require a waiver.

The Division reviews all waiver requests. If a waiver request is denied, the Division notifies the Qualified Vendor via e-mail, including the reason for the denial.

Approved waivers can be viewed under "Waivers" in the Professional Billing System (PBS)."

Important Considerations

- A. Each service requires a specific three-letter alpha code on *COBV Waiver Request (DDD-1651A)*.
- B. Third Party Liability Exclusions

The following accounts are not considered as liable third party resources and providers will not be required to bill these types of accounts:

- 1. Medical Savings Account (MSA)
 - 2. Health Flex Spending Arrangement (FTA)
 - 3. Health Savings Account (HSA)
- C. Health Reimbursement Arrangement (HRA), also known as Health Reimbursement Account or Personal Care Accounts, are a type of health insurance plan considered as a Third Party Liability resource, and providers shall bill this type of account.

CHAPTER 57-F DENIAL CODE EXPLANATION AND OTHER PAYOR / THIRD PARTY LIABILITY

EFFECTIVE DATE: August 5, 2016

The following are the most common messages that appear in the "Billing Detail Report" when there is other payor (third party liability):

	Error Description	What it Means	What Should the Qualified Vendor Do
1	<i>Waiver not found and reason code not supplied</i>	The claim submitted does not have a <i>COBV Waiver Request</i> form on file and/or a TPL payment or deductible reported within the claim line of the Uniform Billing document.	<p>Review Focus and ensure a waiver is on file for each active policy.</p> <p>Submit <i>COBV Waiver Request</i> form to TPLWaiver@azdes.gov.</p> <p>Submit eligibility information to DDD Claims for an insurance update, if a policy is no longer active.</p>
2	<i>Number of insurances does not match number of active insurances</i>	There is discrepancy between Focus records and the claim lines provided in the Uniform Billing Document (based on EOB submitted on behalf of the member). Claim lines provided in the Uniform Billing Document have different information (more or less) than what is available in Focus.	<p>Review member's medical coverage and verify the insurances reported in Focus.</p> <p>If the insurance reported is not found in Focus, the Qualified Vendor should email TPLbenefits@azdes.gov for an insurance update.</p> <p>If there are two policies in Focus for the same insurance, the Qualified Vendor should email: TPLbenefits@azdes.gov for a review.</p>

	Error Description	What it Means	What Should the Provider Do
3	<i>Invalid Insurance Company</i>	The Master Carrier ID (MCID) reported on the claim line of the Uniform Billing Document does not match Focus records.	<p>The Qualified Vendor should review Focus and ensure the Master Carrier ID (MCID) reported in Focus matches the claim lines of the Uniform Billing Document.</p> <p>If the MCID on the claim line does not reflect the MCID in Focus; claim will need adjustment.</p> <p>If the insurance reported is not found in Focus, the Qualified Vendor should email TPLbenefits@azdes.gov for an insurance review/update.</p>
4	<i>TPL amount greater than zero, no insurance on file</i>	The claim line reports a TPL payment; members record shows no insurance on file	<p>The Qualified Vendor should review the member's medical coverage and verify the reported insurance found in Focus.</p> <p>If the insurance reported is verified, the Qualified Vendor should email TPLbenefits@azdes.gov for an insurance review/update.</p>
5	<i>Pay amount plus TPL amount does not equal rate times unit</i>	This is an indication of the mathematical error. Rate times units minus TPL amount does not match the total amount due.	The Qualified Vendor should check the calculations of the rate times the units minus the TPL amount (if applicable) is equal to the total pay amount. ("Rate" x "Units" - "TPL amount" = "Total pay amount")

CHAPTER 57-G RESPONSIBILITIES

EFFECTIVE DATE: August 5, 2016

The following section provides additional information regarding different aspects of provider responsibility in relation to Other Payor (Third Party Liability [TPL]) processing. Due to the statutory Federal and State requirements of the Other Payor (TPL) billing process, the Qualified Vendor is responsible for creating appropriate methodologies and processes for obtaining required documentation and payment from third parties aligned with Division requirements. Qualified Vendors are required to follow specific steps for processing Other Payor (TPL) documentation at each stage of the billing process. Steps may include, but are not limited to, resubmitting claims, making follow-up phone calls, and submitting additional requested information.

Responsibilities for Other Payor (TPL) Documentation

- A. The Qualified Vendor must report to TPLBenefits@azdes.gov any updates to the member-specific Other Payor (TPL) information within ten (10) business days of learning of the new information.
- B. A Qualified Vendor who has been paid by the Division and subsequently receives reimbursement from an Other Payor (third party) must request a claim reversal and report TPL payment.
- C. The Division/AHCCCS makes payments to Qualified Vendors on behalf of members for medical services rendered, but only to the extent that the member has a legal obligation to pay. This means that if a Division member has third party insurance, the Division's payment will be limited to the member's responsibility (usually the deductible, copay and/or coinsurance).
- D. When a Qualified Vendor receives payment from an Other Payor (third party) in an amount that meets or exceeds the published rate, the Qualified Vendor must report the provision of service on the claim document indicating no amount due from the Division.
- E. When a Qualified Vendor receives payment from an Other Payor (third party) in an amount that is lower than the published rate, the Qualified Vendor must report the provision of service on the claim document up to the Division's contracted rate (the Qualified Vendor can bill the Division for the difference between the Other Payor (third party) paid amount and up to the Division's contracted rate).

Time Frames - Initial Billing Submission and Resubmissions

According to standard terms and conditions of the Qualified Vendor Agreement, the Division is not obligated to pay for services provided without prior authorization. Claims for services delivered must be initially received by the Division no later than six (6) months after the last date of service as indicated on the claim or as otherwise authorized by contract. Claims should be submitted within the specified time period from the date of service for a first submission to retain appeal rights, whether the other insurance explanation of benefits has been received or not. A resubmitted claim shall not be considered for payment unless it is received by the Division as a clean claim no later than twelve (12) months after the last date of service shown on the original claim.

Billing Codes

Qualified Vendors can only bill for service of categories for which they are approved from AHCCCS. It is the responsibility of the Qualified Vendor to be aware of the most updated CPT/HCPCS codes for billing purposes. CPT/HCPCS codes related with specific category of services may change. Information regarding this topic is available at <http://www.cms.gov/> (Center for Medicare & Medicaid Services).

CHAPTER 57-H PROCESS FOR UPDATING INSURANCE CHANGES IN FOCUS

EFFECTIVE DATE: August 5, 2016

Internal documentation created by the Qualified Vendor for data collection or member tracking purposes is not sufficient insurance updates. The Qualified Vendor is required to submit updated insurance information to the Third Party Liability (TPL) unit via e-mail to TPBenefits@azdes.gov for requested TPL changes in Focus. The following chart identifies common scenarios and the information Qualified Vendors are required to submit to the TPL unit when requesting an insurance change in Focus:

	Scenarios	Required Information
1	New Insurance	<ul style="list-style-type: none"> • Insurance Card or • Member Eligibility Page or • Explanation of Benefits (EOB)
2	Termed Insurance (Policy expired)	<ul style="list-style-type: none"> • Member Eligibility Page or • EOB and • 4 Alpha Vendor Code and • Service Codes for Billed Services
3	Duplicate Insurance More than one policy reflected in the system with similar: <ul style="list-style-type: none"> • Insurance company name • Effective/end dates • Policy number 	<ul style="list-style-type: none"> • 4 Alpha Vendor Code and • Service Codes for Billed Services and • Details about the policy requested for removal (Policy number plus Master Carrier ID [MCID])
4	Invalid Insurance (Insurance policy does not exist)	<ul style="list-style-type: none"> • EOB with denial/rejection indicating member not enrolled (e.g., "member not found") or • The following information from the insurance company contacted: <ul style="list-style-type: none"> ○ Phone number of the insurance company ○ Name of the representative spoken to ○ Reference/confirmation number associated with the call
<p>For all scenarios, member name and member ASSIST ID is required information.</p>		

CHAPTER 57-I OTHER PAYOR (THIRD PARTY LIABILITY) BILLING SCENARIOS

EFFECTIVE DATE: August 5, 2016

Other Payor (TPL) Billing Scenarios

Third Party Liability (TPL) billing scenarios can be divided into two groups:

Group A - No waiver required, as discussed in Scenarios #1 through #4.

Group B - Waiver required, as discussed in Scenarios #5 and #6.

Group A - No Waiver Required

A. Scenario #1

1. If insurance pays **equal** to the Division contracted rate:
 - a. Division does not pay.
 - b. No Waiver is required.

Insurance Paid Amount =	\$50.00
Division Contracted Rate =	\$50.00
Payment To Provider =	\$0.00

2. Detail and Explanation

When the Qualified Vendor receives payment from a third party payor in an amount that meets the Division published rate, the Qualified Vendor must report the provision of service on the claim document showing no amount due from the Division. This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company "TplAmt1" in column "L" and entering \$0.00 in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
50.00	90655	\$50.00	\$0.00

B. Scenario #2

1. If insurance pays **higher** than the Division contracted rate:
 - a. Division does not pay.
 - b. No Waiver is required.

Insurance Paid Amount = \$60.00
Division Contracted Rate = \$50.00
Payment To Provider = \$0.00

2. Detail and Explanation

In the event the Qualified Vendor receives payment from a third party payor in an amount that exceeds the published rate, the Qualified Vendor must report only an amount up to the Division's contracted rate. The claim line should show no amount due from the Division. This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company - "TplAmt1" in column "L" and entering \$0.00 in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
\$50.00	90655	\$60.00	\$0.00

C. Scenario #3

1. If insurance pays **lower** than the Division contracted rate:
 - a. The Division pays the difference between the contracted rate and insurance payment.
 - b. No Waiver Required.

Insurance Paid Amount = \$30.00
Division Contracted Rate = \$50.00
Payment To Provider = \$20.00

2. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company (TplAmt1) in column "L" and the difference between column "J" (Division rate for the service) and column "L" (amount paid by the insurance company) in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
\$50.00	90655	\$30.00	\$20.00

D. Scenario #4

Insurance applies claim towards the deductible, copay, or coinsurance. The following different scenarios may occur.

1. Scenario: No Payment Issued

a. If the insurance processes the claim and applies the claim towards the deductible, copay, or coinsurance and does **not** issue a payment. Provider submits monthly billing to Division and no waiver required.

b. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," entering "01" in column "M" and entering the rate which the Division would pay for the service in in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
K	MCID number
M	Deductible Code 01
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode2	Total Amt Due
\$50.00	90655	01	\$50.00

2. Scenario: Payment Issued Greater than Division Rate

a. If the insurance processes the claim and applies a portion of the claim towards the deductible, copay, or coinsurance and makes a payment that is more than the Division contracted rate.

Insurance Paid Amount = \$60.00
Division Contracted Rate = \$50.00
Payment To Provider = \$0.00

b. Detail and Explanation

In the event the Qualified Vendor receives payment from a third party payor in an amount that exceeds the published rate, the Qualified Vendor shall report only an amount up to the Division's contracted rate. This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company - "TplAmt1" in column "L" and entering \$0.00 in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
\$50.00	90655	\$50.00	\$0.00

3. Scenario: Payment Issued Less than Division Contracted Rate

- a. If the insurance processes the claim and applies a portion of the claim towards the deductible, copay or coinsurance payment made by the insurance company is **less** than the Division contracted rate, no waiver required.

Insurance Paid Amount = \$30.00
Division Contracted Rate = \$50.00
Payment To Provider = \$20.00

b. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," MCID number in column "K," amount paid by the insurance company (TplAmt1) in column "L," the difference between column "J" (Division rate for the service) and column "L" (amount paid by the insurance company) in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
\$50.00	90655	\$30.00	\$20.00

Group B - Waiver Required

A. Scenario #5

1. Insurance company does not pay.
 - a. The Qualified Vendor receives EOB from the primary insurance(s).
 - b. The Qualified Vendor applies for Waiver Request with the Division.
 - c. The Division processes Waiver Request.
 - d. If Waiver is approved, the Division pays contracted rate, if clean claim status exists.

2. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," and entering the total amount due up to the contracted rate in column "T," off the Uniform Billing Template as shown below (assuming that the waiver has been approved).

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode1	Total Amt Due
\$50.00			\$50.00

B. Scenario #6

1. Primary insurance does not respond.

- a. The Qualified Vendor is unable to obtain documentation or resolution from the insurance company, file a grievance with the insurance carrier as all other efforts to procure the documentation have failed.
- b. The Qualified Vendor applies for Waiver Request with the Division.
- c. The Division will use the grievance decision documentation to make appropriate determination regarding the finalization of the waiver process.
- d. The Division processes Waiver Request.
- e. If the Waiver Request is approved, the Division pays contracted rate.

2. Detail and Explanation

This process can be completed by entering the Division rate for the specific service in column "J," and entering the total amount due up to the contracted rate in column "T," of the Uniform Billing Template as shown below (assuming that the waiver has been approved).

Legend - Uniform Billing Template

Column Name	Explanation
J	Division rate for specific service
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode1	Total Amt Due
\$50.00			\$50.00

CHAPTER 57-J RECOMMENDATIONS FOR WORKING WITH INSURANCE COMPANIES

EFFECTIVE DATE: August 5, 2016

REFERENCES: A.R.S § 20-3101, A.R.S § 20-3102

- A. Submit a claim to the insurance company as soon as possible after the delivery of service.
- B. If no response has been received after 14 days, call the insurance company's customer service department to determine the status of the claim.
- C. If the insurance company has not received the claim, refile the claim.
 - 1. If sending by mail, stamp the claim as a repeat submission, or
 - 2. If sending by fax, use a cover note indicating as a repeat submission.
- D. If the insurance company has received the claim but considers the billing insufficient:
 - 1. Supply all additional information requested by the insurance company.
 - 2. Confirm that all requested information has been submitted.
- E. Allow seven (7) more days for the claim to be processed. If there is no response after seven (7) days and all information has been supplied as requested, contact the insurance company again. If the company acknowledges the receipt of the claim and considers the billing valid, but has not responded to the claim, make a note and follow-up with a written request for a response
- F. If there is no response after an additional seven (7) to eight (8) days, based on A.R.S § 20-3102, consider filing a grievance with the insurance carrier, as all other efforts to procure the documentation have failed. "Grievance" means any written complaint that is subject to resolution through the insurer's system as discussed in A.R.S § 20-3101.
- G. The Qualified Vendor may visit Arizona Department of Insurance's website at www.azinsurance.gov to find information about the grievance process. Grievance documentation should include specific information regarding the claim in question, reason for the grievance, and any supporting information/documents.
- H. The Division will require the grievance decision documentation in order to make the appropriate determination in reference to the finalization of the waiver process.

FREQUENTLY ASKED QUESTIONS - APPENDIX

EFFECTIVE DATE: August 5, 2016

1. **How can the Qualified Vendor bill DDD when the insurance company does not pay, as the amount may be over the maximum benefit allowed amount?**

If the insurance company denies the claim because the amount paid for the benefit has exceeded the maximum allowed benefit, the Qualified Vendor can request a waiver from the Division. The Division will review the denial reason provided by the primary insurance company's explanation of benefits. If a waiver is granted, the Qualified Vendor can bill the Division appropriately until the expiration or termination of the waiver.

2. **How can the Qualified Vendor bill the Division if the insurance company is not willing to pay, as the claim is not an allowed expense?**

If the primary insurance denies the claim because the service is not an allowed expense, the Qualified Vendor may request a waiver from the Division. The Division reviews the denial reason on the primary insurance company's Explanation of Benefits (EOB).

If a waiver is granted, the Qualified Vendor can bill the Division appropriately until the expiration or termination of the waiver.

3. **When should a waiver request be submitted?**

Waivers are requested when the primary insurance company or companies deny the claim.

4. How do the Qualified Vendors report two different insurance companies on the Uniform Billing Template?

The Master Carrier Identification (MCID) for each insurance company should be reported separately on the uniform billing template. Review the following examples.

J	K	L	N	P	T
Rate	TplCode1	TplAmt1	TplCode2	TplReCode2	TotalAmtDue
\$50.00	90655	\$30.00	94940	01	20.00

Primary Insurance Company

In the above example, column J is the contracted rate, column K is the primary insurance MCID number, and column L is partial payment from primary insurance.

Secondary Insurance Company

In the above example, column N is secondary insurance MCID number, column P is applied to deductible, and column T is total amount paid.

5. What is the typical turnaround timeframe for waiver request approval?

Waivers are generally approved within 2-3 business days.

6. How is the Qualified Vendor notified that a waiver request has been approved?

The Qualified Vendor can check the waiver report in Professional Billing System (PBS) to confirm that the waiver request has been approved. In addition, the vendor will receive an e-mail notification in reference to the status.

7. How is the Qualified Vendor notified that a waiver request is not approved?

If a waiver request is not approved, the vendor will receive an e-mail notification in reference to the status.

8. If a member has Medicare Parts A, B, C or D, what type of coverage would require a waiver?

A waiver is only required for Medicare Part B.

9. **When is a Medicare waiver required?**

The Division issues waivers for Qualified Vendors that are non-certified Medicare providers.

The Medicare Certified Provider must bill Medicare to obtain an EOB showing benefits were denied in order to request a waiver. Refer to the section "DES/DDD Waiver Request Process" for more information on this topic.

The waiver request should show the type of services that is being billed and the start date. To facilitate this process, indicate on the *COBV Waiver Request* form, "Not a Medicare Certified Provider."

10. **When the EOB indicates that the insurance company made a partial payment, where is the partial payment information reported on the Uniform Billing Template?**

For a detailed response, please refer to the section "Third Party Billing Scenarios - Scenario #3."

11. **When the EOB indicates that the insurance company paid over and above what the Division would pay, where should the information be reported on the Uniform Billing Template?**

For a detailed response, please refer to the section "Third Party Billing Scenarios - Scenario #2."

12. **When the EOB indicates that the payment was applied to the deductible, where should the information be reported on the Uniform Billing Template?**

For a detailed response, please refer to the section "Third Party Billing Scenarios - Scenario #4."

13. **What is the Qualified Vendor's responsibility if the primary insurance company refuses or fails to issue an EOB?**

For a detailed response on this topic, please refer to the "Recommendation for Working with Insurance Companies"

14. **What is an "MCID"?**

The MCID (Master Carrier Identification) identifies a specific insurance company with a specific street address. The MCID number is on the final authorization screen (under the Medical drop-down) or on the authorization report in Focus. If the incorrect MCID number is billed, the claim will deny.

15. **What process should be followed to update insurance changes (such as new insurance, policy termination, etc.)?**

For a detailed response on this topic, please refer to Chapter 57-H Process for Updating Insurance Changes in Focus of the Provider Manual.

Chapter 58 Medication Management Services

EFFECTIVE DATE: May 13, 2016

The Division allows Primary Care Providers (PCPs) to treat members diagnosed with anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD). For purposes of medication management, it is not required that the PCP be the member's assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. The Division provides for these services both in the prospective and prior period coverage timeframes.



CHAPTER 59 BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICAL HEALTH SERVICES

REVISION DATE: May 13, 2016

ADHS, either directly or through subcontractors, shall be responsible for the provision of all medically necessary covered behavioral health services to DD-ALTCS eligible members in accordance with applicable federal, state, and local laws, rules, regulations, and policies, including services described in AHCCCS policy AMPM 432.

CHAPTER 60 – PROVIDER NOTIFICATIONS

EFFECTIVE DATE: May 13, 2016

The Division provides notification to its network as required by the Arizona Health Cost Containment System (AHCCCS), AHCCCS Contractor Operations Manual (ACOM).

Material Change

The Division communicates any alteration or development within the provider network that may reasonably be foreseen to affect the quality or delivery of services provided to affected providers at least 30 days prior to the change. The Administrative Services Subcontractor (AdSS) is responsible for notifying their providers prior to a material change.

For Qualified Vendors, a material change includes a material event as outlined in the DES DDD Standard Terms and Conditions for Qualified Vendors. The provider must notify the Division's Contract Administrator at DDDContractsmanager@azdes.gov within 24 hours of a material event.

Operational Change

- A. If a provider's (i.e., Qualified Vendor, AdSS) overall operational change (e.g., policy, process, protocol) affects, or can reasonably be foreseen to affect, the provider's ability to meet the performance standards of the contract or agreement with the Division:
 - 1. The Qualified Vendor must provide written notification to the Division's Contract Administrator at DDDContractsmanager@azdes.gov at least 60 days prior to the proposed change.
 - 2. The AdSS must provide written notification as required by contract to the Division's Compliance Unit at DDDALTCSCompliance@azdes.gov.
- B. If an overall operational change (e.g., policy, process, protocol) affects, or can reasonably be foreseen to affect, the Division's ability to meet the performance standards of the Division's contract with AHCCCS, the Division notifies AHCCCS, Division of Health Care Management, Operations and Compliance Officer at least 60 days prior to the proposed change.

Contract Notifications

The Division makes contract notifications:

- A. In writing to provide the reason for declining any written request for inclusion in the network
- B. To ensure contract compliance and to document progressive contract action, when necessary.

General Notifications

- A. The Division provides notification via provider meetings, email (e.g., Vendor Blast), or US mail:
 - 1. For routine changes and updates to AHCCCS Guidelines, Policy, Manual Changes, and any other information that AHCCCS may require the Division to disseminate on behalf of the Administration
 - 2. For routine changes and updates to Division Guidelines, Policy/Provider Manual
 - 3. For changes to the AHCCCS Minimum Subcontract, within 30 calendar days of the published change
 - 4. To disseminate information designed to bring the providers into compliance with Disease/Chronic Care Management practice guidelines.
- B. Qualified Vendors are required to maintain and update Primary Contract Contact information to receive provider notifications.
- C. Communication with Independent Providers is via US mail.
- D. Communication with Administrative Services Subcontractors (AdSS) is not duplicated if the AdSS is also contracted with AHCCCS.
- E. The Division delegates notifications to acute care and behavioral health providers to its Administrative Services Subcontractors.

CHAPTER 61 - HOME AND COMMUNITY BASED SERVICES (HCBS) CERTIFICATION AND PROVIDER REGISTRATION

EFFECTIVE DATE: June 17, 2016

REFERENCES: 42 CFR Part 431.107

All providers of AHCCCS-covered services (either Fee-For-Service [FFS] or managed care) must be HCBS certified and registered with the Arizona Health Care Cost Containment System Administration. The Division's Office of Licensing, Certification, and Regulation (OLCR) assists Division providers with this process including signing the Provider Agreement that includes Federal requirements under 42 CFR Part 431.107.

HCBS Certification

- A. Independent Providers, agencies, and Individual Independent Providers with a Qualified Vendor Agreement, may submit an application packet for an initial HCBS Certification to the Office of Licensing, Certification and Regulation (OLCR). This application packet must include:
1. *An Application for Initial HCBS Certification*
 2. *A Provider Participation Agreement*
 3. A copy of the Fingerprint Clearance Card (FCC) issued by the Arizona Department of Public Safety (DPS) for the CEO/President/Owner of the agency
 4. A copy of the *Criminal History Self Disclosure Affidavit* for the CEO/President/Owner.
 5. Three reference letters for the agency or the CEO/President/Owner.
 6. If the CEO/President/Owner intends to provide direct care to members, proof of successful completion of training for CPR, First Aid, and Article 9.
 7. *Declaration of Household Member 18 Year or Older* if services will be A provided in the home of the CEO/President/Owner.
 8. Agencies only - A copy of the agency's brochure, a link to its website, or other description of the program.
 9. Agencies only - A *Staff Roster* for all direct care employees or contractors, including the CEO/President/ Owner on the matrix if he or she provides direct care.

- B. Agencies or persons with a Qualified Vendor Agreement (excluding agencies or providers who provide therapy services) must include the following completed forms in the application packet:
1. Arizona Health Care Cost Containment System (AHCCCS) Provider Registration
 2. ADES/ DDD Disclosure of Ownership Control/ Criminal Offenses Statements
 3. State of Arizona Substitute W-9 and Vendor Authorization

A complete application packet may be sent to OLCR by U.S. Postal Service, fax, or email to:

Mail: Arizona Department of Economic Security
OLCR-HCBS Certification
P.O. Box 6123 – 077F
Phoenix, AZ 85005-6213

Fax: (602) 257-7045

E-mail: HCBScertification@azdes.gov

For Qualified Vendors providing HCBS services, the Division also schedules an onsite physical inspection prior to issuance of an HCBS certificate. After certification, a physical inspection and file audit are completed a minimum of every two years to retain certification.

AHCCCS Registration

- A. AHCCCS registration is mandatory for consideration for payment to providers by the Division. It is also required for submission of encounter data to the AHCCCS Administration by the Division.
- B. Individual Independent Providers and agencies providing therapy services must contact AHCCCS directly for registration.
- C. All other HCBS providers will be registered by OLCR upon completion of the certification process.

AHCCCS mandates that all providers:

- A. Comply with all federal, state, and local laws, rules, regulations, executive orders and Division policies governing performance of duties under the Qualified Vendor or other contractual agreements.
- B. Sign and return attestations found on the Provider Registration section of the AHCCCS website that are applicable to their individual practices or facilities.
- C. Meet AHCCCS requirements for professional licensure, certification, or registration.
- D. Complete all applicable registration forms.

Qualified Vendor Application and Directory System (QVADS)

Provider Instructions – Agency with Choice Option





<p style="text-align: center;">Department of Economic Security Division of Developmental Disabilities</p>
<p>Project: Qualified Vendor Application and Directory System Subject: Agency with Choice</p>

Division of Developmental Disabilities
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1 How to Login to QVADS

1. Login to QVADS by going to url <https://www.azdes.gov/main.aspx?menu=96&id=2476> and click the Qualified Vendor Application Directory System link.

The screenshot shows the website's navigation menu on the left with options like 'Assistant Director's Message', 'Contact Us', and 'Apply for DD Services'. The main content area is titled 'Provider Login' and contains a 'SELECT AN APPLICATION' section. Under this section, there are two options: 'FOCUS - A comprehensive management system to streamline eligibility and authorization of services' and 'QVADS - Qualified Vendor Application Directory System to register and manage service providers as eligible contractors'. At the bottom, there is a contact number: 'Need help? Give us a call at (602) 542-0419 or toll free at (866) 229-5553.'

2. A new window will open; click the '**Login to Vendor Directory**' option.

The screenshot shows the 'Qualified Vendor Application & Directory System Signup/Login' page. It features three main options with green arrows: 'Begin Application' (for those interested in becoming a Qualified Vendor), 'Login to Vendor Directory' (for those who have started the application process or are already Qualified Vendors), and 'QVADS Home Page' (to return to the home page). The date 'Thursday, August 15, 2013' is visible in the top right corner.

3. A login prompt will open; enter Email login, Password, and click [Login]

The screenshot shows the 'Vendor Login Page' with a 'Login' section. It includes the text 'To login, please enter your email address and password below.' There are two input fields: 'Email:*' and 'Password:*'. Below the password field is a checkbox labeled 'Notification System Only'. A 'Login' button is located at the bottom of the form.

2 Updating the Agency with Choice Selection

1. Click Amend my Contract



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Project: Qualified Vendor Application and Directory System

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The screenshot shows the main menu of the Division of Developmental Disabilities website. The header includes the PBS logo, the text "Division of Developmental Disabilities", and the date "Thursday, August 22, 2013". A "Logout" link is visible in the top right. The main menu contains the following items:

- Amend my Contract** (highlighted in green): Status: **MANAGEMENT APPROVED**
- Review my Previous Contract**: Status: Expired 12/31/2010
- Vendor Directory**: View and change general information such as your information and how you want to be notified.
- Professional Billing System (PBS)**: Run reports and download files for the PBS application.
- HCBS Provider Search**: Opt-in and maintain provider information for provider search application for members.

At the bottom, there is a footer with links for "Contact", "Site Map", and "Help", and a note: "Best viewed with IE 7 & Above". Copyright information for 2003-2013 is also present.

2. Click My Services

The screenshot shows the "Amendment System" page, specifically the "My Services" section. The header includes the PBS logo, the text "Division of Developmental Disabilities", and the date "Tuesday, August 05, 2014". A "Logout" link is visible in the top right. The page contains the following items:

- Contact Information**: My company's phone numbers, mailing address, billing address etc.
- Policy Information**: General information about Recruitment & Training and the Quality Management plan.
- Assurances & Submittals Form 2014**: Mandatory survey that must be filled out to be considered for Qualified Vendor status.
- My Services** (highlighted in green): View or edit Services my company offers.
- My Administrative & Service Sites**: View or edit Administrative and Service Sites.

Two buttons are visible: "Submit for Review" and "Print Proposed Changes". At the bottom, there is a footer with links for "Contact", "Site Map", and "Help", and a note: "Best viewed with IE 7, 8 & 9". Copyright information for 2003-2014 is also present.



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3. From the My Services tab select AGW w Choice checkbox and click the [Save] button.

Division of Developmental Disabilities
Tuesday, August 19, 2014
[Logout]

Amendment System - QV Application: Vendor Services
Main Menu Amendment System My Services

My Services

Add New Services Save Changes

[Delete]	ATTENDANT CARE	<input checked="" type="checkbox"/> *AGN w Choice
[Delete]	HABILITATION SERVICES - GROUP HOME - WITH ROOM & BOARD	
[Delete]	HABILITATION SERVICES - INDIVIDUALLY DESIGNED LIVING ARRANGEMENT	<input checked="" type="checkbox"/> *AGN w Choice
[Delete]	HABILITATION SERVICES - SUPPORT - HOURLY	<input checked="" type="checkbox"/> *AGN w Choice
[Delete]	HABILITATION SERVICES - SUPPORTED DEVELOPMENTAL HOME (ADULT & FOSTER CARE CHILD) - WITH ROOM & BOARD	
[Delete]	HOUSEKEEPING - CHORE/HOMEMAKER	<input checked="" type="checkbox"/> *AGN w Choice
[Delete]	RESPIRE CARE HOURLY & DAILY	
[Delete]	ROOM & BOARD, ALL GROUP HOMES	
[Delete]	ROOM & BOARD, DEVELOPMENTAL HOME	
[Delete]	TRANSPORTATION	

Contact | Site Map | Help | Best viewed with IE 7, 8 & 9
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NOTE: The **Agency with Choice** option is **only available** for the following services: **Attendant Care, Habilitation - Hourly Support, Habilitation - Individually Designed Living Arrangement** and **Homemaker (formally Housekeeping)**.

No amendment submission is required to select the Agency with Choice option it will show immediately.

Vendors can enroll at any time even if they have an amendment submitted for review.

The Agency with Choice option can only be deselected once all open 'Agency with Choice' member authorizations are not open and/or active.

DDD Agency With Choice User Guide – FOCUS Vendor

Version 1.0
July 28, 2014



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1. Introduction

Agency with Choice is a member-directed option that is available to home-based ALTCS members. Under the Agency with Choice option, the provider agency and the member enter into a co-employment relationship and share employer-based responsibilities for the paid caregiver. The provider agency maintains the authority to hire and fire the caregiver and provide or arrange for the required minimum standardized training for the caregiver.

Member directed models or options allow members to have more control over how certain services are provided, including services like attendant care, personal care and housekeeping – HSK, HAI, ATC and HAH. The models are not a service, but rather define the way in which services are delivered. Member-directed options are available to most Arizona Long Term Care System (ALTCS) members who live in their own home. The options are not available to members who live in an alternative residential setting or nursing facility. ALTCS members or their representatives are encouraged to contact their case manager to learn more about and consider member-directed options.

2. Changes in FOCUS Vendor Application

The following changes will be seen in FOCUS Vendor application by Vendors that opted for Agency With Choice.

2.1 Acknowledge within 3 business days

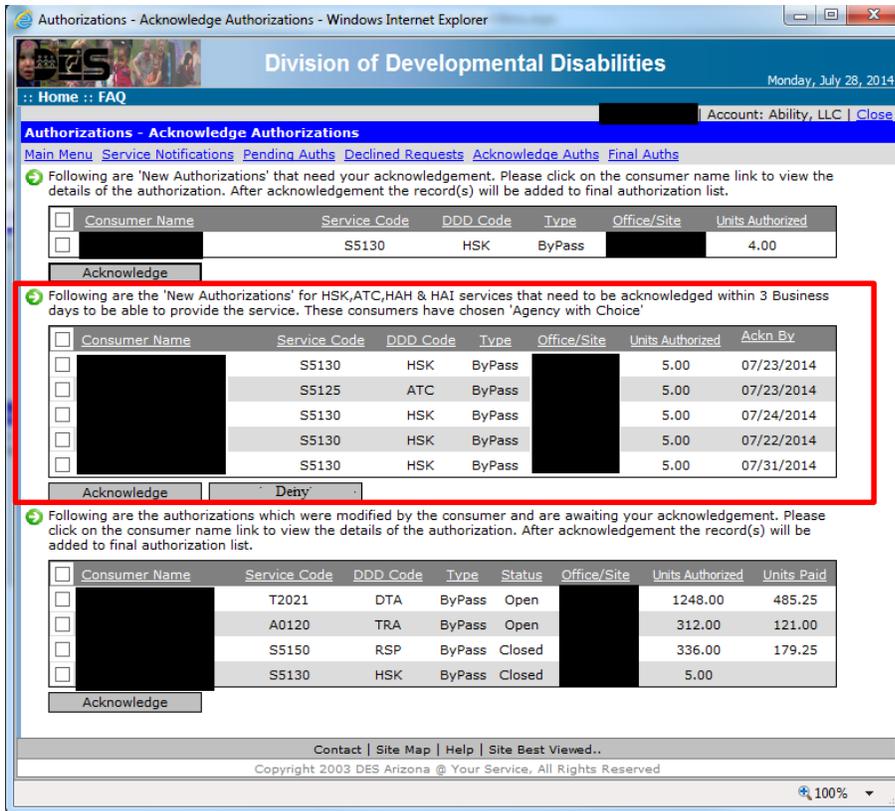
User needs to log in to the FOCUS Vendor application > Service Authorizations > Acknowledge Authorizations

User will see a new grid displaying the list of members with 'AWC' authorizations awaiting for acknowledgement within 3 business days. User as a choice to select the members and 'acknowledge/deny' within 3 busniess days. Unacknowledged AWC authorizations in this grid past the 3 business day rule will be automatically terminated.

Example:



Count for Authorizations awaiting acknowledgement/deny within 3 business days is displayed on the Service authorizations main screen require AWC Count



User will be able select members and Acknowledge/Deny the authorization.

2.2 Use U-7 modifier

User needs to log in to the FOCUS Vendor application > Service Authorizations > Acknowledge Authorizations > Select a member with authorization created with AWC

Upon Acknowledgement, user will be prompted to use U-7 modifier for submitting claims for services provided under Agency with choice option.

Example:

Authorizations - Acknowledge Authorizations - Windows Internet Explorer

Division of Developmental Disabilities
Monday, July 28, 2014

Home :: FAQ

Account: Ability, LLC | Close

Authorizations - Acknowledge Authorizations

Main Menu | Service Notifications | Pending Auths | Declined Requests | Acknowledge Auths | Final Auths

Following are 'New Authorizations' that need your acknowledgement. Please click on the consumer name link to view the details of the authorization. After acknowledgement the record(s) will be added to final authorization list.

<input type="checkbox"/>	Consumer Name	Service Code	DDD Code	Type	Office/Site	Units Authorized
<input type="checkbox"/>	[REDACTED]	S5130	HSK	ByPass	[REDACTED]	4.00

Acknowledge

Following are the 'New Authorizations' for HSK,ATC,HAH & HAI services that need to be acknowledged within 3 Business days to be able to provide the service. The consumer has been contacted with Choice.

<input type="checkbox"/>	Consumer Name	Service Code	DDD Code	Type	Status	Office/Site	Units Authorized	Units Paid	Authorized	Ackn By
<input type="checkbox"/>	[REDACTED]	T2021	DTA	ByPass	Open	[REDACTED]	1248.00	485.25	00	07/23/2014
<input type="checkbox"/>	[REDACTED]	A0120	TRA	ByPass	Open	[REDACTED]	312.00	121.00	00	07/23/2014
<input type="checkbox"/>	[REDACTED]	S5150	RSP	ByPass	Closed	[REDACTED]	336.00	179.25	00	07/24/2014
<input type="checkbox"/>	[REDACTED]	S5130	HSK	ByPass	Closed	[REDACTED]	5.00		00	07/22/2014
<input type="checkbox"/>	[REDACTED]					[REDACTED]			00	07/31/2014

Acknowledge Deny

Following are the authorizations which were modified by the consumer and are awaiting your acknowledgement. Please click on the consumer name link to view the details of the authorization. After acknowledgement the record(s) will be added to final authorization list.

<input type="checkbox"/>	Consumer Name	Service Code	DDD Code	Type	Status	Office/Site	Units Authorized	Units Paid
<input type="checkbox"/>	[REDACTED]	T2021	DTA	ByPass	Open	[REDACTED]	1248.00	485.25
<input type="checkbox"/>	[REDACTED]	A0120	TRA	ByPass	Open	[REDACTED]	312.00	121.00
<input type="checkbox"/>	[REDACTED]	S5150	RSP	ByPass	Closed	[REDACTED]	336.00	179.25
<input type="checkbox"/>	[REDACTED]	S5130	HSK	ByPass	Closed	[REDACTED]	5.00	

Acknowledge

Message from webpage: Please use U7 Modifier for the claim when submitting the bill

Contact | Site Map | Help | Site Best Viewed..

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100%