Table of Contents

PREFACE – INTENDED USERS OF THE PROVIDER POLICY MANUAL

REVISION DATE: 2/28/2024, 12/6/2023, 10/1/2021, 7/14/2017,
5/31/2017 EFFECTIVE DATE: May 26, 2017

The Division provides all Home and Community Based Services (HCBS) for members except Physical Therapy for members aged 21 and over and members receiving therapy services through a Multi-Speciality Interdisciplinary Clinic (MSIC). The Division contracts with Health Plans to provide all Behavioral Health services, Physical Health services, Physical therapy to members aged 21 and over, and services provided through an MSIC.

As specified in the table below, the Provider Policy Manual applies to these intended users:

- Tribal Health Program/Fee-For-Service (THP/FFS) providers
- Qualified Vendors/Qualified Vendor Applicants (QV/QVA)
- Acute Health Plans/Administrative Services Subcontractors (Acute/AdSS)
- State-contracted Developmental Homes, through 06/30/2024
- Individual independent providers.

Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
1 Introduction to the Division of Developmental Disabilities	x	x	x	x	x
2 Provider Responsibilities and Expectations		x		x	x
3 Provider Customer Service and Network Support	x	x	x	x	x
4 Covered and Non-Covered Services	x	x	x	x	x
5 Emergency Room Utilization	x	x	x	x	x
6 Early and Periodic Screening, Diagnostic and Treatment	x		x		
7 Dental/Oral Health Care	x	x	x	x	x
8 Maternity and Family Planning	x		x		
9 PCP Assignments	x		x		
10 Referrals to Specialists	x		x		

Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
11 ALTCS Inquiries, Grievances, Claim Disputes, and Appeals	x				x
12 Billing and Claim Submission	x	x	x	x	x
13 Utilization Management	x	x	x	x	x
16 Remittance Advice, Eligibility, and Cost Sharing	x	x	x	x	x
17 Prior Authorization Requirements	x	x	x	x	x
18 Claims Medical Review	x	x	x	x	x
19 Concurrent Review	x		x		
20 Fraud, Waste and Abuse	x	x	x	x	x
21 False Claims Act	x	x	x	x	x
22 Pharmacy Services	x		x		
23 Appointment Standards	x	x	x	x	x
24 Americans with Disabilities Act	x	x	x	x	x
25 Enrollment Verification			x		
26 Cultural Competency and Member and Family Centered Care	x	x	x	x	x
27 Peer Review and Inter-Rater Reliability	x		x		
28 Member Rights	x	x	x	x	x
29 Advising or Advocating on Behalf of a Member	x	x	x	x	x

Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
30 Clinical Practice Guidelines	x	x	x	x	x
31 Change of Contractor			x		
34 Provider Publications		x			
35 Progress Reporting Requirements		x		x	x
36 Fire Safety		x			
37 Therapy Services (Occupational, Physical, and Speech-Language)		x			
38 Emergency Communication When Transporting a Member		x		x	x
40 Insurance Requirements for Qualified Vendors		x			
41 Termination of a Qualified Vendor Agreement Upon Request of the Qualified Vendor		x			
42 Electronic Monitoring in Program Sites		x			
43 Respite Provided at Camp to ALTCS Members		x			
46 Agency With Choice		x			
47 Managing Vendor Call Lists, Vendor Directories, Scope of Services and Reporting Requirements	x	x		x	x

Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
48 Credentialing of Contracted Providers		x			x
49 Responsible Driving		x		x	x
50 Vendor Call Requirements for Qualified Vendors		x			
51 Oversight and Monitoring of Developmental Home Services		x		x	
52 Habilitation Staffing Schedule Requirements and Annual Review		x			x
53 Supporting Children in Care of the Department of Child Safety in Community Residential Settings		x		x	
54 Group Home Requirements		x			
57 Third Party Liability Waiver Requests		x			
58 Medication Management Services	x		x		
59 Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services	x		x		
60 Notification to Qualified Vendors		x		x	x
61 Home and Community Based Services (HCBS) Certification and Provider Enrollment	x	x	x	x	x

Chapter # / Title	THP/ FFS	QV/ QVA	Acute/ AdSS	State-Contracted Developmental Home	Individual Independent Provider
62 Electronic Visit Verification		x			x
63 Workforce Development		x			
64 Preventing Member Abuse, Neglect, and Exploitation		x			
65 Providing Out of State Services		x		x	x
66 Behavioral Health	x	x	x		
67 General and Informed Consent	x	x	x	x	x
68 Advance Directives	x	x	x	x	x
69 Care Coordination	x	x	x	x	x
70 Qualified Vendor Incident Reporting		x		x	x
Appx A QV Provider Instructions - Agency with Choice Option DDD		x			
Appx B Agency with Choice User Guide - FOCUS Vendor Medicaid		x			
Appx C Encounter Data Validation		x	x	x	x

CHAPTER 1 INTRODUCTION TO THE DIVISION OF DEVELOPMENTAL DISABILITIES

REVISION DATES: 4/10/2024, 1/19/2022, 10/1/2021, 12/13/2017, 5/26/17, 4/16/14

REVIEW DATE: 7/13/2023

EFFECTIVE DATE: March 29, 2013

REFERENCES: A.R.S. § 36-554(A)(10)

PURPOSE

This policy provides Service Providers with an introduction to the Division of Developmental Disabilities.

DEFINITIONS

1. "Case Management" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
2. "Developmental Disability" means as defined in A.R.S. § 36-551.
3. "Home and Community-based Services" or "HCBS" means as defined in A.R.S. § 36-2931.

4. "Individual Independent Provider" means an individual who has a service agreement with the Division to provide Attendant Care (ATC), Homemaker (HSK), Respite (RSP), or Habilitation (HAH/HAI) and who is a DCW.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

6. "Qualified Vendors" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.

7. "Service Provider" means the same as defined in A.R.S. § 36-551.

8. "Support Coordination" means a collaborative process, which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet the Member's needs through communication and available supports to promote quality, cost-effective outcomes.

9. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

POLICY

A. PROGRAM DESCRIPTION

1. The Arizona Department of Economic Security's Division of Developmental Disabilities (Division) provides supports and services for eligible Arizonans diagnosed with one of the following Developmental Disabilities:
   a. Autism;
   b. Cerebral palsy;
   c. Epilepsy;
   d. Cognitive / Intellectual Disability;
   e. Down syndrome; or
   f. Are under the age of six and at risk of having a Developmental Disability.
2. The Division serves individuals who have a qualifying

Developmental Disability and have three documented functional limitations as outlined in Division Eligibility Policy 200-G.

3. The Division's mission is to empower individuals with Developmental Disabilities to lead self-directed, healthy, and meaningful lives.

4. The Division believes that individuals can best be supported in integrated community settings.

5. The majority of the Division's programs and services are tailored to meet the individual needs of individuals with Developmental Disabilities and their families at home and in community-based settings.

6. The Division coordinates services and resources through its central administrative offices, and Case Management through seven districts with local offices located in communities throughout Arizona. The seven districts include:

    a. Central

    b. Early Intervention

c. East

d. North

e. South

f. Specialty

g. West

7. The Division's administrative structure and organizational chart are located on the DDD Homepage on the DES website at:

https://des.az.gov/ddd

B. SUPPORT COORDINATION

1. The primary service that the Division provides directly is Case Management, also called Support Coordination.

2. The Division assigns a Support Coordinator to support each Member based on their eligibility type as outlined in Division Eligibility Manual Chapter 900.

C. HOME AND COMMUNITY BASED SERVICES (HCBS)

1. Home and Community Based Services (HCBS) are delivered through a network of agencies (Qualified Vendors) and Individual Independent Providers throughout Arizona.

    a. HCBS are designed 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.

2. The Division uses the Qualified Vendor Agreement to contract for HCBS services to meet Member needs across the state.

3. The Division certifies HCBS Service Providers and licenses family homes to provide Member care. They also inspect and approve locations where HCBS occur.

D. PHYSICAL AND BEHAVIORAL HEALTH SERVICES

1. The Division also contracts with Health Plans known as Administrative Services Subcontractors (AdSS) that provide statewide physical and behavioral health care to Division Members who are ALTCS eligible and also collaborates with AHCCCS for members who are part of the Tribal Health Program

(THP).

2. The AdSS are responsible for assigning or allowing each person who is enrolled the choice of a primary care provider (PCP).

3. Currently, the contracted AdSS are UnitedHealthcare Community Plan and Mercy Care.

4. The Division is responsible for ensuring that the delivery of physical and behavioral health services meets the needs of Members being served by coordinating care with and providing oversight of the AdSS.

5. Behavioral health services are provided by the Division's contracted AdSS. Crisis services are provided to the Division's ALTCS Members by the Regional Behavioral Health Authority agencies (RBHAs), through a contract with AHCCCS, which receives funding from the legislature.

6. The Division offers a Tribal Health Program (THP) which may be selected as the primary plan by American Indian/Alaska Native (AI/AN) Members. Members who choose THP may receive services through any AHCCCS registered provider. Division AI/AN

Members may also access services from IHS/638 facilities at any time regardless of plan/program enrollment.

E. STATE OPERATED SERVICES

The Division operates a small state operated services program including Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and state operated group home services.

F. QUALITY MANAGEMENT

The Division operates a Quality Management program to ensure health safety and oversight of Members and services.

G. NETWORK OPERATIONS, MANAGEMENT, AND LICENSING

1. The Division's Network Operations Units provide technical assistance to Support Coordinators, Qualified Vendors, and Individual Independent Providers for HCBS.
2. The Network Management Units are responsible for workforce development, development of new HCBS providers, oversight of the contracted HCBS provider network, and the provider network of the contracted Division Health Plans.

3. The Office of Licensing Certification and Regulation (OLCR) completes Life Safety inspections of HCBS service sites, licenses developmental home providers, and certifies Qualified Vendor Agencies and Individual Independent Providers.

2 PROVIDER RESPONSIBILITIES AND EXPECTATIONS

REVISION DATE: 12/27/2023, 04/21/2023, 10/26/2022, 06/29/2022, 10/01/2019, 8/12/2016, 4/16/2014
REVIEW DATE:
EFFECTIVE DATE: March 29, 2013
REFERENCES: RFQVA DDD-2024; 34 C.F.R. § 361.5(c)(9); 34 C.F.R. 361; 42 C.F.R. § 438.100; 45 C.F.R. § 160 and 164; A.A.C R6-6-1001; A.A.C R6-6-1101; Division Medical Policy 1301 and 1302

PURPOSE

This policy outlines the responsibilities and expectations for Division of Developmental Disabilities (Division) service providers. It applies to all Qualified Vendors of Division services.

DEFINITIONS

1. "Business Associate" means a person or entity that provides any of a specifically listed type of service to or for a covered entity; or performs a health plan provider, clearinghouse function, or activity on behalf of a covered entity involving the use or disclosure of Protected Health Information.
2. "Business Day" means the hours between 8:00 a.m. and 5:00 p.m. Monday through Friday, excluding observed state holidays as defined in A.A.C. R2-5A-101.

3. "Center Based Employment" means a structured employment environment to support Members who choose to receive employment services that offer intensive supervision and support for paid work in a work center or in the community. This service provides a healthy, safe, and highly structured work environment to support Members to develop employment skills and refine their career focus. All Members using this service are paid by the Qualified Vendor or employer for work performed in accordance with state and federal law.
4. "Community Residential Setting" means the same as defined in A.R.S. § 36-551.
5. "Competitive Integrated Employment" means work that is performed on a full-time or part-time basis for which an individual is compensated at or above minimum wage and comparable to the customary rate paid by the employer to employees without disabilities performing similar duties and with similar training and experience; receiving the same level of benefits provided to other employees without disabilities in

similar positions; at a location where the employee interacts with other individuals without disabilities; and presented opportunities for advancement similar to other employees without disabilities in similar positions.

6. "Cultural Competency" means the ability to acknowledge and understand the influence cultural history, life experiences, language differences; values and disability have on individuals and families.
7. "Day Services " means a service that engages Members in their communities to develop, or enhance skill development, for activities of daily living and employment while meeting their specialized sensorimotor, cognitive, communication, social interaction, and behavioral needs and foster the acquisition of skills explore their communities, to learn about their interests, to engage with others, and to gain skills needed for greater independence.
8. "Direct Care Worker" or "DCW" means a Direct Support Professional who has passed the required DCW competency

tests and who assists Members with a disability with activities necessary to allow them to reside in their home.

9. "Direct Support Professional" or "DSP" means a person who delivers direct support in Home and Community-Based services with current training according to the training and certification or licensing requirements of the Home and Community-Based Services they provide.
10. "Disability 101" or "DB 101" means an online tool that provides information on benefits, health coverage, and employment to assist Social Security beneficiaries with making informed decisions about going to work.
11. "Group Supported Employment" means a service that provides employment and training activities to support a successful transition to Competitive Integrated Employment or to self-employment to Members employed in integrated businesses and industries in the community using mobile crews, small enclaves, and other small groups.
12. "Health Insurance Portability And Accountability Act" or

"HIPAA" means the Kennedy-Kassebaum Act, signed August 21, 1996, as amended, and as reflected in the implementing regulations as specified in 45 § § C.F.R. Parts 160, 162, and 164.

13. "HIPAA Privacy Rule" means a federal regulation that establishes national standards to protect individuals' medical records and other individual health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.
14. "HIPAA Security Rule" means a federal regulation that establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.
15. "Home and Community-Based Services Final Rule" or "HCBS Settings Rule" means the final rule issued by the Center for Medicare and Medicaid Services that ensures people receiving

HCBS have full access to the benefits of community living and are able to receive services in the most integrated setting. Community Developmental Disability Services are subject to this rule.

16. "Individual Supported Employment" means a service that supports Members to gain or maintain Competitive Integrated Employment or sustainable self-employment by providing job search and job coaching services including assistance in matching the individual with Competitive Integrated Employment, or support for finding meaningful self-employment.
17. "Integrated Community Work Setting" means a worksite that is located in a naturally occurring community of residential, business, social, or educational environments.
18. "Member" means the same as "client" as defined in A.R.S. § 36-551.
19. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family

members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

20. "Qualified Vendor" or "contractor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
21. "Qualified Vendor Agreement" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the relationship between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.
22. "Residential Services" means, for the purpose of this policy, the same as Community Residential Setting defined in A.R.S. § 36-551, except this policy does not apply to state-operated services.

23. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult or a developmentally disabled adult who is a Member for whom no guardian has been appointed.
24. "Work Incentive Consultation" means a meeting with a work incentive consultant trained in Social Security, Medicare, AHCCCS, and other government programs, who can help a Member understand Social Security work incentives, disability benefit programs, and how they are impacted by work.

POLICY

A. Qualified Vendors and service providers shall:

1. Use the AHCCCS Provider Enrollment Portal, located on the AHCCCS website to:
    a. Apply to become an AHCCCS registered provider;
    b. Maintain continuous enrollment as an AHCCCS registered provider; and
    c. Access instructions on how to use the portal.

2. Comply with all federal, state, and local laws, rules, regulations, executive orders, and Division policies governing performance of duties under the Qualified Vendor Agreement or other contractual agreements.
3. Meet requirements for professional licensure, certification, or registration.
4. As applicable, have a National Provider Identifier.
5. As applicable, maintain documentation indicating compliance with local fire and sanitation codes and regulations.
6. Submit claims for services only if they comply with the DDD Claims Submission Guide.
7. Ensure that each DSP or DCW meets required training requirements within their scope of practice, including Article 9 as outlined in A.A.C. 6-6-901 et seq. and as required in Division Policy.
8. Ensure that each DSP or DCW completes the following:
    a. Background checks as required in the Qualified Vendor Agreement; and

b. A Criminal History Self Disclosure Affidavit (LCR-1034A FORNA) form annually.

9. Ensure each Member's privacy is protected, in accordance with HIPAA and only disclose protected health information (PHI):
   a. To the Member or Responsible Person, unless required for access or accounting of disclosures;
   b. For treatment, payment, and health care operations;
   c. With opportunity to agree or object (Informal permission by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency situation, or not available, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.)
   d. Incidentally to an otherwise permitted use and disclosure;
   e. For public interest and benefit activities; or
   f. With limited data set for the purposes of research, public health, or health care operations.

10. Follow 45 § C.F.R. 160.203 General Rule and exceptions:
    a. To prevent fraud and abuse related to the provision of or payment for health care;
    b. To ensure appropriate state regulation of insurance and health plans to the extent expressly authorized by statute or regulation;
    c. For state reporting on health care delivery or costs;
    d. For purposes of serving a compelling need related to public health, safety, or welfare, and, if a standard, requirement, or implementation specification under Part 164 of this subchapter is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served;
    e. Ensure the confidentiality, integrity, and availability of all electronic PHI the covered entity or Business Associate creates, receives, maintains, or transmits;
    f. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;

g. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E of this Part; and

h. Ensure compliance with this subpart by its workforce.

i. Adhere to the Member rights as outlined in 42 § C.F.R. 438.100, and in the Division's Operation Policy Manual Chapter 1001-A.

j. Follow the code of conduct outlined in the Qualified Vendor Agreement.

B. Each of the Division's Business Associates shall:

1. Develop and maintain policies and procedures for HIPAA practices;

2. Not use or further disclose PHI other than as permitted or required by the contract or as required by law;

3. Use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by the contract;

4. Report to the Division any use or disclosure not allowed by federal regulation of which the Business Associate becomes

aware;

5. Ensure that any agents or subcontractors with whom PHI must be shared agree to the same restrictions and conditions that apply to the Business Associate;
6. Make PHI available to the Member or Responsible Person;
7. Make PHI available for Responsible Person or Member amendment and incorporate any amendments;
8. Make available the information required to provide an accounting of disclosures; and
9. Make internal practices, books, and records relating to the use and disclosure of PHI available to the Division and Department of Health and Human Services- Office of Civil Rights for the purpose of determining compliance with federal requirements.

C. Qualified Vendors shall meet the following HCBS Setting Final Rule requirements:

1. Provide services in a person centered and culturally competent manner that supports and enhances the Member’s

independence, self-esteem, mutual respect, value, and dignity as outlined in the Division's Provider Policy Manual Chapter 26.

2. Ensure the Member always has access to resources about rights in the event they feel their rights are being violated.
3. Utilize the self-assessment and training tools available on the AHCCCS webpage to ensure compliance to the requirements for the following service settings including:
    a. Day Services
        i. The Qualified Vendor shall ensure that Members have the opportunity to engage with others including individuals with and without disabilities who are not paid staff;
        ii. The Qualified Vendor shall provide services in a service site located in a community setting that includes planned opportunities for interaction with community members, information about resources and the ability to participate in community events based on individual preferences;

iii. The Qualified Vendor shall provide exploration and learning opportunities related to work and volunteer experiences; and

iv. The Qualified Vendor shall support Members in developing relationships of their choice.

b. Integrated Community Work Settings

i. The Qualified Vendor shall ensure Members work alongside workers without disabilities, other than paid staff who are providing services to that individual;

ii. The Qualified Vendor shall ensure Members perform the same tasks with the same expectations that a non-disabled peer would perform for pay; and

iii. The Qualified Vendor shall ensure Members freely participate in the social aspects common to the workplace, including but not limited to, having access to all common areas of the enterprise, eating lunch, and taking breaks together.

c. With respect to facility-based services and these other standards for Integrated Work Settings, the Qualified Vendor shall ensure Members have the choice and opportunity to:

i. Develop products and services which are prepared in the facility but sold or provided out in the general community;

ii. Have alternate schedules for services and activities;

iii. Schedule activities at their own convenience;

iv. Have access to entrances and exits to the setting and any and all areas within the setting;

v. Engage in work and non-work activities that are specific to their skills, abilities, desires, needs, and preferences including engaging in activities with people of their own choosing and in areas of their own choosing (indoor and outdoor spaces); and

vi. Have access to food during breaks and lunch.

d. Center-Based Employment

i. Qualified Vendors shall ensure that Members have the opportunity to engage with others including individuals with and without disabilities who are not paid staff;

ii. Qualified Vendors shall provide services in a service site located in a community setting that includes planned opportunities for interaction with community members, information about resources, and ability to participate in community events based on individual preferences;

iii. Qualified Vendors shall ensure that the setting supports Members' access to daily activities, the physical work or program environment, and that Members choose with whom they wish to interact;

iv. Qualified Vendors shall provide support for transportation training or mobility training as

outlined in the Member's person centered service plan (PCSP);

v. Qualified Vendors shall provide Members with the opportunity to explore, observe, or participate in a variety of work opportunities, including integrated work environments to evaluate appropriateness for progressive employment moves including Competitive Integrated Employment or self employment;

vi. Qualified Vendors shall ensure that the Member has the opportunity to participate in productive and meaningful work and that the job is aligned with the Member's capacities and interests;

vii. Qualified Vendors shall provide orientation, training, and skill development to Members, along with teaching general work skills;

viii. Qualified Vendors shall incorporate Arizona Disability Benefits 101 (DB 101) and Work Incentive Consultation into the Member's plan to reach

employment outcomes;

ix. Qualified Vendors shall maintain ongoing assessments of strengths, areas for improvement, and overall job performance;

x. Qualified Vendors shall, at least annually, consult with the Member's planning team to assess with their support coordinator whether:

1) The service is still applicable for the Member, is meeting the Member's needs, and is advancing the Member's employment outcomes or vision for employment;

2) The Member's employment needs could be better supported, additionally coordinated, through other programs, such as school or with a referral to vocational rehabilitation for employment services;

3) The Member's needs could be met through natural supports, independent volunteer

experiences, technology, or adaptive equipment; or

4) The Member could participate in other employment services to further advance their vision for employment.

e. Group Supported Employment

i. Qualified Vendors shall provide vocational or job related discovery or assessment by providing ongoing monitoring of the performance and general job-related skills of Members to identify both strengths and barriers to maintain and advance employment;

ii. Qualified Vendors shall incorporate DB 101 and Work Incentive Consultation into the Member's PCSP to reach employment outcomes;

iii. Qualified Vendors shall refer Members at their request for a progressive move into Competitive Integrated Employment; and

iv. Qualified Vendors shall provide transportation within the Member's scheduled workday from worksite to worksite and provide support for transportation training or mobility training as outlined in the Member's PCSP.

f. Qualified Vendors offering Community Residential Settings shall:

i. Refer Members who want to work or gain work-related skills to the Planning Team to consider adding an employment service;

ii. Ensure that Member responsibilities and expectations are explained to Members prior to service delivery; and

iii. Ensure Members are provided information about rights in their home as outlined in Division Operations Policy Manual 1001-A.

4. Actively participate in the Member's Planning Team by:

a. Attending Planning Team meetings at the date, time, location, and method when requested by the Responsible

Person;

b. Submitting assessments, including recommendations, to the support coordinator at least five Business Days prior to the scheduled Planning Team meeting;

c. Notifying the Member's support coordinator to request a Planning Team meeting whenever there is a significant change in the Member's status;

d. Writing plans of care or teaching strategies necessary to implement assigned outcomes and submit them as required by the Division;

e. Completing other assignments and action items as determined by the Planning Team;

f. Meeting with the Member and, if applicable, the primary caregiver prior to initiating service and obtaining necessary information about needs and preferences, including cultural and language needs;

g. Ensuring that a pre-service orientation occurs with each DSP or DCW before supporting the Member;

h. Providing services as authorized by the Division;

i. Prohibiting an individual DSP or DCW from providing care for more than 16 hours in a 24 hour period; and

j. Maintaining a Member record that minimally contains:

   i. Contact information for the legally Responsible Person;

   ii. The Member's name;

   iii. The Member's date of birth;

   iv. The Member's AHCCCS identification number;

   v. The Member's emergency contacts;

   vi. Intake information and special needs or preferences of the Member;

   vii. Planning documents, progress reports, behavior support plans;

   viii. Summaries of service documentation progress toward goals;

   ix. Medical information;

x. General consent for routine and emergency medical treatment; and

xi. For Community Residential Settings, requirements outlined in the Division's Provider Policy Manual Chapter 33.

k. Reporting incidents, accidents, and deaths in accordance with the Division's Provider Policy Manual Chapter 70.

3 PROVIDER CUSTOMER SERVICE AND NETWORK SUPPORT

REVISION DATE: 12/21/2022, 07/01/2020, 5/16/2018, 2/14/2018, 5/5/2017, 5/27/2016, 1/29/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013

PURPOSE

The purpose of this document is to provide information on the customer service assistance and network support offered by the Division of Developmental Disabilities (DDD) to Qualified Vendors, Independent Providers, and parties interested in providing services to Division Members.

A. CUSTOMER SERVICE CENTER

1. Qualified Vendors and Independent Providers may contact the DDD Customer Service Center by phone at 1-844-770-9500 or by email at DDDCustomerServiceCenter@azdes.gov or DDDCustomerServiceCenter-Providers@azdes.gov for support with the following matters, including but not limited to:
    a. Billing and claims submission to the Division
        i. WellSky support.
        ii. Submitting clean claims.

iii. Entering and resolving claims issues in the Division's Resolution System.

iv. Accessing Division reporting tools.

b. Submitting inquiries or grievances to the Division for resolution.

c. Contracts questions.

d. Health care services questions.

B. PROVIDER NETWORK SUPPORT

1. Qualified Vendors may contact Provider Network Support by email at DDDProviderNetworkSupport@azdes.gov to request support with the following:

   a. Technical assistance with service delivery or provision.

   b. Support with initial development of Qualified Vendor policies related to service delivery.

   c. Review and approval of Qualified Vendor policies.

   d. Readiness review meetings.

   e. Qualified Vendor statewide directory management.

   f. Statewide provider meeting schedules.

2. Independent Providers may contact Provider Network Support by email at ProviderNetworkSupportIP@azdes.gov to request support with the following:
    a. Technical assistance with service delivery or provision.
    b. Reviews for Independent Provider readiness.
    c. Rate assessments.
    d. Technical assistance with fiscal intermediary agency, Public Partnership Limited.

C. NETWORK DEVELOPMENT AND RECRUITMENT UNIT

Qualified Vendors may contact the Network Development and Recruitment Unit at NetworkProviderRecruitment@azdes.gov for assistance with the following:

1. Expansion of services to other geographical areas.
2. Amendments to Qualified Vendor Agreements, to include additional services based on need.

CHAPTER 4 – COVERED AND NON-COVERED SERVICES

REVISION DATES:6/15/2022, 6/9/2017, 10/14/2016, 5/27/2016, 4/1/2015, 8/1/2014, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: A.A.C. Title 9, Chapter 28, Articles 2 and 11, and the AHCCCS AMPM.

PURPOSE

The purpose of this policy is to outline guidelines related to services that are covered and service limitations under the ALTCS program as set forth in the AHCCCS Medical Policy Manual (AMPM).

DEFINITIONS

1. "Covered Services" means services that may be provided to members eligible for Medicaid in Arizona
2. "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21, to ensure the availability and accessibility of health care resources as well as to

assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "Non-Covered Services" means services that may not be provided to members eligible for Medicaid in Arizona

POLICY

Covered Services

The Division of Developmental Disabilities follows AHCCCS guidelines related to services that are covered and service limitations under the ALTCS program as set forth in the AHCCCS Medical Policy Manual (AMPM) Chapter 300, 400, and 1200. Chapter 300 outlines medical services (physical and behavioral health). Chapter 400 outlines Maternal and Child Health services, and Chapter 1200 outlines ALTCS Services and Setting for Members who are Elderly and/or Have Physical Disabilities and/or have Developmental Disabilities. In order to be covered, services must be medically necessary, cost-effective, and federally and state reimbursable as stated in A.A.C. R9, Chapter 22, 28, and 31.

In addition, Medicaid members under the age of 21 are entitled to services provided under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program which includes comprehensive treatment and preventive health care services for both physical and behavioral health conditions and illnesses. For persons eligible for EPSDT, federal law requires coverage of all Medicaid services listed in federal law 42 USC 1396d(a) when the services are medically necessary and cost-

effective- even if the services are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies. Services cannot be denied based on moral and religious grounds. Providers should review the AMPM on the AHCCCS website for further information about covered uncovered services and service limitations.

A. Examples of covered medical services include, but are not limited to:

1. Doctor's Visits
2. Immunizations (shots)
3. Prescriptions (prescription coverage is limited for people who have Medicare),)
4. Lab and X-rays
5. Early and Periodic Screening Diagnosis and Treatment (EPSDT) Services for Medicaid eligible children under age 21
6. Specialist Care
7. Hospital Services
8. Transportation to doctor's visits

9. Emergency Services
10. Podiatry Services Performed by a Podiatrist
11. Pregnancy Care
12. Surgery Services
13. Physical Exams
14. Behavioral Health
15. Family Planning Services
16. Dialysis
17. Glasses (for children under age 21)
18. Vision Exams (for children under age 21)
19. Dental Screening (for children under age 21)
20. Dental Treatment (for children under age 21)
21. Emergency Dental (for adults 21 and older. Up to $1000 per contract year)
22. Hearing Exams (for children under age 21)

23. Hearing Aids (for children under age 21)

B. Examples of covered behavioral health services include, but are not limited to:

1. Behavioral Health Day Programs including supervised day programs, therapeutic day programs, medical day programs;

2. Crisis Services including mobile team services, telephone crisis response, and urgent care Inpatient Services including hospital, sub-acute, and residential treatment;

3. Rehabilitation Services including living skills, cognitive rehabilitation, supported employment, and education support;

4. Health Promotion – Prevention, Education and Medication Training – education and standardized training for the purpose of increasing an individual's behavioral knowledge of a health-related topic such as medication management, the nature of an illness, relapse and symptom management, stress management, parenting skills, and healthy lifestyles;

5. Residential Behavioral Health Services include a range of up to 24hr/day services in a structured living environment for

individuals needing support.

6. Support Services include case management, personal assistance, Family & Peer Support, therapeutic foster care, respite, housing support, interpreter services, transportation, assistance accessing community resources and locating and applying for benefits, child care connections; and

7. Treatment Services - counseling, consultation, assessment and specialized testing, and substance abuse treatment.

C. Examples of covered Home and Community-Based Services (HCBS)

1. In-home services such as Homemaker, attendant care. respite, and habilitation

2. Therapy services such as physical, occupational, and speech

3. Community residential services such as developmental Home and group home

4. Employment Services that are not covered by Rehabilitative Services Administration/Vocational Rehabilitation (RSA/VR)

5. Day Treatment Services

6. Home health nursing services

7. Transportation

D. Institutional Services such as Nursing Home or Intermediate Care Facility

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. Daycare

4. Additions to homes

5. Pill crushers

6. Service animals
7. Life coaches
8. Home repairs
9. Rent
10. Medical marijuana
11. Any services provided to members outside the United States

CHAPTER 5 - EMERGENCY ROOM UTILIZATION

REVISION DATE: 2/14/2018, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013

Emergency services are provided for the treatment of an emergency medical or behavioral health condition. Emergency medical or behavioral health conditions are defined as an acute condition that, if left untreated, could be expected to result in placing a member's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ/part, or serious harm to another person.

Non-emergent services should be obtained in non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekend, or in a doctor's office.

The following are examples of minor problems when an emergency room should not be used:

- A sprain or strain
- A cut or scrape
- An earache
- A sore throat
- A cough or cold.

Emergency services are covered for all Division Arizona Long Term Care System (ALTCS)-eligible members when there is a demonstrated need, and/or medical assessment services indicate an emergency condition. Prior authorization is not required for emergency services.

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 providers to educate members on appropriate utilization of emergency room and urgent care centers.

Chapter 6 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT

REVISION DATES: 6/15/2022, 3/7/2018, 5/26/2017, 5/27/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 441.56(b)(1), 42 U.S.C. 1396d(a), AMPM, A.A.C. R9-22-205, R9-22-213. AMPM Policy 510, AMPM 430 Attachment A, AMPM 431 Attachment A

PURPOSE

This policy establishes provider requirements for the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.

DEFINITIONS

1. "Commercial Oral Supplemental Nutrition" means nourishment available without a prescription that serves as sole caloric intake or additional caloric intake.

2. "Diagnostic" means determination of the nature or cause of a condition, illness, or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests, and X-rays, when appropriate.

3. "Early" means in the case of a child already enrolled with an AHCCCS Contractor, as soon as possible in the child's life, or in

other cases, as soon after the member's eligibility for AHCCCS services has been established.

4. "Early and Periodic Screening, Diagnostic and Treatment (EPSDT)" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for AHCCCS members under the age of 21. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Periodic" means at intervals established by AHCCCS for screening to assure that a condition, illness, or injury is not incipient or present.

6. "Screening" means regularly scheduled examinations and evaluations of the general physical and behavioral health, growth, development, and nutritional status of infants, children, and adolescents, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

7. "Treatment" means any of the 29 mandatory or optional services described in 42 U.S.C. 1396d(a), even if the service is not covered under the (AHCCCS) State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening

POLICY

A. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Members age 20 years and under who are eligible for AHCCCS are also eligible for Early and Periodic Screening, Diagnostic 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

behavioral health conditions discovered by screenings. This includes preventive, dental, physical, behavioral health, developmental, rehabilitative and specialty services in accordance with AMPM 430 Attachment A, and AMPM 431 Attachment A).

EPSDT services include, but are not limited to, the coverage of:

1. Inpatient and outpatient hospital services
2. Laboratory and x-ray services
3. Physician and nurse practitioner services
4. Medications and medical supplies
5. Dental services
6. Therapy services
7. Behavioral health services
8. Orthotics and prosthetic devices
9. Eyeglasses
10. Transportation
11. Family planning services

12. Diagnostic, screening, preventive, and rehabilitative services.

EPSDT services do not include services that are experimental, that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions or treatments.

EPSDT screening services are provided in compliance with the periodicity requirements of 42 CFR 441.58. The Administrative Services Subcontractor (AdSS) shall ensure members receive required health screenings in compliance with AMPM Policy 430 Attachment A and the AMPM Policy 430 Attachment F, which are intended to meet reasonable and prevailing standards of medical and dental practice and specify screening services at each stage of the child's life. The service intervals are minimum requirements, and any services determined by a primary care provider (PCP) to be medically necessary shall be provided, regardless of the interval. The requirements and reporting forms for an EPSDT screening service are described in this Policy. EPSDT focuses on continuum of care by assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

B. EPSDT Covered Services

All applicable Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and Uniform Billing (UB-04) revenue codes are listed in the AHCCCS Rates and Billing webpage found on the AHCCCS website.

Providers are required to utilize national coding standards including the use of applicable modifier(s). Refer to the AHCCCS Medical Coding Resources webpage on the AHCCCS website.

C. EPSDT Visits Include

1. A comprehensive health and developmental history, including growth and development screening [42 CFR 441.56(B)(1)] that includes physical, nutritional, and behavioral health assessments

   Refer to the Centers for Disease Control and Prevention website for Body Mass Index (BMI) and growth chart resources.

2. Nutritional Assessment provided by a PCP

   a. Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention,

b. Nutritional assessment is a separately billable service by PCPs who care for EPSDT age members,

c. The Division covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings and on an inter-periodic basis, as determined necessary by the member's PCP,

d. Division also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT members who are underweight or overweight,

e. To initiate the referral for a nutritional assessment, the PCP shall use the AdSS' referral form in accordance with AdSS protocols, and

f. If a member qualifies for nutritional therapy due to a medical condition, the following is covered:

   i. For medically necessary WIC-exempt formula

   ii. Refer to Arizona WIC Programs Food List,

iii. For medically necessary WIC-exempt formula, the AdSS shall also be responsible for procurement of and the primary funding source for any other nutritional supplementation that is medically necessary.

3. Behavioral Health Screening and Services provided by a PCP

The AdSS covers behavioral health services for members eligible for EPSDT. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety.

American Indian members may receive behavioral health services through an Indian Health Service or Tribal operated 638 facility, regardless of AdSS enrollment or behavioral health assignment.

4. Developmental Screening Tools used by a PCP

a. Developmental screening is a separately billable service by PCPs who care for EPSDT age members.

b. PCPs who bill for developmental screening shall be trained in the use and scoring of the developmental screening

tools as indicated by the American Academy of Pediatrics (AAP).

c. Any abnormal developmental screening finding shall result in referrals for appropriate follow-up.

d. As specified in AMPM Behavioral Health Practice Tools 210 and AMPM Policy 320-O, a copy of the developmental screening tool shall be kept in the medical record.

e. General Developmental Screening at nine months, 18 months, and 30 months EPSDT visits.

i. General developmental screening shall occur at the 9 months, 18 months, and 30 months EPSDT visits.

ii. Accepted tools are described in the CMS Core Measure Developmental Screening in the First Three Years of Life. AHCCCS approved tools include the Ages and Stages Questionnaire, Third Edition (ASQ-3), and the Parents' Evaluation of Developmental Status (PEDS), Birth to Age Eight.

iii. The CPT code 96110 shall be used with EP modifier.

f. Autism Spectrum Disorder (ASD) Specific Developmental Screening at the 18 months and twenty-24 months EPSDT visits:

i. ASD specific developmental screening should occur at the 18 months and 24 months EPSDT visits. The Modified Checklist for Autism in Toddlers (M-CHAT-r) shall be used.

5. A comprehensive unclothed physical examination

6. Immunizations

a. EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood as specified in the CDC recommended childhood immunization schedules and as specified in AMPM Policy 310- M, according to age and health history, and

b. For members under age 19 years, unless otherwise noted in AMPM Policy 310-M, providers shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used.

c. For adult immunizations, refer to AMPM Policy 310-M.

7. Laboratory tests

a. Laboratory including anemia testing and diagnostic testing for sickle cell trait (if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test).

b. EPSDT covers blood lead screening and testing appropriate to age and risk. Blood lead testing is required for all members at 12 months and twenty- 24 months of age and for those members between the ages of 24 months through 6 years who have not been previously tested or who missed either the 12-month or 24-month test. Lead levels may be measured at times other than those specified if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to responsible person's concerns. Additional screening for children through 6 years of age is based on the child's risk as determined by either the member's residential zip code or presence of other known risk-factors.

8. Health education, counseling, and chronic disease self-management

9. Oral Health Screening

   Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, and the application of fluoride varnish conducted by a physician, physician's assistant, or nurse practitioner

   Fluoride varnish is limited in a PCPs office to once every six months, during an EPSDT visit for children who have reached six (6) months of age with at least 1 tooth erupted, with recurrent applications up to 2 years of age.

10. Appropriate vision, hearing, and speech screenings

    a. EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT periodicity schedule and as medically necessary using standardized visual tools.

    b. Ocular photo screening with interpretation and report, bilateral is covered for children ages 3 through 6 as part of the EPSDT visit due to challenges with a child's ability to

cooperate with traditional chart-based vision Screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one.

c. Automated visual Screening is for vision Screening only, and not recommended for or covered by AHCCCS when used to determine visual acuity for purposes of prescribing glasses or other corrective devices, and

d. Prescriptive lenses and frames are provided to correct or ameliorate defects, physical illness, and conditions discovered by EPSDT screenings, subject to medical necessity. Frames for eyeglasses are also covered.

11. Tuberculin skin testing, as appropriate to age and risk

Children at increased risk of tuberculosis (TB) include those who have contact with persons who have been:

a. Confirmed or suspected as having TB

b. In jail or prison during the last 5 years

c. Living in a household with an HIV-infected person or the child is infected with HIV.

d. Traveling/emigrating from, or having significant contact with persons indigenous to, endemic countries.

D. Sick Visit Performed In Addition To An EPSDT Visit

A "sick visit" can be performed at the same time as an EPSDT visit if:

1. An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented Evaluation and Management (E/M) service, and

2. The "sick visit" is documented on a separate note.

History, exam, and medical decision-making components of the separate "sick visit" already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine E/M service, and which does not require additional work and the performance of the key components of a problem-

oriented E/M service is included in the EPSDT visit and should not be reported.

E. Provider Requirements

EPSDT services shall be provided according to community standards of practice in accordance with Section 42 USC 1396d(a) and (r), 1396a(a)(43), 42 CFR 441.50 et seq. and AHCCCS rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Policy 430, Attachment A and AMPM Policy 431, Attachment A).

Providers shall refer members for follow-up, diagnosis, and treatment. Treatment is to be initiated within 60 days of Screening services.

Providers are required to provide health counseling/education at initial and follow-up visits.

Refer to the specific AdSS regarding PA requirements.

A PCP referral is not required for Naturopathic services.

Additionally, providers shall adhere to the below specific standards and requirements for the following covered services:

1. Breastfeeding Support per AAP recommendation, PCPs will ensure that families receive evidence-based breastfeeding information and support.

2. Immunizations:

   a. All appropriate immunizations shall be provided according to the Advisory Committee on Immunization Practices Recommended Schedule as specified in the CDC recommended immunization schedules and AMPM Policy 310-M.

      Refer to the CDC website: www.cdc.gov/vaccines/schedules/index.html for current immunization schedules. The vaccine schedule shall also reflect current state statutes governing school immunization requirements as listed on www.AZDHS.gov. If appropriate, document in the member's medical record the member/responsible person's decision not to utilize EPSDT services or receive immunizations, and

   b. Providers shall coordinate with the ADHS for the VFC program in the delivery of immunization services.

3. Blood Lead Screening

   a. The ADHS Parent Questionnaire, which was formerly used as part of Screening, is no longer required in this population. However, the questionnaire may be utilized to help determine if a lead test should be performed outside of the required testing ages. Screening efforts should focus on assuring that these children receive blood lead testing,

   b. Anticipatory guidance to provide an environment safe from lead, shall still be included as part of each EPSDT visit from 6 months through 6 years of age, and

   c. A blood lead test result equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or fingerstick shall be confirmed using a venous blood sample.

4. Organ and Tissue Transplantation Services Refer to Division Medical Policy 310-DD for information regarding AHCCCS-covered transplants.

5. Metabolic Medical Foods

If an AHCCCS covered member has a congenital metabolic disorder identified through the Bloodspot Newborn Screening Panel (such as Phenylketonuria, Homocystinuria, Maple Syrup Urine Disease, or Galactosemia), refer to Division Medical Policy 310-GG.

4. Nutritional Therapy

   a. AHCCCS covers nutritional therapy for EPSDT members on an Enteral Nutrition, TPN Therapy, or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake,

   b. PA is required from the AdSS for Commercial Oral Supplemental Nutrition, unless the member is also currently receiving nutrition through Enteral Nutrition or TPN Therapy,

      i. Medical necessity for commercial oral nutritional supplements shall be determined on an individual basis by the member's PCP or specialty provider, using the criteria specified in this policy. An example

of a nutritional supplement is an amino acid based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or specialty provider shall use the AHCCCS approved form, AMPM Policy 430 Attachment B, to obtain authorization from the AdSS.

1) Attachment B shall indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements.

    a) The member has been diagnosed with a chronic disease or condition,

    b) The member is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the AAP, and

c) There are no alternatives for adequate nutrition

OR

a) The member had met at least two of the following criteria to establish medical necessity:

- Is at or below the 10th percentile for weight-for- length or BMI on the appropriate growth chart for age and gender, as recommended by the CDC, for three months or more.
- Reached a plateau in growth and/or nutritional status for more than 6 months, or more than 3 months if member is an infant less than 1 year of age.
- Demonstrated a medically significant decline in weight within

the 3 month period prior to the assessment.

- Can consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

c. Additionally, each of the following requirements must be met:

i. The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems).

ii. The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period of no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a trial of higher caloric

foods would be detrimental to the member's overall health, the provider may submit the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements located in the AMPM Policy 430 Attachment B), along with supporting documentation demonstrating the risk posed to the member, for the AdSS Medical Director or Designee's consideration in approving the provider's prior authorization request.

iii. Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Members 21 Years of Age or Greater - Initial or Ingoing Requests). This documentation must demonstrate that the member meets all of the required criteria, and it includes:

1) Initial Requests

Documentation demonstrating that nutritional counseling has been provided as a part of the health risk assessment and screening services provided to the member by the PCP or

specialty provider, or through consultation with a registered dietitian

Clinical notes or other supporting documentation dated within 3 months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity (The physical assessment must include the member's current/past weight-for-length and BMI percentiles (if member is two years of age or older.)

Documentation detailing alternatives that were tried in an effort to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, and as member adherence to the prescribed dietary plan/alternatives attempted.

2) Ongoing Requests

Subsequent submissions shall include a clinical note or other supporting documentation dated within 3 months of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current weight-for-length or BMI percentile (if member is two year of age or older).

Note: Members receiving nutritional therapy must be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually. Additionally, documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

5. Oral Health Services

As part of the physical examination, the physician, physician's assistant, or nurse practitioner shall perform an oral health Screening. A Screening is intended to identify gross dental or oral lesions but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home shall be made as outlined in policy, see AdSS Medical Policy 431.

6. Cochlear and Osseointegrated Implantation

a. Cochlear implantation

Cochlear implantation provides an awareness and identification of sounds and facilitates communication for individuals who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or post-lingual. AHCCCS covers medically necessary services for cochlear implantation solely for EPSDT age members' candidates for cochlear implants shall meet criteria for medical necessity, including but not limited to, the following indications:

i. A diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation,

ii. Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation,

iii. No known contraindications to surgery,

iv. Demonstrated age-appropriate cognitive ability to use auditory clues, and

v. The device shall be used in accordance with the FDA approved labeling.

b. Coverage of cochlear implantation includes the following treatment and service components:

i. Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist, or audiologist,

ii. Pre-surgery inpatient/outpatient evaluation by a board-certified otolaryngologist,

iii. Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability,

iv. Pre-operative psychosocial assessment/evaluation by psychologist or counselor,

v. Prosthetic device for implantation (shall be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions),

vi. Surgical implantation and related services,

vii. Post-surgical rehabilitation, education, counseling, and training,

viii. Equipment maintenance, repair, and replacement of the internal/external components or both if not operating effectively. Examples include but are not limited to the device is no longer functional or the used component compromises the member's safety. Documentation which establishes the need to replace components not operating effectively shall be provided at the time prior authorization is sought,

ix. Cochlear implantation requires PA from the AdSS Medical Director, and

c. Osseointegrated implants (Bone Anchored Hearing Aid [BAHA]) AHCCCS coverage of medically necessary services for Osseointegrated implantation is limited to EPSDT members. Osseointegrated implants are devices implanted in the skull that replace the function of the middle ear and provide mechanical energy to the cochlea via a mechanical transducer. These devices are indicated only when hearing aids are medically inappropriate or cannot be utilized due to congenital malformation, chronic disease, severe sensorineural hearing loss, or surgery.

Osseointegrated implantation requires PA from the AdSS Medical Director. Maintenance of the Osseointegrated implants is the same as described above for cochlear implants.

d. Conscious Sedation

The AdSS covers conscious sedation for members receiving EPSDT services.

7. Behavioral Health Services

The AdSS covers behavioral health services for members eligible for EPSDT services as described in Contract and Policy. EPSDT behavioral health services include the services necessary to correct or ameliorate mental illnesses and conditions discovered by the Screening services.

For the diagnosis of behavioral health conditions including, but not limited to Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. If

allowable within their scope of practice, the clinical guidelines are to be used by PCPs as an aid in treatment decisions.

8. Religious Non-Medical Health Care Institution Services

The AdSS covers religious non-medical health care institution services for members eligible for EPSDT services as specified in AMPM Policy 1210.

9. Care Management Services

The AdSS covers care management services for both physical and behavioral health care, as appropriate for members eligible for EPSDT services. In EPSDT, care management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.

10. Chiropractic Services

The AdSS covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the AdSS to ameliorate the member's medical condition.

11. Personal Care Services

The AdSS covers personal care services, as appropriate, for members eligible for EPSDT services.

12. Incontinence Briefs

Incontinence briefs, including pull-ups and incontinence pads, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:

a. The member is over 3 years and under 21 years of age,

b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder,

c. The PCP or attending physician has issued a prescription ordering the incontinence briefs,

d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder,

e. The member obtains incontinence briefs from vendors within the AdSS' network, and

f. PA has been obtained as required by the Division, AdSS, or AdSS' designee. The AdSS may require a new PA to be issued no more frequently than every 12 months. PA for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. PA will be permitted to ascertain that:

i. The member is over 3 years and under 21 years of age,

ii. The member has a disability that causes incontinence of bladder and/or bowel,

iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the AdSS, and

iv. The prescription is for 240 briefs or fewer per month unless evidence of medical necessity for over 240 briefs is provided.

13. Medically Necessary Therapies

AHCCCS covers medically necessary therapies including physical therapy, occupational therapy, and speech therapy, necessary to correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the Screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

CHAPTER 7 DENTAL/ORAL HEALTH CARE

REVISION DATES: 8/16/2023, 6/24/2022, 11/10/16, 4/15/15, 4/16/14
EFFECTIVE DATE: March 29, 2013
REFERENCES: AHCCCS Medical Policy Manual (AMPM) policies 310-D1, 310-D2, 430 and 431

PURPOSE

The purpose of this document is to provide information to Qualified Vendors regarding the provision of medically necessary dental services for Division of Developmental Disabilities (Division) Members age 21 and older. This document also provides information for medically necessary, routine dental services for Division Arizona Long Term Care System (ALTCS) for Members aged 21 and older and covered medically necessary dental services for Members under 21 years of age.

DEFINITIONS

1. "Dental Emergency" means an acute disorder of oral health resulting in severe pain or infection as a result of pathology or trauma.
2. "Dental Provider" means:

a. An individual licensed under A.R.S. Title 32, Chapter 11, whose scope of practice allows the individual to independently engage in the practice of dentistry as defined in A.R.S. § 32-1202.

b. A dentist as defined in A.R.S. § 32-1201.

c. A dental therapist as defined in A.R.S. § 32-1201.

d. A dental hygienist as defined in A.R.S. § 32-1201.

e. An affiliated practice dental hygienist as defined in A.R.S. § 32-1201.

3. "Informed Consent" means a process by which the provider advises the Responsible Person of the diagnosis, proposed treatment and alternate treatment methods with associated risks and benefits of each, as well as the associated risks and benefits of not receiving treatment.

4. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

5. "Physician Service" means medical assessment, treatments, and surgical services provided by licensed allopathic or osteopathic physicians within the scope of practice.

6. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed.
7. "Simple Restoration" means silver amalgam, or composite resin fillings, stainless steel crowns or preformed crowns.

INFORMATION

A. COVERED DENTAL SERVICES

1. The following services are covered when provided by a licensed Dental Providers for Members who are 21 years of age or older:
   a. Emergency dental services up to $1,000 per Member per Contract year (October 1st to September 30th) as specified in A.R.S. § 36-2907.
   b. Medical and surgical services furnished by a Dental Provider or Physician Service.
2. The services specified in subsection (b) shall be related to the treatment of the following medical conditions:

a. Acute pain excluding Temporomandibular Joint Dysfunction (TMJ) pain,

b. Infection, or

c. Facture of the jaw.

3. Covered emergency services include:

a. Limited problem-focused examination of the oral cavity;

b. Required radiographs;

c. Complex oral surgical procedures such as treatment of maxillofacial fractures;

d. Administration of an appropriate anesthesia; and

e. Prescription of pain medication and antibiotics.

4. The diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) are not covered except for reduction of trauma.

5. For Members who require medically necessary dental services as a prerequisite to AHCCCS-covered organ or tissue transplantation, covered dental services include:

a. The elimination of oral infections and the treatment of oral disease, which include:

i. Dental cleanings,

ii. Treatment of periodontal disease,

iii. Medically necessary extractions, and

iv. Provision of Simple Restorations.

6. AHCCCS covers the services outlined in subsection (5) of this section only after a transplant evaluation determines that the Member is an appropriate candidate for organ or tissue transplantation.

7. Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck, or head is covered.

8. The services outlined in subsection (4), (5), and (7) of this section are not subject to the $1,000 adult emergency dental limit.

9. Dental cleanings are only covered in a hospital setting when performed by a hygienist working under the supervision of a Physician or Dentist Provider for Members who are in an inpatient hospital setting and are experiencing the following:

   a. Placed on a ventilator, or

   b. Physically unable to perform oral hygiene.

10. Services outlined in subsection 9 (a)(b) are not subject to the $1,000 adult emergency dental limit. If services are billed under the physician, medical codes are submitted and are not subject to the $1000 adult emergency dental limit.

B. EMERGENCY DENTAL SERVICES COVERAGE FOR MEMBERS AGE 21 AND OLDER

1. Medically necessary emergency dental care and extractions are covered for Members aged 21 and older who meet the criteria for a Dental Emergency.
2. The following services and procedures are covered as emergency dental services:
    a. Emergency oral diagnostic examination, limited oral examination – problem focused;
    b. Radiographs and laboratory services, limited to the symptomatic teeth;
    c. Composite resin due to recent tooth fracture for teeth;
    d. Prefabricated crowns, to eliminate pain due to recent tooth fracture only;

e. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges;

f. Pulp cap, direct or indirect plus filling;

g. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain;

h. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis;

i. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition;

j. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis;

k. Temporary restoration which provides palliative or sedative care limited to the tooth receiving emergency treatment;

l. Initial treatment for acute infection including:

   i. Periapical and periodontal infections; and

   ii. Abscesses by appropriate methods.

m. Preoperative procedures and anesthesia appropriate for optimal patient management; and

n. Cast crowns limited to the restoration of root canal treated teeth only.

3. Follow up procedures necessary to stabilize teeth as a result of the emergency service are covered and subject to the $1,000 limit.

C. EMERGENCY DENTAL SERVICES LIMITATIONS FOR MEMBERS AGE 21 AND OLDER

1. The following adult dental services are not covered:

a. Maxillofacial dental services provided by a Dental Provider, except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible;

b. Diagnosis and treatment of temporomandibular joint dysfunction, except for the reduction of trauma;

c. Routine restorative procedures and routine root canal therapy;

d. Treatment for the prevention of pulpal death and imminent tooth loss except:

i. Non-cast fillings;

ii. Crowns constructed from pre-formed stainless steel;

iii. Pulp caps; and

iv. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain.

e. Fixed bridgework to replace missing teeth; and

f. Dentures.

D. AdSS AND FEE-FOR-SERVICE (FFS) PROGRAM RESPONSIBILITIES

1. The AdSS provides the following:

a. Coordination of covered dental services for enrolled AHCCCS Members;

b. Documentation of current valid contracts with Dental Providers who practice within the AdSS service area(s);

c. Primary care provider to initiate Member referrals to Dental Provider(s) when the Member is determined to be in need of emergency dental services, or Members may self-refer

to a Dental Provider when in need of emergency dental services;

d. Monitoring of the provision of dental services and reporting of encounter data to AHCCCS; and

e. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted Dental Provider(s).

2. Tribal ALTCS and FFS providers provide the following:

a. Coordination of covered dental services for enrolled AHCCCS Members; and

b. Documentation of Primary Care Provider's initiation of Member referrals to a Dental Provider when the Member is determined to be in need of emergency dental services. Members also may self-refer to a Dental Provider when in need of emergency dental services.

3. The annual $1,000 adult emergency dental limit is Member specific and remains with the Member if the Member transfers between AdSS's or between FFS and an AdSS.

4. Dental services provided to American Indian/Alaska Native Members within an IHS/638 Tribal facility are not subject to the $1,000 adult emergency dental limit.
5. AdSS or Tribal Case Manager transferring the Member will notify the accepting entity regarding the current balance of the dental benefit.
6. The relinquishing AdSS will use the ALTCS Enrollment Transition Information (ETI) (DDD-1541A), AMPM Policy 520, Attachment A, and AMPM Exhibit 1620-9 for reporting dental benefit balance to the receiving AdSS that meet the following requirements:
    a. All services are subject to retrospective review to determine whether they satisfy the criteria for a Dental Emergency. Services determined to not meet the criteria for a Dental Emergency are subject to recoupment;
    b. The Member is not be permitted to carry-over unused benefit from one year to the next; and
    c. Services need to be utilized within a year that begins on October 1st and ends on September 30th.

7. Prior authorization for emergency dental services are not required for Members enrolled with either FFS or Managed Care.

E. NOTIFICATION REQUIREMENTS FOR CHARGES TO MEMBERS AGE 21 AND OLDER

1. Emergency dental services of $1,000 per contract year will be covered for AHCCCS Members age 21 and older. Billing of AHCCCS Members for emergency dental services in excess of the $1,000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 for acute services and A.A.C. R9-28-701.10 for ALTCS Members.
2. In order to bill the Member for emergency dental services exceeding the $1,000 limit, the following will occur:
    a. The provider must first inform the Member in a way the Member understands, that the requested dental service exceeds the $1000 limit and is not covered by AHCCCS;
    b. The provider will furnish the Member with a document to be signed in advance of the service, stating that the Member understands that the dental service will not be fully paid by AHCCCS;

c. The document will contain information describing the type of service to be provided and the charge for the service, and

d. The Member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by AHCCCS.

e. The Member will sign the document before receiving the service in order for the provider to bill the Member.

F. FACILITY AND ANESTHESIA CHARGES

1. Facility and anesthesia charges are subject to the $1,000 emergency dental limit when:

   a. A Member has an underlying condition which necessitates that services provided under the emergency dental benefit be provided in:

      i. An ambulatory service center, or

      ii. An outpatient hospital.

   b. Anesthesia is required as part of the emergency service.

2. Dental Providers performing General Anesthesia (GA) on Members will use dental codes and the cost will count toward the $1,000 emergency dental limit.
3. Physicians performing GA on Members for a dental procedure will bill medical codes and the cost shall count toward the $1,000 emergency dental limit.

G. INFORMED CONSENT

1. Informed Consent for oral health treatment will be completed at the time of initial examination and will be updated at each subsequent six-month follow-up appointment.
    a. A separate written consent will be completed for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomies.
    b. A written treatment plan will be reviewed and signed by both parties, as specified below, with the Member or Responsible Person receiving a copy of the complete treatment plan.
2. All providers will complete the appropriate Informed Consents and treatment plans for AHCCCS Members as listed above, in

order to provide quality and consistent care, in a manner that protects and is easily understood by the Member or Responsible Person. This requirement will extend to all Contractor mobile unit providers.

3. Consents and treatment plans will be in writing and signed and dated by both the provider and the Member or Responsible Person.
4. Completed consents and treatment plans will be maintained in the Members' chart and will be subject to audit.

H. ARIZONA LONG TERM CARE SYSTEM (ALTCS) ADULT DENTAL SERVICES

1. In accordance with A.R.S. § 36-2939, ALTCS Members age 21 or older may receive medically necessary dental benefits up to $1,000 per Member per Contract year (October 1st to September 30th) for diagnostic, therapeutic, and preventative care, including dentures.
2. ALTCS Members under age 21 are eligible for services as specified in AMPM Policy 431.

3. ALTCS Members are also eligible for services as specified in AMPM Policy 310-D1.
4. The services specified in AMPM Policy 310-D1 do not count toward the ALTCS $1,000 limit as they are separate.

I. CONTRACTOR AND TRIBAL ALTCS RESPONSIBILITIES

1. Contractors provide the following:
   a. Coordination of covered dental services for enrolled ALTCS Members;
   b. Documentation of current valid contracts with Dental Providers who practice within the Contractor service area(s);
   c. Primary care provider to initiate Member referrals to Dental Provider(s) when the Member is determined to be in need of ALTCS dental services, or Members may self-refer to a Dental Provider when in need of dental services;
   d. Monitoring of the provision of dental services and reporting of encounter data to AHCCCS; and

e. Assurance that copies of ALTCS dental policies and procedures have been provided to contracted Dental Providers.

2. Tribal ALTCS and FFS providers provide the following:
   a. Coordination of covered dental services for enrolled AHCCCS Members; and
   b. Documentation of Primary Care Provider's initiation of Member referrals to a Dental Provider when the Member is determined to be in need of emergency dental services. Members also may self-refer to a Dental Provider when in need of emergency dental services.
3. The annual ALTCS dental benefit limit is Member specific and remains with the Member if the Member transfers between AdSS's or between FFS and an AdSS.
4. The ALTCS Contractor, or Tribal ALTCS Case Manager, transferring the Member will notify the receiving entity regarding the current balance of the ALTCS dental benefit. AMPM Exhibit 1620-9 will be utilized for reporting an ALTCS dental benefit balance.

5. Dental services provided within an Indian Health Service (IHS) or 638 Tribal Facility also shall not be subject to the ALTCS dental benefit $1,000 limit.
6. Frequency limitations and services that require prior authorization apply. The AdSS will refer to the Dental Uniform Prior Authorization List as listed on the AHCCCS website under Resources: Guides-Manuals-Policies.

J. FACILITY AND ANESTHESIA CHARGES

1. If an underlying medical condition of an ALTCS Member necessitates that the services provided under the ALTCS dental benefit be provided in an ambulatory service center or an outpatient hospital and may require anesthesia, the facility and anesthesia charges are subject to the ALTCS $1,000 limit.
2. Dental Providers performing General Anesthesia (GA) on ALTCS Members will use dental codes and the cost will count toward the ALTCS $1,000 limit.
3. Physicians performing GA on an ALTCS member for a dental procedure will bill medical codes and the cost will count toward the ALTCS $1,000 limit.

K. NOTIFICATION REQUIREMENTS FOR CHARGES TO ALTCS MEMBERS

1. Providers will provide medically necessary services within the ALTCS $1,000 dental benefit allowable amount.
2. If medically necessary services are greater than $1,000, the provider may perform the services as set forth in A.A.C. R9-28-701.10 and R9-22-702, after the following notifications take place:
    a. In accordance with A.A.C. R9-28-701.10 and R9-22-702, the provider will inform and explain to the Member both verbally and in writing, in the Member's primary language, that the dental service requested is not covered and exceeds the ALTCS $1,000 limit.
    b. If the Member agrees to pursue the receipt of services:
        i. The provider will supply the Member a document describing the service and the anticipated cost of the service.
        ii. Prior to service delivery, the Member will sign and date a document indicating that the Member

understands that the Member is responsible for the cost of the service to the extent that it exceeds the ALTCS $1,000 limit.

L. DENTAL SERVICES FOR MEMBERS AGE 20 AND YOUNGER

1. Members who are Medicaid eligible and age 20 years and younger are covered for the following preventative and restorative dental services:
    a. Examinations,
    b. Cleanings,
    c. Extractions,
    d. Sealants,
    e. X-rays,
    f. Amalgam or resin restorations,
    g. Fluoride varnish, and
    h. Other covered services.

CHAPTER 8 – MATERNITY AND FAMILY PLANNING

REVISIONDATE: 8/22/2018, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: AMPM 410, AMPM 420

Maternity Services

The Division of Developmental Disabilities (Division) ensures the provision of maternity services. These services include, but are not limited to medically necessary preconception counseling, pregnancy identification, medically necessary education and prenatal care for the care of the pregnancy, treatment of pregnancy-related conditions, labor and delivery services, and postpartum care for members. All maternity care services must be provided by qualified physicians, physician assistants, nurse practitioners, certified midwives, or licensed midwives. Refer to Division Medical Policy 410 Maternity Care Services for further information. See AHCCCS AMPM 410 for a complete description of covered maternity services. Members may select or be assigned to a Primary Care Provider (PCP) specializing in obstetrics while they are pregnant. Members who transition to a new AdSS or become enrolled during their third trimester must be allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.

The Division allows women and their newborns to receive 48 hours of inpatient hospital care after a routine vaginal delivery and 96 hours of inpatient care after a cesarean delivery. The attending health care provider, in consultation with the mother, may discharge the mother or newborn prior to the minimum length of stay. A newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the 48-hour or 96–hour stay. However, for payment purposes, inpatient limits will apply to the extent consistent with Early Periodic Screening, Diagnosis and Treatment (EPSDT).

Family Planning

The Division ensures the provision of family planning services to delay or prevent pregnancy. Covered family planning services include medical, surgical, pharmacological, laboratory services, and contraceptive devices. Covered family planning services also include Long-Acting Reversible Contraceptives (LARC) which are methods for family planning that provide effective contraception for an extended period of time with little or no maintenance or user actions required. Covered services also include the provision of accurate information and counseling services allow members to make informed decisions regarding family planning methods. Refer to Division Medical Policy manual 420 Family Planning for additional information. See AHCCCS AMPM 420 for a complete description of covered family planning services. The AdSS is required to educate their providers on the full scope of available family planning services and how members may maintain them.

Pregnancy Termination and Sterilization services may be covered in accordance with Division Medical Policy 420. For further details, see Division Medical Policy 420.

CHAPTER 9 - PCP ASSIGNMENTS

REVISION DATE: 10/1/2021, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Mercy Care Plan website; UnitedHealthcare website; Arizona Physicians, IPA website

The Division of Developmental Disabilities (Division) contracts with two Acute Care Health Plans (Administrative Services Subcontractors (AdSSs) to deliver acute health services for its members. The acute care health plan is responsible for assigning a Primary Care Provider (PCP) to enrolled members. Refer to the health plan's website for information about the PCP assignment process or call the Member Services Department at:

UnitedHealthcare Community Plan: 1-800-445-1638

Mercy Care: 1-800-624-3879

Members who are of American Indian descent may choose to receive acute care services through the DDD Tribal Health Program (THP)/Fee-For-Service (FFS). The Division operates the acute care service delivery system for these members. When a member elects THP/FFS, the Division's Support Coordinator works with the member to select a PCP that provides geographically convenient and culturally appropriate services. For THP questions call THP member services at 602-771-8080.

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 listed above to execute a PCP change. For questions regarding the THP services contact 602-771-8080.

Chapter 10 REFERRALS TO SPECIALISTS

REVISION DATE: 10/1/2021, 10/1/2019, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013

Members served by the Division of Developmental Disabilities (Division), who are AHCCCS eligible (Medicaid and DD/Arizona Long Term Care System [ALTCS]), may be referred to a specialist for their medical needs. The Primary Care Provider is responsible for initiating, supervising, and coordinating referrals for specialty care and inpatient services, maintaining continuity of member care, and maintaining the member's medical record.

Referrals to Specialists: Physical Health

Primary Care Providers (PCPs) must deem a specialist referral to be medically necessary. Members served by a Division subcontracted health plan must adhere to AHCCCS and Division criteria and requirements for referral to a specialist for a medical need. This information is in the member handbook for each of the Division's subcontracted health plans.

The Division subcontracted health plan each have their own procedures for referrals to specialists and for authorization. However, referrals to medical specialists must still align with AHCCCS and Division requirements for specialists' referrals as defined in the AHCCCS Medical Policy manual (AMPM).

Any Division DDD Tribal Health Program (THP) member utilizing a non-IHS/638 provider or facility rendering AHCCCS covered services must obtain prior authorization from the Division Prior Authorization Unit for specialist services. Prior Authorization is not required for Fee-for-service (FFS) members receiving services from Indian Health Service/638 (IHS/638) providers and facilities.

For Prior Authorization, providers must be prepared to submit the following information:

A. Provider name and provider ID

B. Member/patient name and AHCCCS ID number

C. Type of specialist/service

D. Service date

E. ICD-10 diagnosis code(s)

F. CPT or CDT procedure code(s) or HCPCS code(s)

G. Anticipated charges (if applicable), and

H. Medical justification.

Division Prior Authorization Unit staff, upon receipt and assessment of information provided, will issue to the requesting provider an approval, a provisional prior authorization number, or notify the provider of a denial of coverage.

Referrals to Specialists: Behavioral Health

Members served by the Division's subcontracted health plan shall be provided coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health services provided by a PCP within their scope of practice, or behavioral health medical provider. The member does not require a referral from the PCP to see a behavioral health medical provider.

Members who are AHCCCS eligible and are also American Indian may access behavioral health services through the Tribal Regional Behavioral Health Authority (TRBHA) or Indian Health Service Facilities.

Coordinating care for Behavioral Health Medication Management

When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be referred to a behavioral health provider for evaluation and/or continued medication management services, Subcontracted Health plans shall require and ensure that the PCP coordinates the referral. If a member is determined to have a Serious Mental Illness (SMI), the PCP shall coordinate the transfer of the member's care to a RBHA or TRBHA provider, as applicable (does not apply for members with SMI who have integrated service delivery). All affected subcontracts shall include coordination of care provisions.

Policies and procedures shall address, at a minimum, the following:

A. Guidelines for PCP referral to a behavioral health provider for medication management,

B. Guidelines for transfer of a member with an SMI determination to a RBHA or TRBHA for ongoing treatment, as applicable,

C. Protocols for notifying entities of the member's transfer, including reason for transfer, diagnostic information, and medication history,

D. Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to requests for additional medical record information,

E. Protocols for transition of prescription services, including but not limited to notification to the appropriate entities of the member's current medications and timeframes for dispensing and refilling medications during the transition period. This coordination must ensure at a minimum, that the member does not run out of prescribed medications prior to the first appointment with the behavioral health provider prescriber and that all relevant member medical information including the reason for transfer is forwarded to the behavioral health provider prior to the member's first scheduled appointment, and

F. Contractor monitoring activities to ensure that members are appropriately transitioned for care.

Statewide Crisis Lines:

- Maricopa County (800) 631-1314, (602) 222-9444, TTY (800) 327-9254
- Northern Arizona (Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties) (877) 756-4090
- Southern Arizona Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties Crisis Line- (866) 495-6735
- Gila River and Ak-Chin Indian Communities Crisis Line- (800) 259-3449

Health Plans:

A. Mercy Care Plan

Member Services:
602-586-1841
1-800-564-5465
Hearing Impaired TTY/TDD 711

Nurse Line:
602-263-3000
1-800-624-3879

B. UnitedHealth Care

Member Services:
1-800-348-4058
TTY: 711
Nurse Line:
1-877-440-0255

Tribal Regional Behavioral Health Authorities (TRBHA)

A. Gila River Regional Behavioral Health Authority

Member Services:
1-888-484-8526, ext. 7010
520-562-3321, ext. 7010
602-528-7100

Crisis Line:
1-800-259-3449

B. White Mountain Apache Regional Behavioral Health Authority

Member Services and Crisis Line:
1-928-338-4811 or
1-877-336-4811

C. Pascua Yaqui Tribe

Member Services:
Tucson: 1-520-879-6060
Guadalupe: 480-768-2000

Crisis Line during Business Hours:
Tucson: 520-879-6060
Guadalupe: 480-768-2000

Crisis Line after hours, weekends, and holidays:
Tucson: 520-591-7206
Guadalupe: 480-736-4943

Coordination of Care

Once a referral is made, the provider will contact the member and/or the responsible person to complete the referral. Division contracted providers may also contact the member's Support Coordinator for assistance. The assigned coordinator will assist in care coordination. When the provider or agency does not have the Support Coordinator's contact information, they may call the Division's Customer Service Center at 844-770-9500. They then provide the Division's operator with the name of the member and the operator will provide the Support Coordinator's information.

CHAPTER 11 ALTCS INQUIRIES, GRIEVANCES, CLAIM DISPUTES, AND APPEALS

REVISION DATE: 3/29/2023, 6/15/2022, 8/28/2019, 6/23/2017, 11/10/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

PURPOSE

The purpose of this policy is to provide guidelines for provider inquiries, grievances, claim disputes, State Fair Hearings (regarding Notice of Decision), appeals, and State Fair Hearings (regarding Notice of Appeal Resolution). This policy also provides information for providers on member inquiries, grievances, and appeals.

DEFINITIONS

1. "Member Grievance" is an expression of dissatisfaction:
    a. From a member, responsible party, advocate, etc., with any aspect of a member's care other than an adverse benefit determination.
    b. That may pertain to the quality of care or services provided or dissatisfaction with providers, direct care

workers, or Division of Developmental Disabilities (Division) staff.

2. "Member Inquiry" means any question related to member matters.
3. "Provider Grievance" means a provider's expression of dissatisfaction with an unresolved issue that:
   a. May pertain to the quality of care or services provided or dissatisfaction with providers, direct care workers, or Division of Developmental Disabilities (Division) staff.
   b. Is not a dispute involving the payment of a claim, denial of a claim, imposition of a sanction, or reinsurance.
4. "Provider Inquiry" means any question related to provider matters or issues that can be resolved within the first call or email or in less than 30 days, and billing issues including claims less than 30 days from the day of billing.

POLICY

A. MEMBER INQUIRIES

1. Member inquiries do not require follow-up as they are addressed on the first communication.

2. If the issue needs additional follow-up for resolution or assistance, it shall be treated as a member grievance.

B. MEMBER GRIEVANCES

1. A member grievance should be resolved within 10 days but no longer than 90 days.
2. To file a grievance, contact: Division of Developmental Disabilities Customer Service Center 1-844-770-9500 (toll free) or DDDCustomerServiceCenter@azdes.gov.
3. The Division shall establish procedures to provide a model for handling and tracking of member and provider inquiries, to outline the monitoring of phone call and inquiry standards, and to define the roles and responsibilities.

C. PROVIDER INQUIRIES

1. Provider Inquiries are acknowledged within three days of receipt and resolved in less than 30 days.
2. If resolution is not provided within 30 days, then it shall be elevated as a Provider Grievance.

D. PROVIDER GRIEVANCES

1. Provider Grievance shall be resolved within 30 days.

2. To file a grievance, providers shall contact: Division of Developmental Disabilities Customer Service Center at 1-844-770-9500 (toll free) or DDDCustomerServiceCenter@azdes.gov.

E. PROVIDER CLAIM DISPUTES

1. If providers wish to file a claim dispute to maintain their rights, they shall follow the instructions provided below.
2. 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. The providers may challenge the claim denial or adjudication by filing a formal claim dispute with the Office of Administrative Review.
3. Pursuant to Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual (ACOM) Policy 203, all claim disputes challenging claim payments, denials, or recoupments shall 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.

4. The claim dispute shall state the factual and legal basis for the relief requested, and shall include all supporting documentation such as claims, remittances, billing detail reports, explanation of benefits, time sheets, medical review sheets, medical records, and correspondence, etc.
5. Incomplete submissions or those that do not meet the criteria for a claim dispute shall be denied.
6. Providers shall mail, email, or fax written claim disputes to:

   OFFICE OF ADMINISTRATIVE REVIEW

   4000 North Central Avenue

   3rd Floor, Suite 301 - Mail Drop 2HE5

   PHOENIX ARIZONA 85012

   Email: dddofficeofcompliance@azdes.gov

   Fax: 602-277-0026
7. If providers have questions, they shall call 602-771-8163 or 1-844-770-9500.
8. The Division shall 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.

F. STATE FAIR HEARINGS (REGARDING NOTICE OF DECISION)

1. If the providers disagree with the Division's Notice of Decision, they may submit a written request for a State Fair Hearing within 30 calendar days of receipt of the Notice of Decision.
2. In the request for State Fair Hearing, providers shall reference the following information:
   a. Re: Request for State Fair Hearing
   b. DDD Claim Dispute Number
   c. Member Name and AHCCCS ID.
3. Providers shall mail, email, or fax written requests for State Fair Hearing to:

   OFFICE OF ADMINISTRATIVE REVIEW

   4000 North Central Avenue

   3rd Floor, Suite 301 - Mail Drop 2HE5

   PHOENIX ARIZONA 85012

   Fax: 602-277-0026

   Email: dddofficeofcompliance@azdes.gov

4. If providers have questions, they shall call 602-771-8163 or 1-844-770-9500.

G. APPEALS

1. 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 shall be received by the Division within 60 calendar days from the date of the Notice of Action letter.
2. 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) may ask for an expedited appeal.
3. Expedited appeals are resolved within three business days.
4. If the Division does not agree that an expedited appeal is needed, the Division shall notify the provider in writing (when the provider requested the expedited appeal on the member's behalf) and the member within two days. The Division shall also

contact the requesting party via telephone. The Division shall decide the appeal within 30 days.

5. Reasons for filing an appeal include:
    a. Denial or limited authorization of a requested service, including the type or level of service
    b. Reduction, suspension, or termination of a previous authorization
    c. Denial, in whole or in part, of payment of a service
    d. Failure to provide service in a timely manner as defined by the State
    e. 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
    f. Failure of the health plan to act timely
    g. 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.

6. To file a written appeal, member (or the provider on behalf of the member) shall mail, email, or fax the written appeal to:

   OFFICE OF ADMINISTRATIVE REVIEW

   4000 North Central Avenue

   3rd Floor, Suite 301 - Mail Drop 2HE5

   PHOENIX ARIZONA 85012

   Fax: 602-277-0026

   Email: dddofficeofcompliance@azdes.gov

7. To file a telephonic appeal, or if there are any questions, member (or the provider on behalf of the member) shall call 602-771-8163 or 1-844-770-9500.

H. STATE FAIR HEARINGS (REGARDING NOTICE OF APPEAL RESOLUTION)

1. If the member disagrees with the Notice of Appeal Resolution, the member (or the provider on behalf of the member) may submit a written request for a State Fair Hearing no later than 120 calendar days of receipt of the Notice of Appeal Resolution.
2. In the request for State Fair Hearing, the member (or the provider on behalf of the member) shall reference:

a. Re: Request for State Fair Hearing

b. DDD Appeal Number

c. Member Name and AHCCCS ID.

3. The member (or the provider on behalf of the member) shall mail, email, or fax written requests for State Fair Hearing to:

   OFFICE OF ADMINISTRATIVE REVIEW

   4000 North Central Avenue

   3rd Floor, Suite 301 - Mail Drop 2HE5

   PHOENIX ARIZONA 85012

   Fax: 602-277-0026

   Email: dddofficeofcompliance@azdes.gov

4. If the members or providers have questions, they shall call 602-771-8163 or 1-844-770-9500.

12 BILLING AND CLAIM SUBMISSION

REVISION DATE: 04/21/2023, 10/1/2021, 09/15/2021, 9/11/2019, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: CFR 42-433.316; CFR 42-455.410; A.R.S. § 36-551; A.R.S. § 36-2903.01(K); A.R.S. § 36-2903.01(L); A.R.S. § 36-2904(G), A.R.S. § 36-2904(G)(1), A.R.S. § 36-2907; A.R.S. § 36-2931 et seq; A.A.C. R9-29-30; ACOM 201; ACOM 203; ACOM 434

PURPOSE

This policy outlines the requirements for service providers when submitting claims to the Division of Developmental Disabilities (the Division) for services provided to Members eligible for Arizona Long Term Care Services.

DEFINITIONS

1. "AHCCCS" means the Arizona Health Care Cost Containment System.
2. "ALTCS" means the Arizona Long Term Care System.
3. "Internal Control Number" or "ICN" means claim reference number or internal control number unique to each claim and remains the same over the life of the claim.
4. "Clean Claim" means a claim that may be processed without obtaining additional information from the subcontracted

provider of care, from a non-contracting provider, or from a Third Party, but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

5. "Tribal Health Program" or "THP" means the program that provides medically necessary services for Division enrolled Members. The program provides coverage for acute, preventive, and behavioral health care services.
6. "Evaluation and Management Codes" or "E&M" means a category of Current Procedural Terminology (CPT®) codes used for billing purposes. The majority of patient visits require an E&M code. There are different levels of E&M codes, which are determined by medical decision making, time, and documentation requirements.
7. "Fee for Service" or "FFS" means a method in which doctors and other health care providers are paid for each service performed.
8. "Home and Community Based Services" or "HCBS" means one or more of the following services provided to Members: Attendant Care, Habilitation, Home Health Aide, Home Health Nurse, Occupational Therapy, Physical Therapy, Respiratory

Therapy, Respite Services, Speech-language pathology, and other comparable services as approved by the AHCCCS Director.

9. "International Classification of Diseases 10th revision or "ICD-10" means the diagnosis coding system used by physicians and facilities.
10. "Member" means the same as "Client" prescribed in A.R.S. § 36-551.
11. "Qualified Medicare Beneficiary Only" or "QMB Only" means Qualified Medicare Beneficiary under the federal program but does not qualify for Medicaid.
12. "Service Provider" means a person or agency that provides services to clients pursuant to a contract, service agreement or qualified vendor agreement with the Division.
13. "Third Party" means an individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan.
14. "Third Party Liability" or "TPL" means 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 AHCCCS benefits.

15. "Void" means a reversal of a claim, with the entire claim amount being recouped.

POLICY

A. PROVIDER REQUIREMENTS

All service providers, including but not limited to out-of-state providers, those providing services under a State plan or under a waiver of a plan, attending and servicing providers both within and outside of a hospital setting, and billing providers shall meet the following requirements to be reimbursed for covered services provided to AHCCCS Members:

1. Enroll with AHCCCS;
2. Have an assigned AHCCCS Provider Identification Number; and
3. Register their National Provider Identifier (NPI) if applicable to the service provider type, with AHCCCS.

B. GENERAL BILLING REQUIREMENTS

1. Service providers shall adhere to the billing requirements observed by Medicare, Medicaid, and other Third-Party payers.

2. Service providers shall determine the extent of TPL coverage and bill all Third Party payers, including Medicare, before billing the Division.
3. Service providers shall adhere to applicable prior authorization requirements found in DDD Provider Manual Chapter 17 for all ALTCS/HCBS claims.
4. The service provider shall submit claims only for rendered goods or services.
5. The service provider shall enter their Federal Tax ID number associated with their Division contract on all claims.
6. The service provider shall enter their NPI on all claims, if applicable to the service provider type.
7. The service provider shall not submit claims to the Division if a Member is absent for any service.
8. The service provider shall adhere to the same timely filing and billing format requirements in this policy as is required for submitting initial claims for the following types of claims:
    a. Resubmitted claims;
    b. Corrected claims; and

c. Voided claims.

C. SERVICE DATES AND CLAIMS SUBMISSION TIME FRAMES

1. The service provider shall ensure that the last date of service billed is prior to or on the same date the claim is signed and submitted to the Division if the claim is covering a date range over which the service was provided.
2. The service provider shall submit claims for service rendered dates spanning within one month. If billing for multiple months, the service provider shall submit separate claims for each month.
3. The service provider shall adhere to the following time frames for submitting initial claims to the Division:
    a. No later than six months after the date of service.
    b. No later than six months from the date that eligibility is posted for claims involving retro-eligibility.
4. The service provider shall use the first date the item(s) were delivered to the Member as the date of service for durable medical equipment claims.

5. The service provider shall adhere to the following time frames when submitting corrected claims previously processed by the Division to achieve Clean Claim status:
    a. Within 12 months from the date of service.
    b. Within 12 months from the date eligibility was posted for claims involving retro-eligibility.
    c. Within 60 days of the last adverse action.

D. CLAIMS SUBMISSION REQUIREMENTS

1. The service provider shall refer to the Claims Submission Guides on the Division's website for instructions on submitting claims.
2. The service provider shall submit one of the following types of claims forms:
    a. Single claim entries via the WellSky professional billing system.
    b. Nationally standardized, original paper claim forms:
        i. CMS 1500 Form: For claims for professional services, including long term care and HCBS.
        ii. CMS 1450 (Institutional) or UB-04 Form: For claims for intermediate care facilities, hospital in-patient

and out-patient services, dialysis, hospice, and skilled nursing facility services.

iii. ADA 2012 Form: For claims for dental services.

c. Electronic claim transmittals:

i. 837P (Professional)

ii. 837I (Institutional)

iii. 837D (Dental)

3. Service providers shall submit claims with current code sets from the ICD-10, CPT®, Healthcare Common Procedure Coding System, Current Dental Terminology, and National Drug Codes.

E. BILLING DIVISION MEMBERS

1. Service providers shall not bill Members eligible for Medicaid, including QMB Only Members, for Division-covered services.
2. Service providers shall not bill Members for missed ALTCS/HCBS appointments.
3. Upon verbal or written notice from the Member that the Member believes the claims are to be covered by Medicaid, a service provider shall not do either of the following unless the service provider has verified through AHCCCS that the Member has

been determined ineligible, has not yet been determined eligible, or was not, at the time services were rendered, eligible or enrolled:

a. Charge, submit a claim to,or demand or otherwise collect payment from a Member who has been determined eligible for Medicaid unless specifically authorized.

b. Refer or report a Member who has been determined eligible for Medicaid, to a collection agency or credit reporting agency for the failure of the Member or person, who has been determined eligible, to pay charges for system covered care or services.

F. OVERPAYMENTS AND RECOUPMENTS

1. The service provider shall notify the Division of any overpayment by submitting a replacement claim to the Division to start the recoupment process.
2. The service provider shall refund the Division within 60 days from the date of notification of overpayment.
3. If an adjustment to a claim is needed, the service provider shall attach documentation substantiating the overpayment, such as

an Explanation of Benefits if the overpayment was due to payment received from a Third-Party payer.

4. If it is necessary to void a claim, the entire payment shall be recouped by the Division and the service provider shall not make direct repayment to the Division.
5. Upon recouping payment from an erroneous payment or overpayment, the Division shall generate a remittance advice showing the original allowed amount, and the new (adjusted) allowed amount for the processed claim.
6. The service provider shall not send a check for the overpayment unless otherwise requested by the Division.

G. MEDICAL REVIEW

1. The Division shall conduct medical review of claims to determine the medical necessity, appropriateness, utilization, and quality of services provided.
2. Service providers shall submit additional documentation for claims identified in the Division claims processing system as near duplicate claims to determine whether it is appropriate to

reimburse multiple providers for the same service on the same day for the same Member.

3. The service provider shall submit medical documentation to the Division for near duplicate payments when requesting an override.

H. SOCIAL DETERMINANTS OF HEALTH

1. Service providers shall routinely screen for and document the presence of social determinants of health.
2. The service provider shall include information about social determinants of health in the Member's chart.
3. The service provider shall include social determinants of health ICD-10 diagnosis codes on submitted claims to comply with state and federal coding requirements.
4. Service providers shall remain current in the use of social determinants of health ICD-10 codes.

CHAPTER 13 - UTILIZATION MANAGEMENT

REVISION DATE: 10/1/2021, 5/26/2016, 4/16/2014
EFECTIVE DATE: March 29, 2013
REFERENCES: ACOM 416; 42 CFR 438.240(b)(3)

The Division of Developmental Disabilities (Division) has mechanisms to detect both underutilization and overutilization of services; see 42 CFR 438.240(b)(3).

Physical and Behavioral Health Services

The Division has developed and implemented processes to monitor and report the utilization for both the subcontracted health plans and the DDD Tribal Health Program (THP). The Division's Medical Management committee monitors, on an ongoing basis, the physical health and behavioral health utilization data findings and makes or approves recommendations based on the variances noted.

A. Subcontracted Health Plans

The member's Primary Care Provider (PCP) is the gatekeeper for medical services, for both preventative and primary services. AHCCCS contracts with the Division for the provision for all Medicaid covered services to eligible members and the Division subcontracts out the medical services for eligible members to specific subcontracted health plans. The subcontracted health plans operate as Managed Care Organizations. Utilization management applies to each of the Division's subcontracted health plans who have a process to evaluate and approve or deny health care services, procedures or settings based on medical necessity, appropriateness, efficacy and efficiency. Utilization management includes a process for prior authorization (see Provider Policy Manual Chapter 17), concurrent review (see Provider Policy Manual Chapter 19), retrospective review, and case management.

B. DDD Tribal Health Program (THP) Providers

All THP providers must be registered with AHCCCS, and comply with all federal, state, and local laws, rules and regulations. The providers must also meet AHCCCS requirements for professional licensure, certification or registration including current Medicare certification. For a small number of American Indians with a developmental disability, an acute Fee-For-Service (FFS) payment methodology is used by all THP providers.

For Division members enrolled with THP, prior authorization is required before rendering any service. The Division's Chief Medical Officer (CMO) or Medical Director will review any denials for the THP population for adherence with medical necessity including cost effectiveness and appropriateness. The Division will pay for health assessments, screening tests, immunizations, and health education under the scope of preventative care for THP members.

Division-eligible American Indian members receive behavioral health services through a Regional Behavioral Health Authority (RBHA), a Tribal RBHA (TRBHA), an Indian Health Services (IHS) facility, or a 638 Tribal facility. Behavioral health services include but are not limited to screening, treatment, and assistance in coordinating care among providers.

C. Behavioral Health Providers

AHCCCS-contracted RBHAs/TRBHAs provide services to Division members through an Interagency Service Agreement (ISA) between AHCCCS and the Division. Data is provided to identify behavioral health utilization for care coordination purposes.

Long Term Services and Supports

The Division monitors utilization to identify patterns of underutilization and over-utilization of Long Term Services and Supports (LTSS). This data is reviewed and analyzed for trends so that appropriate remediation can be identified, as necessary.

CHAPTER 16 – REMITTANCE ADVICE, ELIGIBILITY, AND COST SHARING

REVISION DATE: 07/31/2019, 6/27/2018, 5/30/2018, 5/31/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR § 435.1103, A.R.S. § 36-2903, A.R.S. § 36-2904; A.A.C. R9-22-703, A.A.C. R9-29-301; ALTCS DES/DDD Contract YH6-0014 (Amendment 69), AHCCCS Fee-For-Service (FFS) Provider Billing Manual

This policy contains general information related to the Division of Developmental Disabilities (the Division) remittance advice, eligibility, and cost sharing. Policies regarding submission and processing of Long-Term Care services (LTC) and fee-for-service claims can be found in *Chapter 12 of the Division's Provider Manual* and are also communicated to providers via such channels as Provider Vendor Announcements.

In the absence of specific policies, the Division endeavors to follow the Arizona Health Care Cost Containment System (AHCCCS)/the Centers for Medicare and Medicaid Services (CMS) policy guidelines as closely as possible.

Definitions

A. Cost Sharing - The Division's obligation for payment of applicable Medicare coinsurance, deductible, and copayment amounts for Medicare Parts A and B covered services.

B. Dual Eligible Medicare Beneficiaries (Duals) - A Division member who is eligible for both Medicaid and Medicare services. There are two types of Dual Eligible members: QMB Duals and Non-QMB Duals (FBDE, SLMB+, QMB+)

C. Full Benefit Dual Eligible (FBDE) - A Division member who does not meet the income or resources criteria for a QMB or an SLMB. Eligible for Medicaid either categorically or through optional coverage groups, such as Medically Needy or special income levels for institutionalized or home and community-based waivers.

D. In-Network Provider - A provider that is contracted with the Division to provide services.

E. Medicare Advantage Plan - A private health insurance plan that has a contract with the Centers for Medicare and Medicaid Services (CMS) to provide all Medicare benefits covered under Parts A and B to Medicare beneficiaries who choose to enroll in their plan. Most plans include prescription drug coverage and may also provide additional benefits. Types of Medicare Advantage plans include, Local Health Maintenance Organizations (HMOs), Special Needs Plans (SNPs), and Local and Regional Preferred Provider Organizations (RPPOs).

F. Medicare Part A - Hospital insurance that provides coverage for inpatient care in hospitals, skilled nursing facilities, and hospice.

G. Medicare Part B - Coverage for medically necessary services like doctors' services, outpatient care, home health services, and other medical services.

H. Medicare Part D - Medicare prescription drug coverage.

I. Non-qualified Medicare Beneficiary (Non-QMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in

A.A.C. R9-29-101.

J. Out of Network Provider - A provider that is neither contracted with nor authorized by the Division to provide services to its members.

1. Qualified Medicare Beneficiary Dual (QMB Dual) - A person determined eligible under A.A.C. R9-29-101 et seq. for QMB and eligible for acute care services provided for in A.A.C. R9-22-201 et seq. or ALTCS services provided for in A.A.C. R9-28-201 et seq. A QMB dual person receiving both Medicare and Medicaid services and cost sharing assistance.

K. Qualified Medicare Beneficiary Only (QMB Only) - A person who qualifies to receive Medicare services only and cost-sharing assistance known as QMB.

L. Specified Low Income Medicare Beneficiary (SLMB) - Persons entitled to Medicare Part A whose incomes are between 100-120 per cent of the National Poverty Level. Medicaid also covers the beneficiary's Part B premium costs.

M. Supplemental Benefits - Benefits which may be offered by Medicare Advantage plans which are not traditionally covered under Medicare Parts A and B. These benefits may include, but are not limited to, preventative dental and standard vision benefits.

Remittance Advice

Remittance Advice explains the payment and any adjustments made to a payment during the adjudication of claims. The Division supplies a remittance advice document to the provider which provides the member identification number, member name, service code, Provider number, start date, end date, units, rate, payment amount, Third Party Liability (TPL) amount, and claim line identification. The remittance advice includes the formal claim dispute process and the correction/resubmission process for claims.

AHCCCS Prior Quarter Coverage Eligibility

Effective 1/1/2014, AHCCCS is required to expand the time period AHCCCS pays for covered services for an eligible individual, to include the three months prior to the month the individual applied for AHCCCS, if the individual met AHCCCCS eligibility requirements during the month when the Medicaid service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

A. Received one or more AHCCCS covered services during the month.

B. Would have qualified for AHCCCS at the time services were received if the person had applied for AHCCCS.

If the applicant is determined to qualify for AHCCCS covered services during any one or more of the three months prior to the month of application, then the individual will be determined to have "Prior Quarter Coverage" eligibility during those months. As a result, the AHCCCS will pay for AHCCCS covered services provided during those months.

AHCCCS will determine whether an applicant meets prior quarter coverage criteria. If the applicant

meets the prior quarter coverage criteria, providers will be required to bill the AHCCCS for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from the member of prior quarter coverage eligibility.

Upon notification of prior quarter coverage eligibility, A.A.C. R9-22-703 requires the provider to promptly refund to the member any payments that have been received for services in an approved prior quarter period and must accept payment by AHCCCS as payment in full.

Providers failing to reimburse a recipient for any payments made by the recipient will be referred to the AHCCCS Office of Inspector General (OIG) for investigation and action.

For covered services received during the prior quarter which have not yet been reimbursed or billed the provider must submit a claim to AHCCCS.

AHCCCS Managed Care Contractors, including the Division, are not responsible for determining prior quarter coverage or for payment for covered services received during the prior quarter. Claims submitted to Division Managed Care Contractors, including the Division, for prior quarter coverage will be denied.

Providers may submit prior quarter coverage claims for payment to AHCCCS in one of the following ways:

A. The HIPAA compliant 837 transaction

B. Through the AHCCCS on-line claim submission process

C. By submitting a paper claim form.

Billing requirements can be found at:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

All providers, including Regional Behavioral Health Authority (RBHA) and Tribal Regional Behavioral Health Authority (TRBHA) providers must submit a claim directly to AHCCCS. Pharmacy point of sale claims must be submitted to the AHCCCS Pharmacy Benefits Manager, OptumRx.

Prior Period Coverage for Division Member's

The Division provides Prior Period Coverage for the period of time prior to the Title XIX (Medicaid) member's enrollment with the Division during which time the member is eligible for covered services. Prior Period Coverage refers to the time frame from the effective date of AHCCCS eligibility (usually the first day of the month of application) until the date the member is enrolled with the Division. Once AHCCCS eligibility is approved, the Division receives notification from AHCCCS of the member's enrollment. Irrespective of the date of the member's enrollment with the Division, the Division is responsible for payment of all claims for medically necessary covered services, including behavioral health services and services provided by the Integrated RBHA, received during Prior Period Coverage. The Division will receive a Prior Period Coverage capitation for the cost of Prior Period Coverage.

Services received during Prior Period Coverage are paid by the Division. As mentioned above, the time period for Prior Period Coverage is from the effective date of AHCCCS eligibility until the date

of enrollment with the Division. For example, a member submits an AHCCCS application on April 15th, but the application is not approved for eligibility until sometime in May. The date the member is enrolled with the Division is shortly after the date of the eligibility determination approving AHCCCS coverage. The member's AHCCCS eligibility is retroactive to the first day of the month of application even though enrollment with the Division occurs at a later date. In this example, let's use May 10th as the date the member is enrolled with the Division; the member's AHCCCS eligibility is effective beginning April 1st. The Division is responsible for payment of AHCCCS medically necessary covered services retroactive to April 1st. However, the Prior Period Coverage time period is April 1st through May 9th

Hospital Presumptive Eligibility (HPE)

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

Enrollment for this process is temporary and members are enrolled in Presumptive Eligibility.

Presumptive Eligibility will cover health care services only through the dates of the decision. Presumptive Eligibility coverage is temporary and will stop on the end date determined on the decision unless a full AHCCCS application is submitted.

AHCCCS will pay for AHCCCS covered services provided during this period of enrollment from registered AHCCCS providers. Claims are submitted directly to AHCCCS.

Retro-Eligibility

Retro-eligibility affects a claim when no eligibility was entered in the Division's billing system for the date(s) of service but at a later date eligibility was posted retroactively to cover the date(s) of service.

FFS claims are considered timely if the initial claim is received by the Division not later than six months from the Division date of eligibility posting. Claims must attain clean claim status no later than 12 months from the Division date of eligibility posting.

Adjustments to paid claims must be received no later than 12 months from the date of eligibility posting. This time limit does not apply to adjustments which would decrease the original Division payment due to collections from third party payers.

Cost Sharing

This section defines the Division's cost sharing responsibilities for members that are Dual-Eligible Medicare Beneficiaries (Duals) receiving Medicare Parts A and/or B through Original Fee-For-Service (FFS) Medicare or a Medicare Advantage Plan. The purpose of this section is also to maximize cost avoidance efforts by the Division and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

A. For QMB Duals and Non-QMB Duals, the Division's cost sharing payment responsibilities are dependent upon various factors:

1. Whether the service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid

2. Whether the services are received in or out of network (The Division only has responsibility to make payments to AHCCCS registered providers)

3. Whether the services are emergency services, and/or

4. Whether the Division refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. Title 9, Chapter 29, Article 3.

An exception to the Division's cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the Division must pay 100% of the member cost sharing amount for any Medicare Part A Skilled Nursing Facility (SNF) days (21 through 100) even if the Division has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For the Division responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division Provider Manual, Chapter 57 - Third Party Liability.

B. QMB Duals

QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their Division Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C.R9-22-2 or A.A.C. R9-28-2 from a registered provider is not liable for any Medicare copayment, coinsurance or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

Division Payment Responsibilities

The Division is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this Policy. Refer to the Division's *Provider Policy Manual, Chapter 4 - Covered, and Non-Covered Services.* These services include:

- Chiropractic services for adults
- Outpatient occupational and speech therapy coverage for adults
- Orthotic devices for adults
- Cochlear implants for adults
- Services by a podiatrist
- Any services covered by or added to the Medicare program not covered by Medicaid.

A. The Division is prohibited from using the 09 coverage code to deny payment for medically necessary services to members who are both Medicare and Medicaid eligible. The 09 coverage code is used by AHCCCS to resolve coding discrepancies between Medicare and

Medicaid, and shall not be used to deny payment of claims.

B. The Division only has responsibility to make payments to AHCCCS registered providers.

C. The payment of Medicare cost sharing for QMB Duals must be provided regardless of whether the provider is in the Division's network or prior authorization has been obtained.

D. The Division must have no cost sharing obligation if the Medicare payment exceeds the Division's contracted rate for the services. The Division's liability for cost sharing plus the amount of Medicare's payment must not exceed DDD's contracted rate for the service. There is no cost sharing obligation if the Division has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing. The exception to these limits on payments as noted above is that the Division must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if DDD has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

E. In accordance with A.A.C. R9-29-302, unless the subcontract with the provider sets forth different terms, when the enrolled member (QMB Dual) receives services from an AHCCCS registered provider in or out of network the following applies (Table 1 and Figure 1):

Table 1: QMB DUALS	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST PAY:** *(Subject to the limits outlined in this Policy)*
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	The lesser of: **1.** The Medicare copay, coinsurance or deductible, **or** 2. The difference between the Division's contracted rate and the Medicare paid amount.

FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES **Services are covered by both Medicare and Medicaid** *Subject to the limits outlined in this Policy*			
	EXAMPLE 1 (b. In Table 1 above)	**EXAMPLE 2** (b. In Table 1 above)	**EXAMPLE 3** (b. In Table 1 above)
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100

Medicaid rate for Medicare service (The Division's contracted rate)	$100	$90	$90
Medicare deductible	$0	$0	$40
Medicare paid amount (80% of Medicare rate less deductible)	$80	$80	$40
Medicare coinsurance (20% of Medicare rate)	$20	$20	$20
THE DIVISION PAYS	**$20**	**$10**	**$50**

F. Non-QMB Duals

A Non-QMB Dual eligible member who receives covered services under 9 A.A.C. 22, Article 2 or 9, 9 A.A.C. 28, Article 2 from a provider within the Division's network is not liable for any Medicare copay, coinsurance or deductible associated with those services and is not liable for any balance of billed charges unless services have reached the limitations described within A.A.C. R9-22, Article 2. When the Non-QMB Dual Member elects to receive services out of network that are covered by both Medicare and Medicaid, the member is responsible for any Medicare copay, coinsurance or deductible unless the service is emergent, or, for non-emergency services, the provider has obtained the member's approval for payment as required in A.A.C. R9-22-702.

1. Division Payment Responsibilities (In Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services within the network of contracted providers and the service is covered up to the limitations described within A.A.C. R9-22-2, the member is not liable for any balance of billed charges and the following applies (Table 2):

Table 2: NON-QMB DUALS (IN NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST <u>NOT</u> PAY:**
Medicare Only	Medicare copay, coinsurance or deductible
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST PAY:** *Subject to the limits outlined in this Policy*
Medicaid Only	The provider in accordance with the contract

By both Medicare and Medicaid	The lesser of the following (unless the subcontract with the provider sets forth different terms): 1. The Medicare copay, coinsurance or deductible, **or** 2. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (The Division's contracted rate).

2. Division Payment Responsibilities (Out of Network)

In accordance with A.A.C. R9-29-303, when an enrolled member (Non-QMB Dual) receives services from a non-contracted provider the following applies (Table 3):

Table 3 NON-QMB DUALS (OUT OF NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION** *Subject to the limits outlined in this Policy*
Medicare Only	Has no responsibility for payment.
Medicaid only and the Division **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the Division has referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the Division **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
By both Medicare and Medicaid and the Division **has** referred the member to the provider or has authorized the provider to render services or the services are emergent	Must pay the lesser of: 1. The Medicare copay, coinsurance or deductible, **or** 2. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.

G. Prior Authorization

The Division can require prior authorization. If the Medicare provider determines that a service is medically necessary, the Division is responsible for Medicare cost sharing if the member is a QMB dual, even if the Division determines the service is not medically necessary. If Medicare denies a service for lack of medical necessity, the Division must apply its own criteria to determine medical necessity. If criteria support medical necessity, then the Division must cover the cost of the service for QMB Duals.

H. Part D Covered Drugs

For QMB and Non-QMB Duals, Federal and State laws prohibit the use of Medicaid monies to pay for cost sharing of Medicare Part D medications.

CHAPTER 17 PRIOR AUTHORIZATION REQUIREMENTS

REVISION DATE: 5/11/2022, 10/1/2021, 5/26/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR Part 457, 41 CFR Part 438, AHCCCS Medical Policy Manual (AMPM) - AMPM Chapter 300, Chapter, 400, Chapter 1020, Chapter 810, Chapter 820, DDD-0465A ALTCS Member handbook

PURPOSE

This chapter outlines the prior authorization (PA) process for members enrolled with one of the subcontracted health plans, receiving Home Community Based Services/Long Term Care Services, and members enrolled in the Tribal Health Program (THP).

DEFINITIONS

Home and Community Based Services (HCBS) are services that may be provided in a member's home, at an alternative residential setting or at other behavioral health alternative residential facilities licensed by the Arizona Department of Health Services and approved by AHCCCS.

Prior Authorization (PA) is a process that authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness and any applicable contract provisions.

POLICY

The Division of Developmental Disabilities (Division) adheres to the prior authorization guidelines and timelines specified in the AHCCCS Medical Policy Manual. The Division provides oversight of the prior authorization process done by the subcontracted health plans, including adherence to benefit coverage and timeliness of PA requests.

Prior Authorization (PA) is not a guarantee of payment as specified in A.A.C. R9-22-101.

Prior Authorization is not required for tribal members utilizing Indian Health Services (IHS)/638 Tribal providers and facilities. Non-IHS/638 providers or facilities rendering covered services shall obtain prior authorization.

The Division's Support Coordination and Health Care Services staff provide needed support to homeless clinics to identify available providers and assist in obtaining prior authorization to ensure timely delivery of services that are included in the Person-Centered Service Plan.

A. PRIOR AUTHORIZATION

1. Prior Authorization requirements are determined by AHCCCS, the Division, or the Division's subcontracted health plan. Prior authorization requirements should be confirmed on the AHCCCS, Division, or health plan website at the

time of request for services. Prior authorization may be required for following services:

a. Behavioral Health Residential Facility

b. Non-emergency Acute Inpatient Admissions

c. Level I Behavioral Health Inpatient Facility and RTC Admissions

d. Elective Hospitalizations

e. Elective Surgeries

f. Medical Equipment

g. Medical Supplies

h. Home Health

i. Home and Community Based Services

j. Hospice

k. Skilled Nursing Facility

l. Therapies - Rehabilitative/Habilitative

m. Routine medical and/or behavioral health services,

n. Nursing facility

o. Emergency alert system services

p. Rehabilitative/Habilitative Physical/Occupational Therapy for members twenty-one (21) years of age and older

q. Behavior Analysis

r. Augmentative and Alternative Communication (AAC) services, supplies, and accessories

s. Non-Emergency Transportation

t. Select Medications

2. Services that may not require Prior Authorization:

a. Services performed during a Retroactive Eligibility Period

b. When Medicare or other commercial insurance coverage is primary,

c. Emergency Medical Hospitalization < 72 hours

d. Emergency Admission to Behavioral Health Level 1 Inpatient facility, however, notification of the admission to the health plan must occur within 72 hours.

e. Some Diagnostic procedures, e.g., EKG, MRI, CT Scans, X-rays, Labs; check the member's health plan's prior authorization requirements.

f. Dental Care - emergency and non-emergency, check the member's health plan's prior authorization requirements.

g. Eyeglasses for members < 21 years old

h. Family Planning Services

i. Physician and/or Specialty Consultations and Office Visits

j. Prenatal Care

k. Emergency Transportation

l. Non-Emergency Transportation of less than 100 miles

B. SUBCONTRACTED HEALTH PLANS

The contact information for each subcontracted health plan is listed below:

1. Mercy Care

To check if services require an authorization: Online Prior Authorization Search Tool

To request an authorization, find out what services require authorization or check on the status of an authorization, please visit the provider secure web portal.

a. Websites

i. Prior Authorization: https://www.mercycareaz.org/providers/ddd-forproviders/priorauth

ii. Medication Requests:

1) https://www.mercycareaz.org/providers/ddd-forproviders/pharmacy
2) Helping People get the Medicine They Need | CoverMyMeds
3) Electronic Prior Authorization for Faster Approvals | Surescripts

b. Telephone numbers:

i. Toll Free: 1 (800) 624-3879

ii. 24- hour Nurse Line: 1 (800) 624-3879 or (602) 263-3000 option 2

iii. CoverMyMeds toll free: (866) 452-5017

iv. SureScripts toll free: (866) 797-3239

c. Fax number

i. Authorization requests may be faxed to 1-800-854-7614.

2. United Healthcare Community Plan

a. Website:

i. https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/az/prior-authorization/AZ-UHCCP-DD-Prior-Authorization-Effective-10.1.21.pdf

b. Telephone number:

i. 1-866-604-3267

C. HOME AND COMMUNITY BASED SERVICES (HCBS)

All HCBS Services require authorization by the Support Coordinator or District Nurse through the Person-Centered Service Planning process.

D. MEMBERS ENROLLED IN THE TRIBAL HEALTH PROGRAM (THP):

1. The AHCCCS/Division of Fee For Service Management (DFSM) manages the prior authorization process for the Tribal Health Program (THP). Prior authorization requirements can be located in AHCCCS Medical Policy Manual (AMPM) Chapter 820. Prior authorization requirements should be confirmed at the time of request for services.

   The following services may require prior authorization for a member of the Division who is enrolled with the THP:

a. Routine medical and/or behavioral health services,

a. Nursing facility

b. Emergency alert system services,

c. Rehabilitative/Habilitative Physical/Occupational Therapy for members twenty-one (21) years of age and older,

d. Behavior Analysis,

e. Augmentative and Alternative Communication (AAC) services, supplies, and accessories.

2. Contact information for Tribal Health Program

a. Address:

AHCCCS Division of Fee for Service Management, Care Management Systems Unit, Mail Drop 8900, 8801 East Jefferson, Phoenix, AZ 85034

b. Website:

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

c. Telephone numbers:

i. Toll Free In-state: 1 (800) 433-0425

ii. Toll Free Out of state: 1 (800) 523-0231

iii. Phoenix area: 1 (602) 417-4400

iv. Prescription Medications: OptumRx 1-855-577-6310

E. PRIOR AUTHORIZATION TIMELINES

1. Standard PA requests are completed within 14 calendar days of receipt of the PA request and as expeditiously as the member's condition requires, however the timeline can be extended 14 calendar days if insufficient medical documentation is received and it is in the best interest of the member.

2. Expedited PA requests are processed as expeditiously as the member's health condition requires but no later than 72 hours from the receipt of the PA request, regardless of whether the due date falls on a weekend or a legal holiday. The expedited authorization request must meet federal standards as a delay in processing could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function. If the PA request does not meet expedited criteria, the requesting provider will be notified and given the opportunity to provide additional clinical information to support the expedited request status. However, if the additional clinical information does

not support an expedited status the PA request will be downgraded to Standard and processed within the specified timelines.

3. All PA requests for Behavioral Health Residential Facilities shall be processed within the expedited timelines.

4. Medication PA requests are processed within 24 hours from the receipt of the request, regardless of the due date falling on a weekend or legal holiday. If the PA request lacks sufficient clinical information to render a decision, then a request for additional clinical information shall be sent to the provider no later than 24 hours after receipt of the original request. In these cases, the Pharmacy Benefit Manager (PBM) will issue a final decision no later than 7 working days from the initial receipt of the request. Members are allowed a 4-day supply of a covered outpatient prescription drug to be provided in emergent situations while PA decisions are being made.

5. Providers are offered the option to request a Peer to Peer discussion with a Division Medical Director when additional clinical information is requested or when the PA request is denied.

6. Providers are notified of the PA request decision determination via phone, secure email or fax and upon request.

CHAPTER 18 - MEDICAL CLAIMS REVIEW

REVISION DATES: 6/15/2022; 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 438.210(b); 42 CFR 455.410; 42 CFR 447.26; Fee-For-Service (FFS) Billing Manual Chapter 4; Division of Developmental Disabilities (Division) Provider Manual Chapter 12.

PURPOSE

The purpose of this policy is to outline the requirements for Medical Claims Review by the Division or its subcontracted Health Plans.

DEFINITIONS

1. "Clean Claim" means the same as in A.R.S. § 20-3101(2).
2. "Health Care Acquired Condition (HCAC)" means a condition occurring in any inpatient hospital setting that has negative consequences for the member.
3. "Other Provider Preventable Condition (OPPC)" means a condition occurring in any health care setting that has a negative consequence for the members.
4. "Prior Authorizations (PA)" means a process by which the Utilization team assesses in advance whether a service that

requires prior approval will be covered, based on the initial information received.

5. "Provider Preventable Condition (PPC)" means a condition that is defined by both "Other Provider Preventable Condition" and "Health Care Acquired Condition."
6. "Quality of Care (QOC)" means an expectation that, and the degree to which, the health care services provided to individuals and patient populations improve desired health outcomes and are consistent with current professionally recognized standards of care and service provision.

POLICY

A. MEDICAL REVIEW

1. The Division's Claims Department shall perform medical review:
   a. To determine if services are provided according to AHCCCS policy as it relates to medical necessity and emergency services; and
   b. To audit appropriateness, utilization, and quality of the service provided.
2. To perform the medical review, the Division may ask the providers to submit additional documentation.

3. The Division may 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.

B. MEDICAL REVIEW PROCESS

1. The Division shall ensure that medical claims are reviewed by health care professionals who have the clinical expertise and appropriate credentials to complete the review.
2. The medical claims review process for physical and behavioral health services paid for by the Divisions subcontracted health plans shall be completed by the Division's subcontracted Health Plans. [Please see the Health Plans' provider manual on the health plan website for more information.]

C. REQUIREMENTS

1. All claims shall meet the Division requirements for claims submission.
2. If no medical documentation is submitted after receiving a request from the Division, the adjudication staff shall deny the claim with a denial reason specifying what documentation is required. For example, a claim may be denied with the Medical Review denial code "MD008 - Resubmit with progress notes."

Providers shall not receive a letter requesting documentation because the denial codes are very specific as to what is required.

3. The Division may ask for additional information to complete the claims process.
4. Providers shall not submit the following unless specifically requested to do so:
   a. Emergency admission authorization forms
   b. Patient follow-up care instructions
   c. Nurses' notes
   d. Blank medical documentation forms
   e. Consents for treatment forms
   f. Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
   g. Ultrasound/X-ray films
   h. Medifax information
   i. Nursing care plans
   j. DRG/Coding forms
   k. Medical documentation on prior authorized procedures/hospital stays (Exception: claims that qualify for outlier payment.)

l. Entire medical records

D. DENIALS

1. Medical claims denials shall be sent to the Division Medical Director for review.
2. Provider Preventable Conditions Guidelines

   Title 42 CFR 447.26 prohibits payment for services related to Provider-Preventable conditions.

   a. If during the concurrent review process, an OPPC, HCAC, or PPC is discovered, a Quality of Care (QOC) shall be completed.

   b. The incident shall be reported to the Medical Director or designee and the claims department.

   c. The Division may not pay for services provided without prior authorization.

E. CLAIM SUBMISSION AND PROVIDER ENROLLMENT

Pursuant to the 42 CFR 455. 410 of the Affordable Care Act, the State Medicaid agency (AHCCCS) shall require all ordering or referring physicians, or other professionals providing services under the State plan or under a waiver of the plan, to be enrolled as participating providers. All providers, including, but not limited to out-of-state

providers, attending and servicing providers both within and outside of a hospital setting, and billing providers shall be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.

F. RECONCILING PAID CLAIMS

Payment information, including payment status, shall be provided by the Division. Providers shall review and reconcile the remittance advice payment information and accompanying payments.

G. TIME FRAME FOR INITIAL BILLING SUBMISSION AND RESUBMISSIONS

1. Claims for services rendered shall be received by the Division no later than six months after the date of service as indicated on the claim.
2. Claims shall be submitted within the specified time period from the date of service for the first submission to retain appeal rights, whether the Third Party Liability (TPL) insurance explanation of benefits has been received or not.
3. A resubmitted claim shall not be considered for payment unless it is received by the Division as a clean claim no later than 12 months after the date of service shown on the original claim.

a. Providers shall correct claim errors and resubmit claims to the Division for processing within the 12-month time period from the date of service.

b. FFS providers shall reconcile denied claims based on the Provider Remittance Advice.

CHAPTER 19 CONCURRENT REVIEW

REVISION DATE: 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 447.26, AMPM Chapter 1000

The concurrent review process used by the Division of Developmental Disabilities (Division) includes utilization management activities that occur during an inpatient level of care (physical and behavioral health), rehabilitative level of care, or a skilled nursing facility level of care. The Division's subcontracted acute care health plans perform their concurrent review utilization management activities for Division members enrolled with their health plan during an inpatient level of care, skilled nursing level of care, or home health care services.

Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided, and it supports the health care provider in coordinating a member's care across the continuum of health care services. Concurrent review decisions are reviews for the extension of previously approved ongoing care.

The concurrent review process includes:

- Obtaining necessary clinical information from facility staff, practitioners and providers
- Using the clinical information provided by facility staff, practitioners and providers to determine benefits coverage
- Notifying facility staff, practitioners and providers of coverage determinations in the appropriate manner and time frame
- Identifying discharge planning needs at the beginning of the inpatient stay and reassessing these needs throughout the stay
- Identifying and referring potential quality of care concerns and patient safety events for additional review
- Identifying members for referral to specialty programs, including specific case management and disease management, behavioral health, and women's health programs.

Concurrent review may be conducted by phone, fax or, as applicable, on-site at the facility where care is delivered.

The Division utilizes InterQual evidence-based criteria in the concurrent review process. These criteria for concurrent review validate the medical necessity for admission and continued stay, and they evaluate quality of care.

The Division prohibits payment for Provider-Preventable Conditions that meet the definition of a Healthcare-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC) that may be identified during the concurrent review process (refer to 42 CFR 447.26 or the AMPM Chapter 1000). If an HCAC or OPPC is identified, the Division will report the occurrence to AHCCCS and conduct a quality of care investigation.

Chapter 20 FRAUD, WASTE, AND ABUSE

REVISION DATE: 3/9/22, 10/1/2019, 4/8/2019, 5/26/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: May 19, 2013
REFERENCES: 42 CFR 455.2; A.R.S. §§ 46-451 and 13-3623

PURPOSE

The Division of Developmental Disabilities (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 (FWA). This policy defines FWA and describes procedures for the prevention and detection of FWA, delineates reporting requirements for FWA, describes provider training requirements for FWA, and specifies FWA policy requirements for providers.

DEFINITIONS

1. "Abuse" means the 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 which are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program as specified in 42 CFR 455.2.

2. "Code of Federal Regulations (CFR)" means the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

3. "Claim" means Under the False Claims Act (FCA), the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

4. "Deficit Reduction Act (DRA)" means the DRA of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes annual Medicaid payments, under the State plan, of at least $5 million shall implement written policies for its

employees, management, contractors, and agents regarding the FCA.

5. "False Claims Act (FCA)" means the FCA, also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs. It is the Federal Government's primary litigation tool in combating fraud against the Government. The law includes a qui tam provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing" especially when the relator is employed by the organization accused in the suit).

6. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable Federal or state law. (42 CFR 455.2)

    a. An act of fraud has been committed when a member or provider:

b. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

c. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

d. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

e. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government

7. "Internal Audit Administration (IAA)" means a functional administration within the Department of Economic Security (DES), Office of Inspector General (OIG); Internal Audit Administration (IAA) conducts performance audits of agency systems and programs, and compliance audits of contractors to identify risk, recommend corrective actions to prevent or mitigate issues, recoup improper payments, and assess compliance with laws, regulations, and standards. In addition to

identifying factors inhibiting performance, IAA audits assist in evaluating the effectiveness of programs, activities, and functions; determining whether measures of program effectiveness are valid and reliable; and assessing whether management has considered alternatives that might increase the likelihood of achieving desired results or improve the efficiency or effectiveness of strategies and solutions. The authority to conduct audits of its contracts and subcontracts is derived directly from the Arizona Revised Statute A.R.S. § 35-214.

8. "Prevention" means to keep something from happening.

9. "Provider" means a person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers shall meet the specific qualifications outlined in the Division's Policy Manuals. All providers of Arizona Long Term Care System (ALTCS) services shall be registered with the Arizona Health Care Cost System (AHCCCS). Health Plans under contract with the Division are responsible for credentialing acute care providers.

10. "Waste" means as defined by AHCCCS, the overutilization of services, or other practices that, directly or indirectly, result in

unnecessary costs to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

POLICY

A. Prevention and Detection

The Division is committed to fostering a culture of compliance which is conducive to preventing and detecting fraud, waste, and abuse by requiring its providers, agents, and subcontractors to provide ongoing training to their employees, and to become knowledgeable about their role in reporting concerns and problems in relation to fraud, waste, and abuse. All providers, agents, and subcontractors are required to report any concerns relating to potential fraud, waste, and abuse, including false claims. This responsibility is intended to allow the Division to monitor and do improvement planning pertaining to false claims processing or other aspects of Corporate Compliance. Any provider, agent, or subcontractor who fails to report properly either through their internal lines of communication, the Division, or to AHCCCS OIG, when that person knows of conduct constituting a violation of the FCA or any other related legal provision in the

Division's Corporate Compliance program, they will be subject to contract action.

As part of the Division's Compliance Program objectives to detect, prevent and remedy potential, incidents of fraud, waste, and abuse, it is the policy of the Division that all providers, agents, and subcontractors, in particular those involved in the provision of services or arranging for the provision of services under government programs including members and providers, to report matters which involve potential violations of this policy. Reports may be made anonymously; the person doing the reporting may request confidentiality and will be protected from any retaliatory action.

B. Division Monitoring

The Division:

1. Reviews all participating providers during the credentialing/certification process (including re-credentialing)
2. Monitors providers for non-compliance with Division contracts, rules, policies, and procedures, in addition to AHCCCS policies.
3. Verifies as part of Prior Authorization (PA):

a. Member eligibility

b. Medical necessity

c. Appropriateness of service being authorized

d. Service being requested is a covered service

e. An appropriate provider referral.

The Division's electronic claims processing application executes over 150 pre-payment edits ensuring payment accuracy and guarding against fraud, waste, 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 IAA, conducts post-payment reviews. The Division Post Payment Review guidelines are consistent with statewide standard uniform procedures used to identify, review and correct billing discrepancies. These reviews look retrospectively at a sample of paid claims to ensure provider internal controls are in place. These Include the review of provider files, such as timesheets, to ensure proper documentation. The Division may refer billing discrepancies to other entities for further action. In cooperation with

other program integrity sources, the Division, at all levels, is committed to preventing and detecting overpayments resulting in the recoupment of monies due to billing discrepancies.

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, the incidence of fraud, waste, and/or abuse is suspected or discovered, the matter is referred to the Division's Corporate Compliance Unit for review and potential referral to the AHCCCS OIG.

C. Provider Requirements

1. Training and Education

   As a condition for receiving payments, providers shall establish written policies, and ensure adequate training and ongoing education for all of its employees (including management), members, and any subcontractors and/or agents of the Provider regarding the following:

   a. Detailed information about the Federal False Claims Act,

b. The administrative remedies for false claims and statements,

c. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and

d. The whistleblower protections under such laws.

2. Reporting Fraud, Waste and Abuse

When a provider becomes aware of an incident of potential/suspected fraud, waste, or abuse, the provider shall report the incident to the Division within one business day of becoming aware of the incident.

D. Fraud Contact Information

To report suspected fraud, waste, or abuse of the program, the provider shall make contact with one of the following:

1. DDD Corporate Compliance Unit

a. Phone: 1-877-822-5799.

b. Online:

https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

c. Email: DDDFWA@azdes.gov

d. Or Write to:

e. DES/DDD

Attn: Corporate Compliance Unit

1789 W. Jefferson Street

Phoenix, AZ 85007

2. AHCCCS OIG Fraud Prevention Unit

a. Phone: 602-417-4193

b. Online:

https://azahcccs.gov/Fraud/ReportFraud/onlineform.aspx

3. Provider Fraud:

a. Maricopa County: 602-417-4045

b. Outside Maricopa County: 1-888-487-6686

4. Member Fraud:

a. Maricopa County: 602-417-4193

b. Outside Maricopa County: 1-888-487-6686

5. General Questions:

a. Email: AHCCCSFraud@azahcccs.gov

CHAPTER 21 - FALSE CLAIMS ACT

REVISION DATE: 10/1/2019, 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Public Law 101-12 (Whistleblower Protection Act), Public Law 109-171 (Deficit Reduction Act of 2005); 31 U.S.C. 3729-3733 (False Claims Act)

Overview

This policy provides an overview of key provisions of the False Claims Act (FCA) and related legal requirements as required by the Deficit Reduction Act of 2005 (DRA) for the Division of Developmental Disabilities (Division). This policy defines fraud and describes the expectations for prevention, detection, and reporting of fraud, false claims, and abuse by providers, agents and subcontractors.

Policy Objectives

A. Delineate the False Claims Act

B. Explain the Deficit Reduction Act of 2005

C. Prevent or detect fraud, waste and abuse

D. Describe training requirements

E. Specify policy requirements for providers, agents and subcontractors

Definitions

A. Abuse – Per 42 CFR 455.2, *Abuse* means 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 that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

B. Code of Federal Regulations (CFR) - is the codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

C. Claim – Under the False Claims Act (FCA), the definition of "claim" includes any request or demand, whether under contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient if the United States government provides any portion of the money or property which is requested or demanded, or if the government will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

D. Deficit Reduction Act (DRA) –The DRA of 2005 is a United States Act of Congress concerning the budget. It addresses deficit reductions ranging from education to housing and Medicare to Medicaid. In addition, any entity that receives or makes

annual Medicaid payments, under the State plan, of at least $5 million must implement written policies for its employees, management, contractors and agents regarding the False Claims Act.

E. False Claims Act (FCA) - The FCA, also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs. It is the Federal Government's primary litigation tool in combating fraud against the Government. The law includes a *qui tam* provision that allows people who are not affiliated with the government, called "relators" under the law, to file actions on behalf of the government (informally called "whistleblowing" especially when the relator is employed by the organization accused in the suit).

F. Fraud - "An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or another person. It includes any act that constitutes fraud under applicable Federal or state law." (42 CFR 455.2)

An act of fraud has been committed when a member or provider:

a. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.

b. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.

c. Conspires with others to get a false or fraudulent claim paid by the Federal Government.

d. Knowingly uses (or causes to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money to transmit property to the Federal Government

G. Potential - Based on one's professional judgment, it appears as if an incident of fraud and abuse may have occurred. The standard of professional judgment used would be that judgment exercised by a reasonable and prudent person acting in a similar capacity.

H. Prevention - Keep something from happening.

I. Provider - A person, entity or employee of an entity that subcontracts with the Division for the delivery of services to members. All providers must meet the specific qualifications outlined in the Division's Policy Manuals. All providers of Arizona Long Term Care System (ALTCS) services must be registered with the Arizona Health Care Cost System (AHCCCS). Health Plans under contract with the Division are responsible for credentialing acute care providers.

J. Waste - As defined by (AHCCCS), the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuses of resources.

The Deficit Reduction Act of 2005

The DRA of 2005 imposes the following requirements on any entity that receives or makes at least $5,000,000 annually:

A. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the FCA as established under Title 31 of United States Code, to include administrative remedies for false claims and statements, and any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs.

B. Provide detailed written policies and procedures for detecting and preventing fraud, waste and abuse.

C. Include in any employee handbook for the entity, a specific discussion of the FCA and Whistleblower Protection Act, to include, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award, the person must file a "qui tam" lawsuit. An award is only issued if, and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

The "whistle blower" is protected under the FCA. Any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

False Claims Act

The FCA covers fraud involving any federally funded contract or program, with the exception of tax fraud. Liability for violating the FCA is equal to three times the dollar amount that the government is defrauded and civil penalties of $5,500 to $11,000 for each false claim.

An individual can receive an award for "blowing the whistle" under the FCA. In order to receive an award, the person must file a "qui tam" lawsuit. An award is only issued if,

and after, the government recovers money from the defendant as a result of the lawsuit.

The amount of the award is generally between 15 and 30 percent of the total amount recovered from the defendant, whether through a favorable judgment or settlement. The amount of the award depends, in part, upon the government's participation in the suit and the extent to which the person substantially contributed to the prosecution of the action.

As the "whistle blower" is protected under the FCA, the FCA and related law commits that no person will be subject to retaliatory action as a result of their reporting of credible misconduct. Pursuant to the Division's commitment to compliance with the relevant FCA and other applicable laws, no employee can be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the provider, agent or subcontractor solely because of actions taken to report potential fraud, waste and abuse, or other lawful acts by the employee in connection with internal reporting of compliance issues or an action filed or to be filed under the FCA.

Training

As a condition for receiving payments, the providers must establish written policies, and must ensure adequate training and ongoing education for, all of its employees (including management), members, and of any subcontractors and/or agents of the Provider regarding the following:

A. Detailed information about the Federal False Claims Act,

B. The administrative remedies for false claims and statements,

C. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and

D. The whistleblower protections under such laws.

CHAPTER 22 PHARMACY SERVICES

REVISION DATE: 1/3/2024, 5/11/2022, 7/1/2020, 3/7/2018, 5/26/2017, 6/17/2016, 4/16/2014
REVIEW DATE: 10/27/2023
EFFECTIVE DATE: March 29, 2013
REFERENCES: A.R.S.§ 36-551; AAC R9-21-206.01; AMPM 310-FF; AMPM 310V; AMPM 1024; ACOM 414; 2018 Arizona Opioid Prescribing Guidelines.

PURPOSE

This manual explains how pharmacy services are administered by the Division and the Administrative Services Subcontractors (AdSS) for Division Members and by the Prescription Benefit Manager (PBM) for Tribal Health Plan (THP) Members.

DEFINITIONS

1. "Member" means the same as "client" as defined in A.R.S. § 36-551.

2. "Non-Preferred Drug" means a medication that is not listed on the AHCCCS Drug List. Non-Preferred Drugs require Prior Authorization (PA).

3. "Preferred Drug List" or "PDL" means a list of all the preferred

medications covered by the Division and the AdSS.

SUPPLEMENTAL INFORMATION

Preferred Drug List (PDL)

1. Any Arizona Health Care Cost Containment System (AHCCCS) healthcare provider may prescribe prescription drugs and over-the-counter medications listed on the Preferred Drug List PDL.

2. Prescriptions issued by prescribers should allow for generic substitution, whenever possible for cost effectiveness.

3. The Administrative Services Subcontractors (AdSS) may cover more drugs than are listed but not less than what is listed on the AHCCCS PDL.

4. When the AdSS receives PDL updates from AHCCCS, the updates are reviewed and sent to the Pharmacy Benefits Manager (PBM) for Members enrolled with the AdSS or to OptumRx for Members enrolled in the Tribal Health Program (THP).

5. When the AdSS receives PDL updates from AHCCCS, the

AdSS will post updates to PDL on their websites.

6. Requests for a hard copy of the PDL shall be submitted to the AdSS Customer Service for Division Members or to AHCCCS Customer Service for THP Members.

7. Updates to the PDL are communicated via the AdSS pharmacy and provider newsletters or on the AdSS websites monthly. The updates for Mercy Care Arizona can be found on their website under the provider section, pharmacy services. The updates for United Health Care Community Plan (UHCCP) can be found on their website under plan documents.

8. For medications that are not listed on the PDL, the prescriber must submit the Prior Authorization (PA) request to the AdSS for Division Members or PBM for THP members.

9. The pharmacy benefit shall cover medications, including prescription and Over The Counter (OTC) medications when prescribed by an AHCCCS-registered health care practitioner.

10. Members who are enrolled in the THP may utilize any of the

following network pharmacies to receive their medications:

a. Indian Health Service (IHS) facilities,

b. 638 Tribal Facilities, or

c. Pharmacies that are part of the OptumRx pharmacy network.

Prior Authorization (PA)

1. Some medications require PA or are Non-Preferred. This means the health care practitioner is required to submit documentation or medical records explaining why the medication is medically necessary or why the Member cannot take medication on the PDL.

2. PA requests must be reviewed within 24 hours and if additional information is required, a decision must be rendered within 7 days. A Notice of Adverse Benefit Determination must be mailed to the Member within 3 days. The prescriber will receive a fax of the decision within 24 hours.

3. The AdSS may have PA requests submitted by submitting the request electronically or via fax. The form and information can be found on the AdSS' website.

4. The use of Long-acting opioids requires PA for Members. Per the Arizona Opioid Prescribing Guidelines, providers prescribing long-acting opioids, must document informed consent indicating they have discussed with the Member the risks, and options, and place the documentation in the Member's health record.

Pharmacy Network

Medications may only be filled at AHCCCS registered pharmacies and pharmacies that are part of the AdSS' pharmacy network. Providers may access this information on the AdSS' website under "Find a provider or pharmacy".

Prescriber Monitoring and Education

1. The AdSS monitors the prescribing and dispensing of opioids,

antipsychotics, muscle relaxants, benzodiazepines, sedative hypnotic and stimulant medications for Members enrolled in their plans.

2. Members that are identified as "at risk" may be placed under the exclusive provider or pharmacy program or both.

3. The AdSS will monitor opioid prescribing patterns for concomitant use with benzodiazepine, buprenorphine, or antipsychotics.

4. For Members being prescribed antipsychotic medications, providers must obtain informed consent and place that information in the Member's health record.

Signature of Chief Medical Officer: Anthony Dekker (Dec 29, 2023 15:48 EST)
Anthony Dekker, D.O.

CHAPTER 23 APPOINTMENT STANDARDS

REVISION DATES: 6/15/2022, 1/16/2019, 5/13/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 438.206, ACOM 415, ACOM 417

PURPOSE

This policy provides information for qualified vendors on AHCCCS appointment accessibility and availability standards for physical and behavioral health services. This policy also provides timeliness and access to care requirements for qualified vendors who provide in-home care services.

DEFINITIONS

1. "Appointment" - means a scheduled day and time for an individual to be evaluated, treated, or receive a service by a healthcare professional or service provider in provider and service categories identified below.

2. "Emergency Appointment" - means an appointment that is scheduled the same day or within 24 hours of the member's phone call or other

notification, or as medically appropriate.

3. "Urgent Care Appointment" - means an appointment for medically necessary services to prevent deterioration of health following the acute onset of an illness, injury, condition, or exacerbation of symptoms.

POLICY

Providers shall adhere to all requirements as specified in Qualified Vendor Agreement, Policy, 42 CFR Part 438. The Division shall monitor and report appointment accessibility and availability to ensure compliance with Division standards set forth in the Qualified Vendor Agreement, Division Operations Manual Policy 415 (Provider Network Development and Management Plan Periodic; Network Reporting Requirements) and Division Operations Manual Policy 417 (Appointment Availability, Monitoring and Reporting) and 42 CFR 438.206.

A. General Appointment Standards

1. Appointment Scheduling

   a. For Primary Care Provider (PCP) appointments, members must be provided:

      i. Emergency appointments the same day or within 24 hours of the member's phone call or other notification,

or as medically appropriate.

ii. Urgent care appointments as quickly and efficiently as the member's health condition requires but no later than two business days of the request.

iii. Routine care appointments within 21 calendar days of the request.

b. For specialty provider appointments, members must be provided:

i. Emergency appointments within 24 hours of referral.

ii. Urgent care appointments as quickly and efficiently as the member's health condition requires but no later than two business days from the request.

iii. Routine care appointments within 45 days of referral.

c. For behavioral health services appointments, members must be provided:

i. Urgent need appointments as quickly and efficiently as the member's health condition requires but no later than 24 hours from identification of need.

ii. Routine care appointments, members must be provided:

- Initial assessment within seven calendar days of referral or the request for service.
- The first behavioral health service follows the initial assessment as quickly and efficiently as the member's health condition requires but:
  - For members aged 18 years or older, no later than 23 calendar days after the initial assessment.
  - For members under the age of 18 old, no later than 21 days after the initial assessment.

iii. All subsequent behavioral health services as quickly and efficiently as the member's health condition requires but no later than 45 calendar days from identification of need.

d. For psychotropic medication appointments, members must be provided:

i. The urgency of the need is assessed immediately.

i. If clinically indicated, an appointment is provided with a Behavioral Health Medical Professional within a timeframe that ensures the member does not:

- Run out of needed medications.
- Decline in his/her behavioral health condition before starting medication, but no later than 30 calendar days from the identification of need.

e. For dental appointments, members must be provided:

i. Emergency appointments within 24 hours.

ii. Urgent appointments as quickly and efficiently as the member's health condition requires but no later than three business days of the request.

iii. Routine care appointments within 45 calendar days of the request.

f. For maternity care appointments, members must be provided initial prenatal care appointments:

i. In the first trimester, within 14 calendar days of the request.

ii. In the second trimester, within seven calendar days of the request.

iii. In the third trimester, within three business days of

the request.

iv. High risk pregnancies as quickly and efficiently as the

v. a member's health condition requires, and no later than three business days of identification of high risk by the AdSS or maternity care provider, or immediately if an emergency exists.

2. Transportation

For medically necessary, non-emergent care, transportation must be scheduled so the member:

a. Arrives on time but no sooner than 20 minutes before the appointment.

b. Is not picked up prior to the completion of the appointment.

c. Is not required to wait more than 20 minutes after the conclusion of the appointment for transportation home.

B. In Home Care Services

Provision of In-Home Care Services. Qualified Vendors shall provide In Home Care Services:

a. For existing members within 14 calendar days following assignment of the authorization.

b. For newly eligible members within 30 calendar days following assignment of the authorization.

C. Electronic Visit Verification (EVV)

The Division is using EVV to help ensure, track, and monitor timely service delivery and access to care for members. The list of provider types and services that are mandated to use EVV can be found on the AHCCCS website and includes but is not limited to Attendant Care, Habilitation Nursing, Homemaker, and Respite. See Chapter 62 Electronic Visit Verification for additional information. Refer to AMPM 540 for additional information regarding EVV.

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: 1/16/2019, 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 844-770-9500.

CHAPTER 26 CULTURAL COMPETENCY AND MEMBER AND FAMILY CENTERED CARE

REVISION DATE: 07/26/2023, 9/22/2021, 7/28/2021, 6/10/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: Civil Rights Act of 1964 Public Law § 88-352, 45 CFR 92.4, 42 CFR 438.206(C)(2); ACOM 405.

PURPOSE

This policy defines the Division of Developmental Disabilities (Division) requirements for contracted Qualified Vendors to provide service in a Culturally Competent manner.

DEFINITIONS

1. "Competent" means for the purpose of this policy properly or well qualified and capable.
2. "Culture" means the integrated pattern of human behavior that includes language, thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group. Culture defines the preferred ways for meeting

needs and may be influenced by factors such as geographic location, lifestyle, and age.

3. "Cultural Competency" means, for the purpose of this policy at the interpersonal level, to acknowledge and understand the influence of cultural history, life experiences, language differences; values and disabilities have on individuals and families. At the organizational level, cultural competency means to have policies, procedures, standards, and training to support development of a cultural competence of the workforce.
4. "Disability Etiquette" means for the purpose of this policy, respectful ways to communicate with and about people with disabilities. An organization with a positive workplace Culture in terms of Disability Etiquette fosters opportunities for members of the workforce to develop basic understanding and ongoing opportunities to learn and refresh their knowledge.
5. "Family-Centered" means care that recognizes and respects the pivotal role of the family in the lives of Members. It supports families in their natural care-giving roles, promotes normal

patterns of living, and ensures family collaboration and choice in the provision of services to the Member. When appropriate, the Member directs the involvement of the family to ensure person-centered care.

6. "Interpretation" for the purpose of this policy means the act of verbally conveying the content and spirit of the original message, taking into consideration the cultural context.
7. "Language Assistance Service" means services including, but not limited to:
    a. Oral language assistance, including Interpretation in non-English languages provided in the following manner but not limited to:
        i. In-person by Qualified Interpreters,
        ii. Over the phone by Qualified Interpreters,
        iii. Video Remote Interpreting (VRI) by a Qualified Interpreter, or

iv. Use of qualified bilingual or multilingual staff to communicate directly with individuals with Limited English Proficiency.

b. Written Translation, performed by a Qualified Translator, of written content in paper or electronic form into languages to and from English; and

c. Taglines.

8. "Limited English Proficiency (LEP)" means for purposes of this Policy, individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

9. "Linguistic Need" means for the purposes of this Policy, the necessity of providing services in the Member's primary or preferred language, including sign language, and the provision of Interpretation and Translation services.

10. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

11. "Prevalent Non-English Language" means a language determined to be spoken by a significant number or percentage of Members who have a Limited English Proficiency, for the purpose of this policy include Spanish, and Navajo.
12. "Person First Language" means communication that emphasizes the individuality, equality and dignity of a person with disabilities in an effort to convey respect by emphasizing that disability is only one aspect of an individual.
13. "Qualified Interpreter" means, for the purpose of this policy, an interpreter who via over the phone, video remote interpreting (VRI) service, or an on-site appearance:
    a. Adheres to generally accepted interpreter ethical principles and standards of practice, including client confidentiality,
    b. Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness, and

c. Has demonstrated proficiency in speaking and understanding both spoken English and at least one other language.

14. "Qualified Translator" means for the purpose of this policy, a translator who:

a. Adheres to generally accepted translator ethic principles and standards of practice, including client confidentiality;

b. Has demonstrated proficiency in writing and understanding both written English and at least one other written non-English language; and

c. Is able to translate effectively, accurately, and impartially to and from such languages and English, using any necessary specialized vocabulary, terminology and phraseology, considering cultural appropriateness.

15. "Support Coordinator" means the same as "Case Manager" under A.R.S. § 36-551.

16. "Translation" for the purpose of this policy means the conversion of written communication, while taking into consideration the

cultural context, content and spirit of the message, while maintaining the original intent.

POLICY

A. CULTURAL COMPETENCY PLAN

1. Qualified Vendors shall have a comprehensive Cultural Competency Plan (CCP) that is inclusive of those with Limited English Proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, race, color, national origin, age, and regardless of sex, gender, sexual orientation, or gender identity. This policy defines the requirements for Qualified Vendors to provide services in a Culturally Competent manner,
2. Qualified Vendors shall provide culturally competent services including the use of:
    a. Disability Etiquette and Person First Language when supporting individuals who have disabilities.
    b. Establishing an effective communication strategy when considering acceptance of a referral.

c. Taking reasonable steps to meaningful access to service for individuals with LEP.

d. Providing written information in Prevalent Non-English Languages in its particular service area.

e. Providing Interpretation services at no charge for all non-English languages, not just those identified as prevalent.

B. INTERPRETATION AND TRANSLATION SERVICES

1. Qualified Vendors shall provide Translation and Interpretation services that are accurate, timely, and that protect the privacy and independence of the individual with LEP.
2. The Qualified Vendor shall provide Translation services through a Qualified Translator, and Interpretation services shall be provided by a Qualified Interpreter.
3. The Qualified Vendor shall always, first offer and encourage use of Qualified Interpreter services. Members are permitted to use an adult accompanying the Member with LEP for Interpretation in the following situations:

a. When danger is imminent or there is a threat to the welfare or safety of the Member, and no Qualified Interpreter is immediately available.

b. After receiving an offer and recommendation to use a Qualified Interpreter:

   i. The Member with LEP requests the accompanying adult to interpret or facilitate the communication,

   ii. The accompanying adult agrees to provide communication assistance; and

   iii. Reliance on the accompanying adult for assistance is reasonable under the circumstances.

c. Qualified Vendor workforce shall advocate for use of qualified Interpretation services when an adult accompanying the Member is providing communication assistance and:

   i. There is a concern that the Interpretation is not accurate; or

ii. The content of the conversation is potentially inappropriate to be shared or provided with the accompanying adult.

4. Qualified Vendors shall only rely upon minor children for Interpretation assistance:
   a. In an urgent emergency situation when danger is imminent, or there is a threat to the welfare or safety of the Member, and there is no Qualified Interpreter immediately available.
   b. The Qualified Vendor shall follow up with a Qualified Interpreter to verify information after the emergency is over.
5. Qualified Vendor workforce shall not rely upon an accompanying adult or child to provide Translation of any documents to and from English to another language; documents shall only be translated by a Qualified Translator.
6. Qualified Vendors shall use licensed interpreters for the Deaf and the Hard of Hearing and provide auxiliary aids or licensed sign

language interpreters that meet the needs of the Member upon request.

a. Auxiliary aids include but are not limited to:
    i. Computer-aided transcriptions,
    ii. Written materials,
    iii. Assistive listening devices or systems,
    iv. Closed and open captioning; and
    v. Other effective methods of making aurally delivered materials available to persons with hearing loss.

b. The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed American Sign Language (ASL) interpreters, information on auxiliary aids, and the complete rules and regulations regarding the profession of ASL interpreters in the State of Arizona.

c. The Division’s website lists agencies that provide interpreting services that Qualified Vendors can contract to provide language services to Members who speak other languages or use sign language.

7. The Division shall identify Members requiring language support through service planning, vendor call, and service identification processes.

8 Qualified Vendors, after reviewing and accepting an authorization for a Member, shall ensure the Member has access to all services and communication with the Qualified Vendor, from the initial contact through the conclusion of services provided to the Member, in the Member's language, this can be accomplished through:

   a. Identifying Members of their workforce who speak the primary language of the Member, or
   b. Utilizing Qualified Interpreters who are a part of the Qualified Vendor's workforce, or
   c. Providing language accessibility through a subcontracted Qualified Interpreter who communicates in the Member's language, including American Sign Language.

9. Qualified Vendors may be reimbursed by the Division for subcontracting Qualified Interpreting services for non-prevalent languages.
    a. The Division does not reimburse for Interpretation of prevalent languages which are English, Spanish, or Navajo.
    b. Qualified Vendors must bill separately through the claims submission process and by utilizing the Division's Rate Book.

C. CULTURAL COMPETENCY PLAN

Qualified Vendors shall develop and maintain a Cultural Competency Plan which includes:

1. A method to provide Interpretation and Translation services to Members who need them,
2. A method to notify Members with LEP about the availability of language assistance at no cost,
3. A plan to recruit staff who speak languages other than English,
4. A description of staff training on Cultural Competency and how to apply the training when supporting Members,

5. A method to obtain feedback from Members and families to ensure their cultural and individual needs and preferences are respected.
6. Policies which the vendors use to implement the plan must be made available to members.

D. FAMILY-CENTERED AND CULTURALLY COMPETENT CARE

Qualified Vendors shall provide Member, Family-Centered, and Culturally Competent care in all aspects of the service. Member and Family-Centered care includes:

1. Recognizing the family as the primary source of support for the Member's health care decision-making process. Service systems and personnel shall be made available to support the Member and family's role as decision makers.
2. Promoting a complete exchange of unbiased information between Members, families, and health care professionals in a supportive manner at all times.

3. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families.
4. Implementing practices and policies that support the needs of Members and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs.
5. Participating in Member and Family-Centered Cultural Competence Trainings.
6. Encouraging Member-to-Member and family-to-family support and networking.
7. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family.
8. Acknowledging that families are essential to the Members' health and wellbeing and are crucial allies for quality within the service delivery system.

9. Appreciating and recognizing the unique nature of each Member and their family.

E. SUPPLEMENTAL INFORMATION

The Division of Developmental Disabilities (Division) promotes a Culture of respect and dignity when supporting individuals who have developmental disabilities and their families. The Division values a Competent, diverse provider network capable of effectively addressing the needs and preferences of its culturally and linguistically diverse Members. The Division acts in accordance with contractual obligations and state and federal codes and laws, including the Civil Rights Act of 1964 Public Law § 88-352 which prohibits discrimination in government agencies.

27 PEER REVIEW AND INTER-RATER RELIABILITY

REVISION DATE: 3/22/2023, 7/13/2022, 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Division Medical Manual Policies 910, 950, 960, 970, 980 and 1020, Administrative Services Subcontractors Medical Manual Policies 910, 950, 960, 970, 980 and 1020

PURPOSE

This chapter describes the process and the activities in the Peer Review and Inter-Rater Reliability process of the Division of Developmental Disabilities (Division), as they relate to the improvement of healthcare quality, performance, effectiveness and efficiency of members' care.

DEFINITIONS

1. "Inter-Rater Reliability" means the degree of agreement among individuals who make decisions using the same standardized criteria.
2. "Peer Review" means the objective evaluation of the quality of a physician's performance by colleagues in order to ensure that prevailing standards of care are being met.

POLICY

A. A provider may dispute findings or recommendations that could include an action that affects the provider's credentials or contract with the Division.

B. The provider has 30 days to request reconsideration in writing and submit evidence that supports the provider's position to the Division's Chief Medical Officer (CMO). The CMO will review the reconsideration request and respond, in writing, to the provider.

C. If the provider is still not in agreement, the provider may request a second-level review by the DES/DDD Assistant Director. The DES/DDD Assistant Director's recommendation on the dispute will be considered final. The provider will be notified, in writing, of the outcome.

SUPPLEMENTAL INFORMATION

A. PEER REVIEW

The Division has procedures to ensure the Peer Review process evaluates the necessity, quality of care, and use of services provided by a health care provider. All information used in the Peer Review process is kept confidential and is not discussed outside of the Peer Review process, except for implementing recommendations made by

the Peer Review Committee.Confidentiality statements will be signed by all committee members prior to each scheduled meeting and are maintained by the Division. The Division delegates physical and behavioral health services to the subcontracted health plans but retains oversight of their Peer Review process pertaining to services rendered by their network. Both the Division and the subcontracted health plans ensure any actions recommended by the Peer Review Committee allow for state fair hearing rights and appeals to the affected provider. The process includes information on the state fair hearing process, appeals, timeframes requirements, and the availability of assistance with the process. Peer Review is conducted by health care professionals/providers from the same discipline as the provider under review, or by health care professionals/providers who have similar or equal qualifications as the provider under review, who are not in direct economic competition with the health care provider under review. The process compares the health care provider's performance with the performance of peers and with the standards of care and service within the community.

Peer Review may result from cases identified through quality indicators, as well as from the investigation of significant potential and/or actual quality of care concerns. The goal of the Peer Review process is to provide a review process that is consistent, timely, defensible, educational, balanced, fair, useful, and ongoing.

Peer Review recommendations will be included in the credentialing and contracting process for providers.

The provider receives documentation of the findings and recommendations of the Peer Review.

B. INTER-RATER RELIABILITY

Inter-Rater Reliability ensures consistency and congruence in decision-making using standardized criteria in accordance with adopted practice guidelines. Inter-Rater Reliability may be applied to:

1. Level of care determinations

2. Medical necessity determinations

3. Prior authorization, concurrent review, and retrospective review.

The Division ensures that staff involved in these processes are tested at least annually.

Signature of Chief Medical Officer: Anthony Dekker (Mar 13, 2023 15:50 PDT)

Anthony Dekker, D.O.

CHAPTER 28 - MEMBER RIGHTS

REVISION DATE: 5/26/2017, 3/25/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: 42 CFR 438.3(j)(3), 42 CFR 438.100, 45 CFR 164.524 and 526; A.R.S § 36-551.01, A.R.S. § 36-3205.C.1; Division Operations Manual Policy 1001-A; Qualified Vendor Contract

All members have the right to be treated with dignity and respect. The Division of Developmental Disabilities (Division) is committed to protecting the rights of all individuals who are receiving supports and services operated by, supervised by, or financially supported by, the Division. Division contractors must ensure compliance with any applicable federal and state laws that pertain to member rights and ensure that its staff and subcontractors take those rights into account when furnishing services to members. The contractor must ensure all employees are familiar with the information in the references listed above, and the Division's contractual agreements below.

Members have the right to:

A. Request and receive one copy of the member's medical record at no cost to the member and to request that the record be amended or corrected, as specified in 45 CFR 164.524.

B. Have accommodations to actively participate in the provision of services and have physical access to facilities, procedures, and exams.

C. File a grievance and obtain the grievance process in writing.

D. Exercise their rights without the exercise of those rights adversely affecting the way the contractor or its subcontractors treat the member [42 CFR 438.100(c)].

E. Accept or refuse medical care and the right to execute an advance directive.

The Division's contractors and their subcontractors must:

A. Ensure members and individuals with disabilities are annually informed of their right to request the following information and are offered:

   1. An updated member handbook at no cost to the member

   2. A provider directory as described in the AHCCCS Contractor Operations Manual, Policy 404.

      This information may be sent in a separate written communication or included with other written information, such as in a member newsletter.

B. Maintain written policies that address the rights of adult members to make decisions about medical care. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.

C. Provide written information to adult members regarding an individual's rights under state law to make decisions regarding medical care and the health care provider's written policies concerning advance directives including any conscientious objections [42 CFR 438.3(j)(3)].

D. Ensure that each member is guaranteed the right to request and receive one copy of the member's medical record at no cost to the member, and to request that the record be amended or corrected, as specified in 45 CFR 164.526.

CHAPTER 29 ADVISING OR ADVOCATING ON BEHALF OF A MEMBER

REVISION DATE: 11/22/2023, 5/26/2017, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: 42 CFR 438.100, 42 CFR 438.102, 42 CFR 457.1222, Section 1932(b)(3)(A) of the Social Security Act

PURPOSE

The purpose of this document is to outline the context when 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 Member.

DEFINITIONS

"Member" means the same as "client" as defined in A.R.S. § 36-551.

SUPPLEMENTAL INFORMATION

Pursuant to 42 CFR 438.100, 42 CFR 438.102, 42 CFR 457.1222, and Section 1932(b)(3)(A) of the Social Security Act, the Division of Developmental Disabilities (Division) may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is authorized to receive services from the provider or who is the provider's patient for the following:

1. The Member's health status, medical care, or treatment options including any alternative treatment that may be self-administered;
2 Any information the Member needs in order to decide among all relevant treatment options;
3. The risks, benefits, and consequences of treatment or non-treatment; and
4. The Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

30 CLINICAL PRACTICE GUIDELINES

REVISION DATE: 3/30/2022, 5/8/2019, 5/27/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 C.F.R. § 438.236; ACOM 416

PURPOSE

The purpose of this document is to provide information for providers on how to access the clinical practice guidelines for the Division of Developmental Disabilities (Division) and its subcontracted health plans.

A. ACCESSING DDD'S CLINICAL PRACTICE GUIDELINES

The Division has developed guidelines for its providers, members, and staff to use when determining medical necessity. The Division reviews these guidelines at least annually. Links to the clinical practice guidelines used by the Division and the Division's contracted health plans are provided on the Current Qualified Vendors and Providers page of the Division's website.

CHAPTER 31 - TRANSITIONING MEMBERS BETWEEN DDD HEALTH PLANS

REVISION DATE: 6/15/2022, 5/26/2017, 4/16/2014EFFECTIVE DATE: March 29,2013

REFERENCES: A.R.S. § 36-2944

Purpose

To outline the process of when and how responsible parties must notify the Division's Member Services Unit of their wish to change Acute Care Health Plans

Definitions

A. Open Enrollment

1. The Division reserves the right to conduct an open enrollment, if deemed necessary, by Division Administration. Members or their responsible parties must notify the Division if they wish to change contractors during open enrollment.
2. If the member does not participate in the annual birth month enrollment choice, and
    a. the member's eligibility is maintained, the member will remain with his/her current Acute Care Health Plan.

B. Change Request

1. A member may request Contractor changes at the following times by calling the DDD member services phone number (see also the AdSS Operations Manual, Policy 401) [42 CFR 438.56(c)(1); 42 CFR 438.56(c)(2)(i)-(iii)]:
    a. With cause, at any time, which includes
        i. poor quality of care,
        ii. lack of access to services covered under the Contract, or
        iii. lack of access to providers experienced in addressing the member's care needs [42 CFR 438.56(d)(2)(v)];
    b. Without cause
        i. ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later;
        ii. at least once every twelve (12) months; or
        iii. upon re-enrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period.
2. If it becomes necessary to change the Acute Care Health Plan outside of the open/annual birth month enrollment timeframe,
    a. the member/responsible party must contact the Division'

i. Liaison for the current health plan or

ii. the Division's Member Services Unit.

b. This includes facilitating

i. continuity of care,

ii. quality of care,

iii. efficient and effective program operations, and

iv. in responding to administrative issues regarding member notification and errors in assignment.

C. AHCCCS Contractor Operations Manual (ACOM) Policy 402 documents and delineates the rights, obligations and responsibilities of:

1. The member
2. The member's current health plan
3. The requested health plan
4. The Division.

CHAPTER 34 PROVIDER PUBLICATIONS

REVISION DATE: 2/24/2021
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. In all provider publications, including website content, the Qualified Vendor is responsible for complying with any applicable laws and regulations regarding individual rights and Protected Health Information.

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. 6^{th} 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.

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: 3/4/2020, 6/26/2019, 9/15/2017, 9/1/2014
EFFECTIVE DATE: July 1, 2013

Progress reports and other documentation must be developed and maintained by the vendor based on the service being provided.

Elements of Progress Reports

A. The Division of Developmental Disabilities (Division) does not require a specific format to be used for progress reports, however the following minimum elements must be included in progress reports:

1. Member Name
2. Member DOB
3. Member ID
4. Vendor Name
5. Vendor ID
6. Service provided
7. Overall progress specific to planning document outcomes,
8. Performance data that identifies the member's progress toward achievement of the established outcomes,
9. Current and potential barriers to achieving outcomes,
10. A written summary describing specific service activities,
11. Additional service specific requirements as specified in Section B and D.

B. The Division does not require progress reports for:

1. Attendant Care
2. Housekeeping
3. Respite
4. Transportation

C. The Division does require that vendors 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.

For clinical services, the treating provider/vendor, with appropriate supervision if applicable, is required to complete a treatment note for every skilled service encounter. The treating provider(s)/supervisor's and the member's responsible person's signature is required every visit.

Progress Reports Submission Instructions

Progress reports must be submitted to the Division's File Transfer Protocol (FTP) site using the PBS/Reports/ProgressReports/In folder unless otherwise specified in the reporting requirements.

All reports must be submitted following this file naming convention: DDDProgressReport_YYYY_MM_PBS_ASSISTID_SVC_SQN.EXT (see table below).

Position	Parameter	Description	Size	Example
1	YYYY	4-digit Year	4	2019
2	MM	2-digit Month	2	02
3	PBS	4 Character PBS Vendor Code	4	ABCD
4	ASSISTID	10 Digit Client ASSIST ID	10	1234567890
5	SVC	Service Code: • 3 Character DDD Code • 4 Character REV Code • 5 Character HCPCS Code	3, 4, or 5	OTA 0111 A9901
6	SQN	3-digit Sequence Number	3	000-999
7	EXT	File Extension	(Varies)	.pdf, .xlsx, .docx

Progress Reports Schedule and Reporting Requirements

The required due dates for progress reports are listed below by service:

A. Monthly Progress Reports

Submit progress reports (due within 10 business days following each month) for:

1. Day Treatment and Training, Child (Summer)
2. Habilitation, Group Home
3. Habilitation, Nursing Supported Group Home
4. Home Health Aide
5. Nursing

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 (Non-Habilitation Services)

Submit progress reports (due July 15, October 15, January 15, and April 15) for:

1. Center Based Employment

In addition to the minimum requirements of the progress report, document

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

   In addition to the minimum requirements for the progress report, include:

   a. Performance data that identifies the progress of the member toward achievement of the established objectives.

   b. A detailed record of each contact including hours of service with the member.

   c. Detailed information regarding specific employment support activities.

5. Group Supported Employment

6. Individual Supported Employment

   In addition to the minimum requirements of the progress report, include:

   a. A detailed record of each contact with the member

   b. Detailed information about specific job search activities.

7. Nursing

   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.

8. Therapy Services— (Occupational Therapy, Physical Therapy, Speech Therapy)

   <u>Documentation Requirements</u>

   - Initial Evaluation
   - Plan of Care
   - Reevaluation and Plan of Care Recertification
   - Progress Reporting

   The Qualified Vendor must obtain and develop all of the following documentation to establish authorization for an initial request for therapy services:

   <u>Initial Evaluation</u>

   For new authorizations of therapies, if the submitted request documentation is

not signed and dated by the prescribing provider, the request must be accompanied by a valid written order/prescription.

a. Valid evaluation prescriptions must:

   i. Be prescribed by the member's Primary Care Provider (PCP) or attending Physician including Medical Doctor (MD), Doctor Osteopathy (DO), Physician Assistant (PA), or Nurse Practitioner (NP).

   ii. Include the type of therapy (Speech, Occupational, or Physical).

   iii. Include the verbiage, "Evaluation and treatment as recommended by therapy clinician."

   iv. Include a physician's signature dated less than one year ago.

   v. Be written on the prescribing physician's script pad or letterhead.

   vi. Include the prescribing health professional's NPI number with their signature, and a signature that is legible, or which can be validated by comparing to a signature log or attestation statement.

Plan of Care

Requests for initial services must include a plan of care for the dates of service requested, including all of the following:

a. Member's medical history and background

b. Date of onset of the member's condition requiring therapy or exacerbation date as applicable

c. Date of evaluation

d. Session start and stop time

e. Baseline objective measurements based on standardized testing performed or other standard assessment tools

f. Safety risks

g. Member-specific, measurable short and long-term functional goals within the length of time the service is requested

h. Interpretation of the results of the evaluation, including recommendations for therapy amount, frequency per week and duration of services

i. Therapy treatment plan/POC to include specific modalities and treatments planned

j. Documentation of member's primary language

k. Documentation of member's age and date of birth

l. Adaptive equipment or assistive devices, as applicable

m. Prognosis for improvement

n. Requested dates of service for planned treatments after the completion of the evaluation

o. Responsible adult's expected involvement in member's treatment

p. History of prior therapy and referrals as applicable

q. Signature and date of treating therapist

r. Signature and date of prescribing provider/ Primary Care Provider

Reevaluation and Plan of Care Recertification

A complete recertification request and plan of care should be submitted 30 days before the current authorization period expires, but no later than the expiration period for the current authorization period. Requests for recertification services must include revised plan of care for the recertification dates of service requested, including all the following:

a. A progress summary (see progress summary documentation requirements), and

b. An updated treatment plan or plan of care for the recertification dates of service requested, including all of the following:

    i. Date therapy services started

    ii. Changes in the treatment plan, the rationale and the requested change in frequency of visits for changing the plan

    iii. Documentation of reasons continued therapy services are medically needed

    iv. Documentation of client's participation in treatment, as well as client and responsible adult's participation or adherence with a home treatment program

    v. Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable

    vi. Adaptive equipment or assistive devices, as applicable

    vii. Prognosis with clearly established discharge criteria

    viii. Documentation of consults with other professionals and services or referrals made and coordination of service when applicable

    ix. The updated treatment plan or plan of care must be signed and dated by the therapist responsible for the therapy services.

x. The updated treatment plan or plan of care must be signed and dated by the prescribing provider.

For recertifications of therapies, if the submitted request form is not signed and dated by the prescribing provider, the request must be accompanied by a valid written order/prescription.

Progress Report

The Qualified Vendor shall complete and submit a progress report at least once every 90 days (quarterly) or by the end of the certification timeframe if the plan of care is less than 90 days. A progress report summary, which may be contained in the last treatment note, must be included with the recertification request and contains all of the following:

a. Date therapy started

b. Date the summary completed

c. Time period (dates of service) covered by the summary

d. Member's medical and treatment diagnoses

e. A summary of member's response to therapy and current treatment plan, to include:

f. Documentation of any issues limiting the member's progress

g. Documentation of objective measures of functional progress related to each treatment goal established on the initial evaluation

h. An assessment of the member's therapy prognosis and overall functional progress

i. Documentation of member's participation in treatment as well as member or responsible adult's participation or adherence with a home treatment program

j. Updated or new functional and measurable short and long-term treatment goals with time frames, as applicable

k. Documentation of member 's continued need for therapy

l. Clearly established discharge criteria

m. Documentation of consults with other professionals and services or coordination of service when applicable.

n. The progress summary must be signed and dated by the therapist responsible for the therapy services.

9. Transition to Employment.

C. Quarterly Progress Reports (Habilitation Services)

Submit quarterly progress reports (due July 15, October 15, January 15, and April 15) for:

- Habilitation, Communication
- Habilitation, Community Protection and Treatment Hourly
- Habilitation, Individually Designed Living Arrangement
- Habilitation, Music Therapy
- Habilitation, Hourly Support
- Habilitation, Vendor Supported Developmental Home (Child and Adult).

D. Quarterly Progress Reports (Specialized Habilitation Services)

Submit quarterly progress reports to the member's treatment team. At minimum, include:

- DDD Support Coordinator
- DDD Behavioral Health Administration (BHAdministration@azdes.gov)
- Behavioral Health Case Manager
- As necessary, other providers for care coordination

Submit quarterly progress reports (due July 15, October 15, January 15, and April 15) for:

- Habilitation, Early Childhood Autism Specialized
- Habilitation, Consultation
- Consultation, Positive Behavioral Support.

In each quarterly progress report, provide the following information at a minimum:

1. Member Information
    a. Demographics outlined in A and;
        i. Developmental Disability diagnosis or diagnoses
        ii. Behavioral Health diagnosis or diagnoses
        iii. Physical Health diagnosis or diagnoses
    b. Family/Living/Housing
        i. Who is a part of the member's team/family (e.g., parents, siblings, grandparents, foster parents, group home staff, therapists)?

ii. Who lives with the member? Provide a picture of the member's living environment, potential relationships the member has with people living in his/her home, or state if the member lives alone.

iii. Has the member experienced any recent changes in living environment/situation (e.g., removal from family, divorce, adoption, school suspension, family death, auto accident, loss of job/income)?

c. Home/School/Work Information

i. What school does the member attend, if enrolled?

ii. Is the member employed, or does s/he want to be? If so, where, and for how many hours per week?

iii. Does the member volunteer or participate in community activities? If so, explain.

iv. Is the member experiencing any difficulties in these settings?

d. cultural considerations,

e. prenatal and/or developmental history,

f. medical history,

g. sensory, dietary and adaptive needs,

h. sleep patterns,

i. medications

2. Current Behavior Profile and History of Intervention

Include a brief summary supporting the need for the service. Describe what lesser-intensive supports and services have been attempted or used, and whether they were or were not effective; include why or why not.

3. Review of Recent Assessments and Reports

a. Include any recent assessments that have been completed, including, but not limited to:

i. Functional behavior assessment

ii. Skills assessment(s)

iii. Preference assessment (including identified reinforcers)

iv. Cognitive testing.

b. Provide a summary of findings for each assessment (including any relevant graphs, tables, or grids).

4. Intervention Settings and Activities

   a. State intervention settings and activities completed for the quarter. Include a specific narrative description of the intervention activities and the setting(s) completed for each service date (i.e., the narrative would provide a clear picture of what was done).

   b. Identify skill areas targeted, from among the following:

      i. Language/Communication

      ii. Social

      iii. Motor

      iv. Behavior

      v. Mental Health Concerns

      vi. Cognitive

      vii. Development

      viii. Feeding

      ix. Vocational

      x. Adaptive Skills

      xi. Health/Physical

      xii. Other (specify).

   c. Explain targeted goals and objectives, including an operational definition for each behavior and/or skill and how goals/objectives are measured, as follows:

      i. Identify member's baseline and current level of functioning.

      ii. Describe the behavior that the member is expected to demonstrate, including condition(s) under which it must be demonstrated.

      iii. State date of introduction of each goal/objective.

      iv. Estimated date of mastery for each goal/objective.

      v. Specify plan for generalization of the mastered skill/behavior.

      vi. Specify behavior management (behavior reduction and/or skill acquisition) procedures, such as:

         - Antecedent-based interventions (e.g., environmental modifications, teaching interventions)

- Consequence-based interventions (e.g., extinction, scheduling, reinforcement ratio).

d. Describe data collection procedures and progress toward goals, including the use of the behavior measurement (e.g., rate, frequency, duration, latency) that will reflect the increase or decrease of skills or behaviors, including data from both the consultant and any hourly habilitation support service providers, as follows:

i. Display data in graphic format with relevant environmental variables that might affect the target behaviors indicated on the graph, including any of the following:

- Medication initiation and/or changes in medications
- Baseline or pre-intervention levels of behavior
- Strategy changes.

ii. Explain how the analysis of the data is used to revise the member's behavior plan to ensure the best outcome for the member.

5. Parent(s)/Caregiver(s) Training

Summarize parent(s)/caregiver(s) involvement and proposed goals/objectives, including a description of:

a. Behavior that the parent(s)/caregiver(s) is expected to demonstrate, including conditions under which they will demonstrate mastery,

b. Date of introduction of each goal/objective,

c. Estimate date of parent's/caregiver's mastery of each goal/objective,

d. Parent(s)/caregiver(s) training procedures,

e. Data collection procedures and progress toward goals (i.e., report goal as met, not met, modified, and include explanation).

6. Service Level Recommendation (if requesting a service extension)

a. Identify number of hours for continued authorization based on identified interventions specific to the member's needs.

b. Provide a clinical summary that justifies the hours requested.

7. Coordination of Care

How has/will this service be coordinated with other services or therapies that the member is receiving from the Division or other sources (e.g., Behavioral Health, Health Plan, Education, Child Welfare)?

8. Transition Plan

Plan for transitioning the member from the service, including:

Transition statement and Individualized discharge criteria developed with specific, realistic, and timely follow-up care coordination recommendations.

a. Plan for maintenance and generalization, including how and when this service will be transitioned to other lesser intensive services

b. Discharge must occur when:

i. Intervention services are no longer recommended.

ii. Measurable improvements are not expected, or progress has plateaued.

iii. Intervention services are primarily educational in nature.

iv. Intervention is primarily vocational or recreationally based.

v. If proposed future intervention is experimental or unproven.

vi. The member has obtained age appropriate abilities in targeted goals.

vii. Similar outcomes can be achieved through a lesser restrictive/intensive service.

viii. There is a lack of parental/caregiver involvement or frequent cancellations.

9. Report is signed by the supervising licensed Psychologist or licensed Behavior Analyst.

E. Semiannual Progress Reports

Submit semiannual progress reports (due January 31 and July 31) for these services, using Division forms:

1. Center Based Employment

2. Employment Support Aide

3. Group Supported Employment

4. Individual Supported Employment

In addition to the minimum requirements for the progress report, include:

a. Performance data that identifies the progress of the member toward achievement of the established objectives

b. A detailed record of each contact including hours of service with the member

c. Detailed information regarding specific employment support activities.

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/Impairmant 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 THERAPY SERVICES (OCCUPATIONAL, PHYSICAL, AND SPEECH-LANGUAGE)

REVISION DATE: 12/27/2023, 5/24/2023, 6/29/2022
REVIEW DATE:
EFFECTIVE DATE: August 1, 2014
REFERENCES: 42 U.S.C. § 1396b (r); 42 U.S.C. § 1396d (a); 42 C.F.R. § 409.43-409.44; 42 C.F.R. § 440.70; 45 C.F.R. § 160.102-103; 45 C.F.R. § 162; A.R.S. § 12-2297; A.R.S. Title 32 Chapter 19; A.R.S. Title 32 Chapter 34; A.R.S. §§ 35-214 and 35-215; A.R.S. § 36-551; A.R.S. Title 36 Chapter 17; A.A.C. Title 4, Chapter 24; A.A.C. Title 4 Chapter 43; A.A.C. Title 9, Chapter 16; A.A.C. R6-6-101; A.A.C. R6-6-2101; A.A.C. R9-22-212; A.A.C. R9-28-101; A.A.C. R9-28-201; A.A.C. R9-28-202; ACOM 414; AMPM 310-X; AMPM 430

PURPOSE

The purpose of this policy is to outline the requirements for Qualified Vendors when providing Medically Necessary therapy services to Division of Developmental Disabilities (Division) Members.

DEFINITIONS

1. "Certified Plan of Care" or "CPOC" means a Plan of Care that is signed and dated by the Member's primary care physician (PCP) that becomes the order or prescription for therapy services.
2. "Caregiver" means, for the purposes of this policy, an adult who is providing for the physical, emotional, and social needs of a child or adult with a developmental disability. Examples of Caregivers can include birth parent(s), foster parent(s), adoptive

parent(s), kin or relative(s), group home staff. Caregivers can be licensed, unlicensed, paid, or unpaid.

3. "Co-treatment" means at least two different therapy disciplines delivering therapy to the same Member simultaneously during the same therapy session by licensed therapists.
4. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or

ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

5. "Functional Maintenance Program" means the activities established by a therapist to assist the Member in maintaining the progress made during therapy services, or upon discontinuing therapy services when the condition of the Member is evaluated as insignificant or at a plateau.
6. "Medicaid National Correct Coding Initiative Edits" means correct billing code methodologies set by the Centers for Medicare and Medicaid Services (CMS) that are applied to claims to reduce improper coding and thus reduce improper payments of claims.
7. "Medically Necessary" means a service given by a doctor, or licensed health practitioner that helps with a health problem, stops disease, disability, or extends life.

8. "Member" means the same as "client" as defined in A.R.S. § 36-551.
9. "National Provider Identifier Standard" or "NPI" means a standard, unique 10-digit numerical identifier mandated for healthcare providers as defined in 45 CFR § 160.103 for administrative and financial transactions.
10. "Occupational Therapy" means the diagnosis and treatment of disorders concerned with fine motor sensorimotor including sensory processing/sensory integration, feeding,reflexes/muscle tone, functional living skills including socio-emotional developmental needs; and equipment including training, adaptation and/or modification.
11. "Oral Motor/Swallowing/Feeding Disorders" means impairment of the muscles, structures, or functions of the mouth (physiological or sensory-based that may or may not result in deficits of speech production) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow.

12. "Physical Therapy" means diagnosis and treatment of gross motor disorders, gait, balance, proprioception, strength, fine motor, muscle tone, neuromuscular, cardiovascular, reflex testing as appropriate, and equipment including training, adaptation, and/or modifications.
13. "Plan of Care" or "POC" means a written statement developed by a qualified provider and certified by the primary care provider or physician outlining a specific course of treatment for a Member. The Plan of Care includes the Member's treatment diagnosis, assessment results, long-term treatment goals as well as the type, duration, and frequency of therapy or home health nursing services and discharge criteria, education and training components, according to the Member's needs.
14. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource

providers, representatives from religious/spiritual organizations, and agents from other service systems.

15. "Prior Authorization" means the process by which the DDD or contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost-effectiveness, compliance with the Arizona Administrative Code, and any applicable contract provisions. Prior authorization is not a guarantee of payment.
16. "Procedure Daily Maximum Units" means the maximum units of service that a provider is allowed to claim, per CMS, under most circumstances for a Member on a single date of service.
17. "Progress Report" means a record of the Member's treatment and response to treatment written by the treating therapist at intervals stipulated by the Division that typically states the number of sessions and attendance, services provided, objective measures of progress toward goals, justification of medical necessity for treatment, and changes to the goals or Plan of Care, as appropriate.

18. "Qualified Vendor" or "contractor" for the purposes of this policy means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
19. "Qualified Vendor Agreement" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the relationship between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.
20. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a client or an applicant for whom no guardian has been appointed.
21. "Service Authorization Request" means a request by the Member/Health Care Decision Maker, and Designated Representative (DR) or a provider for a physical or behavioral

health service for the Member which requires Prior Authorization (PA) by the Contractor.

22. "Speech-Language Pathology" or "Speech Therapy" means the diagnosis and treatment of communication, cognition, and swallowing disorders. The scope of practice includes, but is not limited to, disorders of speech fluency, production, resonance, voice, language, feeding, hearing, and swallowing for Members of all ages. Service delivery areas include all aspects of communication and swallowing and related areas that impact communication and swallowing.
23. "Third Party Liability" or "TPL" means 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.
24. "Treatment Note" means a record of a therapy treatment session documented by the treating therapist that demonstrates the treatment provided, the Member's progress toward goals, and the need for therapy services.

POLICY

A. PROVIDER REQUIREMENTS AND QUALIFICATIONS

1. Vendors shall have an active Qualified Vendor Agreement with the Division to provide Physical Therapy, Speech Therapy, and Occupational Therapy services to Division Members.
2. Qualified Vendors shall comply with all applicable service requirements, service specifications, standard terms and conditions, and all other provisions of the Qualified Vendor Agreement.
3. Qualified Vendors shall ensure the following therapy providers are licensed or provide services under the supervision of a licensed therapist of the same discipline within their scope of practice:
    a. Physical therapists;
    b. Physical Therapy assistants;
    c. Speech-Language Pathologists;
    d. Speech-Language Pathology assistants;
    e. Occupational therapists; and
    f. Occupational Therapy assistants.

B. ESTABLISHING THERAPY SERVICES

1. Qualified vendors shall obtain prior authorization from the Division before providing the following therapy services to Members:
    a. Speech Therapy evaluation;
    b. Occupational Therapy evaluation;
    c. Physical Therapy evaluation;
    d. Feeding or swallowing evaluation;
    e. Speech Therapy sessions;
    f. Physical Therapy sessions;
    g. Occupational Therapy sessions; and
    h. Feeding or swallowing therapy sessions.
2. Qualified Vendors shall ensure therapy services are Medically Necessary based on the supporting documentation of medical need and the appropriateness of the equipment, service, or supply prescribed by the physician or other licensed practitioner of the healing arts.
3. Qualified Vendors shall ensure the amount, frequency, and duration of therapy services are always commensurate with the

Member's medical and therapy needs, level of disability, and standards of practice.

4. Qualified Vendors shall require the following documentation prior to providing therapy services to Members:
   a. An order or prescription from the Member's Primary Care Provider (PCP) with the following information:
      i. The type of therapy requested;
      ii. "Evaluation and treatment as recommended by therapy clinician";
      iii. PCP's signature dated less than one year ago; and
      iv. PCP's NPI number.
   b. A service authorization for therapy evaluation from the Member's Support Coordinator.

C. INITIAL EVALUATION AND PLAN OF CARE

1. Upon meeting the criteria in (B) of this policy, Qualified Vendors who provide therapy services shall evaluate the Member's skills and develop a Plan of Care (POC) to substantiate a recommendation for Medically Necessary therapy services.

2. If a Member requires more than one visit to complete a therapy evaluation, the Qualified Vendor providing therapy services shall complete the following prior to the next evaluation visit:
    a. Provide the Support Coordinator justification in writing;
    b. Request a service authorization from the Support Coordinator; and
    c. Attend a peer-to-peer consultation with requesting Division staff to determine appropriateness in certain cases.
3. Based on the Member's evaluation results, the Qualified Vendor providing therapy services shall include the following information in the POC:
    a. Member's date of birth and age;
    b. Member's medical history and background;
    c. History of prior therapy and referrals as applicable;
    d. Diagnoses;
    e. Date of evaluation;
    f. Baseline objective measurements based on standardized testing, performed or other standard assessment tools;
    g. Type of therapy service;

h. Short term and long term treatment goals for the entire episode of care;

i. Goal baselines and timelines;

j. Proposed type of service or interventions;

k. Home program goals;

l. Session start and stop time;

m. Frequency of therapy services;

n. Member's primary language;

o. Prognosis for improvement;

p. Safety risks;

q. Adaptive equipment or assistive devices, as applicable;

r. Criteria for discontinuing therapy services;

s. Date the POC was established;

t. Requested dates of service for planned treatments after the completion of the evaluation;

u. Responsible Person's expected involvement in the Member's treatment; and

v. Signature, date, and credentials of the therapist who developed the POC.

4. The Qualified Vendor that evaluated the Member for therapy services may use any of the following to document the Member's therapy evaluation and POC:
    a. The DDD-2088A Evaluation Report Plan of Care/Treatment Plan: Certification/Recertification form;
    b. The Qualified Vendor's own clinical form; or
    c. The Qualified Vendor's Electronic Medical System (EMR).

D. CERTIFICATION OF THE POC FOR AUTHORIZATION OF THERAPY SERVICES

1. The Qualified Vendor that evaluated the Member for therapy service shall submit the POC to the PCP that originally ordered or prescribed the therapy evaluation and treatment to request certification of the POC and to initiate therapy services if the therapy evaluation results substantiate a recommendation for Medically Necessary therapy service.
2. The Qualified Vendor shall ensure the Certified Plan of Care (CPOC) contains the following information from the PCP that originally prescribed the therapy evaluation and treatment for the Member:

a. The PCP's dated signature; and

b. The PCP's National Provider Identification (NPI) number.

3. Upon receipt of the CPOC from the Member's PCP, the Qualified Vendor shall submit the following to the Member's Support Coordinator:

a. A copy of the CPOC within 21 calendar days to request a service authorization for therapy services; and

b. A statement of whether or not the Member has Third Party Liability (TPL); and

c. If the Member has TPL, information on the Member's TPL coverage.

4. The Qualified Vendor shall not ask the Member's PCP to attest to agreeing with the POC prior to the date the POC is reviewed.

E. DELIVERY OF THERAPY SERVICES

1. Qualified Vendors shall not provide therapy services without a service authorization from the Support Coordinator.

2. The Qualified Vendor shall ensure therapy services provided are consistent with the Member's CPOC rather than primarily for the

convenience of the Member, Responsible Person, or therapy provider.

3. The Qualified Vendor providing therapy services may allow the Member to make up missed therapy sessions during the service authorization period within 30-calendar days as long as:
   a. The total number of sessions or units delivered does not exceed the amount authorized;
   b. The make-up session occurs on a separate and distinguished date;
   c. Medicaid National Correct Coding Initiative Edits and Procedure Daily Maximum Units are followed; and
   d. The CPOC permits make-up sessions.
4. The Qualified Vendor shall refer to the DDD Qualified Vendor Rate Book for more information about the modifiers specific to the missed therapy sessions and make-up therapy sessions.
5. The Qualified Vendor providing therapy services shall develop a Functional Maintenance Program for Members and their Caregivers to implement therapeutic activities as part of the Member's daily routine.

6. The Qualified Vendor providing therapy services shall review and update the Member's Functional Maintenance Program as part of all therapy sessions.

F. RESPONSIBLE PERSON/CAREGIVER PARTICIPATION

1. The Qualified Vendor providing therapy service shall require the attendance and active participation of the following individuals in the Member's therapy sessions to maximize the benefit of the service, improve outcomes, and carry out the Functional Maintenance Program:
   a. Responsible Person if other than the Member;
   b. Caregiver(s);
   c. Family member; or
   d. Other individual(s) designated by the Planning Team if the Member does not have a Responsible Person, Caregiver, or family member available.
2. The Qualified Vendor providing therapy service shall ensure the Responsible Person informs all other Caregivers regarding the therapeutic activities that comprise the Member's therapy program.

3. If the Responsible Person does not attend the therapy session the Qualified Vendor providing therapy service shall,:
    a. Cancel the therapy session;
    b. Notify the Member's Support Coordinator of the lack of participation of the Responsible Person prior to the next therapy session; and
    c. Document the reason for the cancellation of the therapy session on the quarterly Progress Report.
4. If the Qualified Vendor providing therapy service recommends that the Responsible Person or Caregiver observes the therapy session outside the eyesight of the Member, the therapist shall submit this recommendation to the Support Coordinator via the evaluation and CPOC before this type of participation is used.

G. UPDATE TO THE POC, RECERTIFICATION, AND REEVALUATION

1. The Qualified Vendor providing therapy service shall, if the Member requires Medically Necessary therapy past the service authorization end date, complete the following 30 days in advance of the service authorization end date to avoid gaps in service:

a. Provide the Member's PCP with an updated POC for recertification; and

b. Submit the updated CPOC to Member's Support Coordinator via the Division's FTP site for reauthorization of service.

2. The Qualified Vendor providing therapy service shall include the following information on the updated POC when requesting recertification of services:

a. A progress summary;

b. Date therapy services started;

c. Dates of therapy services requested;

d. Changes in the POC and rationale;

e. Requested change in frequency of visits for changing the plan, if applicable;

f. Documentation of reasons continued therapy services are Medically Necessary;

g. Documentation of Member's and Responsible Person's participation in treatment or adherence to a Functional Maintenance program;

h. Updated or new functional and measurable short and long-term treatment goals with new time frames, as applicable;

i. Adaptive equipment or assistive devices, as applicable;

j. Prognosis with clearly established criteria for discontinuing therapy service;

k. Documentation of consults with other professionals and services or referrals made and coordination of service when applicable;

l. The updated POC shall be signed and dated by the therapist responsible for the therapy services;

m. The updated POC shall be signed and dated by the ordering provider; and

n. For recertifications of therapies, if the submitted request is not signed and dated by the ordering provider, the request is accompanied by a valid written order or prescription.

3. The Qualified Vendor providing therapy services shall reevaluate the Member at least every three years, or if any of the following apply:

a. The Member's Support Coordinator identifies a limitation in a functional area.

b. The Member's PCP or other licensed healthcare professional identifies a limitation in a functional area.

c. The Member's Caregiver or Responsible Person identifies a limitation in a functional area.

d. The Member presents with a change in medical status that is not rehabilitative.

e. There is a change in Qualified Vendor and the Member has not had an evaluation within the last year.

f. The Member is undergoing redetermination for eligibility.

4. The Qualified Vendor providing therapy service shall update the POC, obtain recertification of the POC from the PCP, and request reauthorization of therapy services from the Support Coordinator as per G.1 and G.2 of this policy upon completing the reevaluation if Medically Necessary therapy services are required.

5. The Qualified Vendor providing therapy service shall discontinue therapy services as per the requirements in J. of this policy if the Qualified Vendor determines that the Member does not require Medically Necessary therapy services.

H. DAILY TREATMENT NOTES AND PROGRESS REPORTING REQUIREMENTS

1. The Qualified Vendor providing therapy service shall complete a daily Treatment Note for every therapy session with the Member with the following information:
   a. Events of a session;
   b. Member interactions;
   c. The type of therapy;
   d. Any accommodations and modifications to clinical procedures;
   e. The treating therapy provider or supervisor’s signature and credentials; and
   f. Responsible Person’s signature.
2. The Qualified Vendor providing therapy service shall document reasons for visits outside the weekly or monthly frequency

indicated in the CPOC in the Member's daily Treatment Note and quarterly Progress Reports.

3. The Qualified Vendor providing therapy service shall submit a Progress Report to the Division's FTP site at least once every 90 days (quarterly) or by the end of the certification timeframe if the CPOC is less than 90 days.
4. The Qualified Vendor providing therapy service shall submit quarterly Progress Reports to the Division with the required information as outlined in Chapter 35 Progress Reporting Requirement of the DDD Provider Manual.
5. The Qualified Vendor providing therapy service may use the DDD-2063A Ongoing Quarterly Progress Report (QPR) Plan of Care/Treatment Plan: Certification/Recertification form or may opt to use their own clinical form or EMR for submitting quarterly Progress Reports or for recertification of the POC.
6. The Qualified Vendor providing therapy service may use the fourth quarterly Progress Report for updating the POC and submitting the POC to the PCP for recertification.

7. The Qualified Vendor providing therapy service shall document the beginning of the first reporting period as the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, reevaluation, or treatment.
8. The Qualified Vendor providing therapy service shall retain the Member's Progress Reports, Treatment Notes, and all other therapy documentation in accordance with A.R.S. § 12-2297.

I. EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

The Qualified Vendor shall refer to Chapter 6 of the DDD Provider Manual for information on EPSDT covered services that apply to individuals under the age of 21 who need therapy services.

J. DISCONTINUATION OF SERVICES

1. The Qualified Vendor providing therapy service shall not discontinue the Member's therapy services without agreement from the Planning Team.
2. The Qualified Vendor providing therapy service and Planning Team shall discontinue the Member's treatment when any of the following occur:

a. The disorder(s) resulting in therapy services is remediated;

b. Environmental or behavioral modifications strategies are successfully established;

c. The Responsible Person chooses not to participate in treatment;

d. The Member chooses not to participate in treatment;

e. The Member's attendance to therapy is inconsistent or poor and efforts to address these factors are unsuccessful;

e. The Member moves to another location where therapy services from the current therapy provider are not available;

f. The Member or Responsible Person chooses to seek a different therapy provider.

3. The Qualified Vendor providing therapy services shall advise the Planning Team, Member, and Responsible Person if other than the Member of the likely outcomes should discontinuation of therapy services occur.

4. If the Planning Team does not mutually agree upon the Qualified Vendor's request for release, the Qualified Vendor may submit a

request for release from service authorization to the DDD Customer Service Center as outlined in the Provider Manual, Chapter 50, Section II.G.

5. The Qualified Vendor providing therapy services shall:
   a. Review and analyze the treatment provided to the Member by the treating therapist to identify specific modification(s) that have the greatest probability of yielding improved outcomes; and
   b. Based on (a) implement those improvements with ongoing monitoring when considering discontinuing therapy treatment in situations other than those described in this section.
6. The Qualified Vendor providing therapy services shall document in the Member's final Progress Report that the following factors have been addressed before discontinuation of therapy:
   a. Intervention goals and objectives were specified;
   b. Instructional time was provided;

c. Current and suitable intervention methods or materials were used;

d. Functional performance data were collected and analyzed on an ongoing basis to monitor and evaluate progress;

e. Assistive technology or other technology supports were provided when necessary;

f. A plan to address the needs and concerns of culturally or linguistically diverse members and families (e.g., use of interpreter or translator) has been addressed if necessary;

g. Relevant and accurate criteria were used to evaluate the intervention; and

h. Health, educational, environmental, or other supports relevant to communication interventions were provided.

7. The Qualified Vendor providing therapy service shall refer the Member to professionals with specific expertise in the area of concern prior to discontinuing therapy service if any of the following situations occur:

a. The provision of treatment is beyond the expertise of the individual therapist.

b. The therapist's recommendations are not acceptable to the Responsible Person.

c. Treatment no longer results in measurable benefits and any reasonable prognosis for improvement with continued treatment is not evident. Reevaluation should be considered at a later date to determine whether the Member's status has changed or whether new treatment options have become available.

d. The Member is unable to tolerate the treatment because of a serious medical, psychological, or other condition.

e. The Member demonstrates behavior that interferes with improvement or participation in treatment providing those efforts to address the interfering behavior has been unsuccessful.

8. Upon discontinuing therapy services, the Qualified Vendor shall complete and submit via the Division's FTP site to the Support Coordinator a final Progress Report that includes the following:

a. All treatment provided since the last Progress Report to the date therapy services were discontinued;

b. A statement indicating the therapist reviewed all Treatment Notes; and

c. A statement indicating the therapist agrees to discontinue services.

K. FUNCTIONAL MAINTENANCE PROGRAM UPON DISCONTINUING THERAPY SERVICES

1. The Qualified Vendor shall formulate and implement a Functional Maintenance Program for the Member upon discontinuing therapy services to maintain therapeutic gains.
2. The Qualified Vendor shall, upon discontinuing therapy service, instruct the Responsible Person, family member, or Caregiver as appropriate in the established Functional Maintenance Program components.

3. After a Functional Maintenance Program is implemented, the Qualified Vendor shall not bill for services, except for prior authorized reassessments and POC revisions.
4. The Qualified Vendor providing therapy service shall reassess and revise the Member's Functional Maintenance Program as needed.

L. CO-TREATMENT

1. The Qualified Vendor providing therapy services shall include Co-treatment in the CPOC when it is Medically Necessary for the Member to receive therapy from two different therapy disciplines simultaneously.
2. When performing Co-treatment, the two performing therapists shall designate a primary therapist.
3. The Qualified Vendor shall maintain the following Co-treatment documentation requirements in the Member's medical records as follows:
    a. Medical necessity for the individual therapy services before performing Co-treatment;

b. Co-treatment goals and how Co-treatment will help the therapist achieve the therapist's goals for the Member, for each therapy discipline; and

c. Justification of the Member's need to receive Co-treatment.

4. The Qualified Vendor shall cooperate with requests from the Division for retrospective review of the Member's therapy records.

M. BILLING

The Qualified Vendor providing therapy services shall refer to Provider Manual Chapter 12, Billing and Claim Submission for requirements for submitting therapy service claims.

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).

40 INSURANCE REQUIREMENTS FOR QUALIFIED VENDORS

REVISION DATE: 2/28/2024
REVIEW DATE: 5/5/2023
EFFECTIVE DATE: November 10, 2016
REFERENCES: RFQVA DDD-2024

PURPOSE

The purpose of this policy is to outline the Division's general insurance and Sexual Abuse and Molestation (SAM) coverage requirements for Qualified Vendors.

DEFINITIONS

1. "Qualified Vendor" or "QV" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.
2. "Qualified Vendor Agreement" or "QVA" means the valid, executed contract between the Department and a Qualified Vendor describing the services the Qualified Vendor is qualified to provide and the terms and conditions governing the

relationship between the Department and the Qualified Vendor including any amendments, attachments, schedules, or exhibits.

3. "Sexual Abuse and Molestation Insurance" or "SAM" means liability coverage for claims that may arise related to abusive behaviors committed by the insured and insured's employees.

A. GENERAL INSURANCE REQUIREMENTS

1. The Qualified Vendor shall obtain and maintain current insurance coverage as required by the RFQVA DDD-2024.
2. The Qualified Vendor shall submit all required liability insurance coverage documentation and insurance agent's contact information to the Department's insurance tracking and monitoring system portal.

B. ADDITIONAL SEXUAL ABUSE AND MOLESTATION (SAM) INSURANCE REQUIREMENTS FOR QUALIFIED VENDORS PROVIDING THERAPY SERVICES

1. Qualified Vendors that provide occupational, physical therapy, or speech therapy services to Members shall document the name and relationship of the paid or unpaid caregiver present with the

Member during each evaluation or therapy session, including telehealth sessions.

2. Qualified Vendors that provide occupational, physical therapy, or speech therapy services to Members without a caregiver present shall carry SAM insurance coverage as required in the RFQVA DDD-2024 in the section titled, "For All Other Qualified Vendors".

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 Manger 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 IN PROGRAM SITES

REVISION DATE: 03/22/2023, 05/01/2015
EFFECTIVE DATE: April 1, 2015
REFERENCES: A.R.S. §12-2297, A.R.S. §36-551.01, A.R.S. §36.568

PURPOSE

To distinguish the circumstances under which on-site and remote electronic monitoring may be conducted in programs and services funded by the Division.

DEFINITIONS

1. "Common Area" means a room, including a hallway that is designed for use by multiple individuals, including residents. Bedrooms, toileting areas, and bathing areas are excluded from this definition, regardless of the number of individuals for which the area is designed.
2. "Electronic Monitoring Device" means the same as defined in A.R.S. § 36-568(E).
3. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
4. "Responsible Person" means the same as defined in A.R.S. § 36-551.

POLICY

A. Day Program and Employment Services

1. Prior to installing or using Electronic Monitoring Devices in either a service site or a vehicle used for transportation during the provision of services, the Qualified Vendor must notify the Division's Provider Network Support

Unit at providernetworksupport@azdes.gov and provide a copy of the policy, procedures, and notices for approval.

2. The Qualified Vendor shall only use Electronic Device in Common Areas of the service site.

3. The Qualified Vendor shall post a sign in a conspicuous place in each Common Area and vehicle that is under surveillance which indicates the days and hours of surveillance.

4. The Qualified Vendor shall:

   a. Ensure records created by Electronic Monitoring Devices are maintained in accordance with A.R.S. §12.2297.

   b. Produce records upon request of a Responsible Person, the Division, law enforcement, protective agencies, and other persons and entities entitled to access public records under the law.

B. Group Homes and Nursing Supported Group Homes

1. Qualified Vendors of Group Homes, or Nursing Supported Group Homes may only install, oversee, and monitor Electronic Monitoring Devices in Common Areas of the home and then only If written agreement is received from each Responsible Person for Members who live in the home:

   i. To install the Electronic Monitoring Devices in Common Areas, and

ii. To release HIPAA protected information in the form of live stream and recorded information from the Electronic Monitoring Devices to all Responsible Parties for Members who live in the home .

2. The Qualified Vendor may contract with a third party to install, oversee, and monitor Electronic Monitoring Devices.
3. The Division shall consider actions under (2) to be overseen and monitored by the Qualified Vendor for the purposes of this policy.
4. A Qualified Vendor may allow Responsible Persons of Members who live in the home to share in the cost of the installation, oversight, and monitoring of Electronic Monitoring maintained by the Qualified Vendor if the Responsible Party agrees to the arrangement.
5. If all Responsible Persons for Members who live in the home agree, a Qualified Vendor must permit installation of Electronic Monitoring Devices in Common Areas of the setting at the expense of the Responsible Persons.
    a. The Qualified Vendor is not responsible for the installation, maintenance, or monitoring of the Electronic Monitoring Device installed at the expense of the Responsible Persons.

b. The Qualified Vendor may not access the live stream or recordings generated at the expense of the Responsible Persons without the written permission of all Responsible Persons for Members who live in the home.

c. For Electronic Monitoring Device installed at the expense of the Responsible Persons the Qualified Vendor shall not:

i. Turn off or on the Electronic Monitoring Device.

ii. Cover up or in any way obscure the ability of the Electronic Monitoring Device to have full view of the area chosen by the Responsible Person.

iii. Move the Electronic Monitoring Device.

iv. In any other way assist or hamper the operation of and use of the Electronic Monitoring Device.

6. If, after the installation of an Electronic Monitoring Device, any Responsible Person notifies the Qualified Vendor in writing that they are no longer in agreement with use of Electronic Monitoring Devices in Common Areas of the setting, the Qualified Vendor shall:

a. If the Electronic Monitoring Device is maintained and monitored by the Qualified Vendor :

i. Stop using the Electronic Monitoring Devices;

ii. Notify all Responsible Persons of the discontinuation of Electronic Monitoring in the setting;

iii. Remove the Electronic Monitoring Devices or ensure the Electronic Monitoring Device has clearly been disabled.

b. If the Electronic Monitoring Device is maintained and monitored by the Responsible Persons, notify the Responsible Persons in writing that:

i. Use of the Electronic Monitoring Devices must cease immediately;

ii. The Electronic Monitoring Devices must be removed from the setting by the Responsible Persons; and

iii. Any damage caused by the installation or removal of the Electronic Monitoring Device must be repaired by the Responsible Persons at the time of removal.

7. The Qualified Vendor shall post a clearly legible sign at each entrance to the premises and ensure the sign:

a. Reference A.R.S. § 36-568;

b. States that Electronic Monitoring Devices are in use on the premises;

c. Is clearly visible ; and

d. Is printed with a size and font that is easily readable from a reasonable distance.

8. An Qualified Vendor shall:

a. Comply with Health Insurance Portability and Accountability Act ("HIPAA") and other applicable state and federal law addressing confidentiality; and

b. Specify in policy how Electronic Monitoring Device recordings, regardless of format, will be secured to protect the confidentiality of residents, including:

i. Which personnel may have access to the Electronic Monitoring Device recordings; and

ii. Under what circumstances access to the Electronic Monitoring Device recordings may be allowed.

9. The Qualified Vendor shall retain and have accessible any Electronic Monitoring Device recordings, regardless of format, generated by the Electronic Monitoring Devices installed and monitored by the Qualified Vendor for a minimum of 30 calendar days.

10. The Qualified Vendor shall retain the records longer than 30 calendar days if:

a. Required to do so by a contractual obligation;

b. The Qualified Vendor's policy specifies that the Qualified Vendor maintain the records beyond 30 calendar days;

c. The Qualified Vendor reasonably anticipates legal actions for which the records may be relevant;

d. A court order or other legal process requires the retention of all or some of the records for a longer period of time; or

e. A law or regulation that supersedes this policy requires a longer period of record maintenance.

11. A Qualified Vendor who installs an Electronic Monitoring Device shall:

a. Evaluate all Electronic Monitoring Devices at least quarterly to ensure the Electronic Monitoring Devices are properly functioning, secure from access by unauthorized personnel, and are being used in compliance with this Section.

b. Monitor adherence to policies and promptly address non-compliance.

c. Maintain a log of all monitoring of Electronic Monitoring Devices that includes:

i. The date of the monitoring;

ii. The name of the individual who performed the monitoring;

iii. Any deficiencies identified during the monitoring; and

iv. The method, date, and who remediated any deficiencies.

d. Develop and provide training to all personnel who have access to the record that details:

i. The requirements related to disclosure of the record;

ii. HIPAA and all other applicable laws related to confidentiality and privacy;

iii. The maintenance and operation of the Electronic Monitoring Devices and any associated storage devices;

iv. The methods that shall be used to secure the record;

v. A list of all individuals allowed access to the records

vi. The reporting method to be used in the event of any breach in the security of the record or misuse of the Electronic Monitoring Device; and

vii. All policy related to the installation and use of Electronic Monitoring Devices.

e. Provide the training to all personnel who have access to the record.

i. Prior to the personnel being provided access to the record; and

ii. Annually following the initial training.

f. Develop and implement policies for the Qualified Vendor's personnel that:

i. Address disclosure, confidentiality, maintenance, monitoring, and training provisions of this policy;

ii. Outline training that will be provided to ensure that personnel use Electronic Monitoring Devices appropriately;

iii. Outline the maintenance and distribution of records and

iv. Outline how the Qualified Vendor will ensure quarterly monitoring occurs.

g. Make policies, training records, training acknowledgments, evaluations, and monitoring logs available to the Division as requested..

12. Qualified Vendors shall not interfere with or assist in the use of an Electronic Monitoring Device by a Responsible Person in the private bedroom of a Member including:

a. Turning the device on or off.

b. Covering up or in any way obscuring the ability of the device to have a full view of the area chosen by the Responsible Person.

c. Moving the device.

13. The Responsible Persons shall repair any damage caused by the installation of or removal of any Electronic Monitoring Device installed in the home.
14. The Qualified Vendor shall:
    a. Ensure records created by Electronic Monitoring Devices are maintained in accordance with A.R.S. §12.2297.
    b. Produce records upon request of a Responsible Person, the Division, law enforcement, protective agencies, and other persons and entities entitled to access public records under the law.

CHAPTER 43 RESPITE PROVIDED AT CAMP TO DIVISION MEMBERS

REVISION DATES: 11/09/2022, 1/29/2016

EFFECTIVE DATE: April 15, 2015

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

PURPOSE

The purpose of this policy is to establish requirements for Qualified Vendors when respite services are used for members to attend a Camp.

DEFINITIONS

1. **"**Camp" means a Qualified Vendor service site or Community Setting used to provide respite to a member's primary caregiver while concurrently providing recreational activities for the member. Camp may be daily or overnight.
2. "Community Setting" means a location generally available to the public that is not owned or controlled by a qualified vendor.

POLICY

A. UTILIZATION OF RESPITE FOR CAMP

1. Members assessed and authorized eligible to receive respite may choose to use respite to attend Camp.
2. The Qualified Vendor shall bill for respite beginning when the member is transferred from the primary caregiver or other natural support to the Qualified Vendor.
3. The Qualified Vendor may bill Respite when the member is transported to Camp by the vendor.

B. PROGRAM SITE REQUIREMENTS FOR CAMP

1. The Qualified Vendor shall cooperate with the Division's Office of Licensing, Certification, and Regulation (OLCR) inspection at any site owned or controlled by the Qualified Vendor that is used to provide respite services to Division members. The OLCR shall not inspect Community Settings.
2. The Qualified Vendor shall ensure that:
   a. All direct care staff or volunteers working with Division members meet all training and background requirements as outlined in the Qualified Vendor Agreement and A.A.C. Title 6, Chapter 6, Article 15.

b. Staff-to-member ratios comply with and be billed in accordance with the Division's Qualified Vendor Agreement, Respite Services Specification, and Rate Book.

c. All members attending Camp be included in the calculation of staff-to-member ratios, including non-Division funded individuals.

C. CAMP RELATED ACTIVITY FEES

1. The Qualified Vendor may, if necessary and appropriate for the Camp activities and setting, request activity fees covering food and supplies for special Camp activities, since these costs are not included in the respite rate.
2. The Qualified Vendor shall offer an alternative no-cost activity or provide scholarships for members who cannot or do not want to pay an activity fee.
3. The Qualified Vendor shall not determine program participation based on the ability of a member to pay an activity fee.

46 AGENCY WITH CHOICE

REVISION DATE: 05/10/2023;04/03/2019
EFFECTIVE DATE: April 1, 2015
REFERENCES: Social Security Act; A.A.C. R9-28-509; AMPM 1310-A

PURPOSE

The purpose of this policy is to outline the requirements for Qualified Vendors when providing Agency With Choice services for Division Members who are eligible for ALTCS.

DEFINITIONS:

1. "Agency with Choice" or "AWC" means a member-directed service delivery model option offered to Members eligible for ALTCS who reside in their own home in which the provider agency and the Member or Responsible Person enter into a partnership agreement wherein the provider agency serves as the legal employer of the Direct Care Worker and the Member or Responsible Person serves as the day-to-day managing employer of the Direct Care Worker.
2. "Direct Care Worker Agency" means an agency registered with AHCCCS as a service provider of Attendant Care, Personal Care, Homemaker or Habilitation. The agency, by registering with AHCCCS,

warrants that it has a workforce (employees or contractors) with the abilities, skills, expertise, and capacity to perform the services as specified in AHCCCS policy.

3. "Direct Care Worker" means an individual employed by a Direct Care Worker Agency, who assists an individual with a disability with activities necessary to allow them to reside in their home.
4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Qualified Vendor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Division.
6. "Qualified Vendor Agreement" means a contract that consists of the combination of the Request for Qualified Vendor Agreement, the terms and conditions, the specifications, the schedules, the exhibits, the attachments, and any RFQVA amendments.
7. "Request for Qualified Vendor Agreement" means the application a vendor submits to the Division to become a Qualified Vendor.

POLICY

A. The Qualified Vendor and Member or Responsible Person may agree to opt-in anytime for any or all of the following AWC services:

1. Habilitation;
2. Homemaker;
3. Individually Designed Living-Hourly;
4. Attendant Care;
5. Habilitation Hourly Support.

B. The Qualified Vendor shall refer to Division Provider Policy Manual Appendix A Qualified Vendor Application and Directory System (QVADS) Provider Instructions – Agency with Choice Option for guidance to "Opt-In" as an AWC vendor.

C. Once the Qualified Vendor has opted-in to AWC,the Qualified Vendor may opt-out for any or all AWC services only after closure of authorizations for Members who selected AWC service delivery option.

D. The Qualified Vendor shall refer to the Division Provider Policy Manual Appendix B DDD Agency with Choice User Guide – FOCUS Vendor instructions, for billing as an AWC vendor.

E. The Qualified Vendor shall either acknowledge or deny the service authorization within three business days upon receipt of a new service authorization.

F. Upon acknowledgement of the service authorization, the Qualified Vendor shall use a Healthcare Common Procedure Coding System U-7 modifier when submitting claims to the Division for services provided under the AWC service delivery option.

G. For questions about Opting-In to AWC in QVADS, the Qualified Vendor may call l 844-770-9500.

H. For questions about AWC billing, the qualified vendor may contact DDD-Claims@azdes.gov.

CHAPTER 47 MANAGING VENDOR CALL LISTS, VENDOR DIRECTORIES, SCOPE OF SERVICES AND REPORTING REQUIREMENTS

REVISION DATES: 6/2/21, 8/21/19
EFFECTIVE DATE: April 28, 2017
REFERENCES: A.A.C. R6-6-2103–2106

PURPOSE: This policy addresses the process by which a Qualified Vendor notifies the Division of Developmental Disabilities (Division) of its intent to amend or make changes to its scope of services. This includes the intent to reduce the type of service the Qualified Vendor is willing or able to provide and/or the specific geographical area the Qualified Vendor is willing to serve. A reduction in the service offered and/or the specific geographical area to be served is referred to as "Diminishing Scope of Service."

This policy does not address a Qualified Vendor's intent to request termination of its contract with the Division. For termination of services refer to Division's Provider Policy Manual, Chapter 41, Termination of the Qualified Vendor Agreement Upon Request of theQualified Vendor.

A. BACKGROUND

1. The Division maintains vendor call lists and vendor directories for each District to help match members needing service with available vendors.

2. The vendor directories must identify the vendor's:

    a. Type of service(s), location of offices and service site, and contact information.

    b. Cultural and linguistic capabilities, including all languages (including sign language) offered by the vendor; and

    c. Special accessibility features, including physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities (sensory room, noise-cancelling headphones, patient lift assisted devices, etc.).

3. After a Qualified Vendor has been awarded an agreement with the Division, the Qualified Vendor may amend and/or make subsequent changes to its scope of service. These changes may involve:

    a. Adding a new service;

    b. Expanding the geographical area/district the vendor will serve;

    c. Reducing the amount capacity of service provided or changing the geographical area served; or

    d. Reducing the residential capacity in a specific geographical area/district.

B. ADDING A NEW SERVICE

1. To add a new service to an existing Qualified Vendor Agreement, the Qualified Vendor signatory(ies) must document the request in writing and send the request to the designated Contract Management Specialist. The Contract Management Specialist will review the request and assist the signatory(ies) in amending the agreement to reflect the change.

2. Once the Qualified Vendor has finalized the amendment with the Division's Contracts Unit, the District Network Manager/designee will ask the Qualified Vendor to complete and submit a Qualified Vendor Ready to Provide Services form (DDD-1821A). This form will indicate the service(s) to be provided, the geographical area(s) in which the vendor will provide the new service(s), the cultural and linguistic capabilities, and special accessibility features.

3. The Network Manager/designee will:

   a. Update the District vendor directories to include the service type(s)and geographical area(s) in which the services will be made availableby the vendor.

   b. Update all applicable vendor call lists for the District(s) to include all new services.

   c. Issue an announcement to District Support Coordination personnel informing them of changes made to the District vendor directories and vendor call lists. The notice will include the new vendor, services(s) to be provided, geographical area(s) to be served, the cultural and linguistic capabilities, and special accessibility features; and

   d. Forward the Qualified Vendor Ready to Provide Services form to each Network Manager for each District identified on the announcement.

C. EXPANSION IN GEOGRAPHICAL AREA

1. When the Qualified Vendor wants to expand the geographical area in which it currently provides contracted services:

   a. The Qualified Vendor signatory(ies) must notify the District Network Manager/designee, in writing, of the intent to expand service deliveryto that District or a geographical area within that District.

   b. The District Network Manager/designee may schedule a District specific readiness review meeting with the Qualified Vendor to provide District specific information regarding points of contact.

2. Upon completion of the readiness review meeting and/or receipt of the revised Qualified Vendor Ready to Provide Services form, the District Network Manager/designee will:

a. Update the District vendor directories to include the vendor, service type(s), geographical area(s), the cultural and linguistic capabilities, and special accessibility features that are made available by the vendor;

b. Update all applicable vendor call lists;

c. Issue an announcement to District Support Coordination personnel informing of changes made to the District vendor directories and vendor call lists. include the vendor service(s) to be provided and geographical area(s) to be served; and

d. If applicable, Network will send out the Qualified Vendor Ready to Provide Services form to all other Districts that the Qualified Vendor has designated as willing to serve.

D. DIMINISHING SCOPE OF SERVICE

1. Diminishing scope of service may involve:

   a. A decision by a Qualified Vendor not to accept any new referrals statewide, within a specific District or geographical area; or

   b. Consideration or decision by a Qualified Vendor to discontinue a contracted service statewide, within a specific District or geographical area.

2. Under those circumstances the Qualified Vendor must notify the Division's Contracts Unit, in writing, of its intent to reduce the scope of its services. The written notification must include the reason and must be signed by the authorized signatory(ies) for the Qualified Vendor's agreement.

3. Upon notification of a Qualified Vendor's intent to discontinue services statewide, within a specific District or geographical area, the District Network Manager/designee will immediately notify the Division's Contracts Unit. If needed, the District Network Manager will notify the other District Network Units of the Qualified Vendor's intent.

4. Upon notification of a reduction in scope of service(s) by a Qualified Vendor, the following will occur:

   a. If directed by the Contracts Unit, the District Network Manager/designee will develop a transition plan that outlines the steps and associated timelines for the service(s) to be transitioned to an alternative vendor.

   b. The District Network Manager/designee will send a letter to each member or responsible person notifying him/her of the pending change in network. A copy of the letter will be sent to the member's Support Coordinator.

   c. The District Network Unit will work with Support Coordination to identify

alternative vendor options to meet each member's identified service/ support need.

d. If appropriate, the District Network Manager/designee will request that the Qualified Vendor complete and submit a revised Qualified Vendor Ready to Provide Services form that reflects the service(s) and/or geographical area(s) that the vendor will serve.

5. As needed, the District Network Manager/designee will:

a. Update the District vendor directories to reflect the service type(s) and geographical area(s) the vendor will continue to serve.

b. Update applicable vendor call lists.

c. Issue an announcement to Support Coordination personnel informing them of the changes made to the District vendor directories and vendor call lists to reflect the vendor's diminishing scope of service.

d. If appropriate, the District Network Manager/designee will send out the Qualified Vendor Ready to Provide Services form to the other Districts that the Qualified Vendor has designated as willing to serve.

E. CHANGES IN RESIDENTIAL CAPACITY

1. Per ACOM Policy 436, the Qualified Vendor Network must meet specific criteria to meet the needs of members in different geographical areas. This requirement is met by awarding Homes in specific geographical areas to meet the needs of members.

2. Relocation of residential service sites outside of awarded district or geographical area:

a. 60 days prior to any planned relocations outside the current district/ geographical area for which the site was awarded, the qualified vendor must:

i. Contact the Network Manager to request approval to relocate the site outside of the district/geographical area identified on the award letter for the site, including the reason for the request.

ii. The Network Manager will respond within three business days of this request.

iii. If approved, the Qualified Vendor will follow the Relocation Process.

iv. If the request is denied, the vendor may elect to keep providing in the current awarded area or request a release from service. If the

release is approved, Network will issue a vendor call to identify a new vendor.

b. The vendor will continue to provide the services until the new Qualified Vendor is identified and the home is issued a new site code.

c. Upon completion of the transition to a new vendor, the Qualified Vendor will remove the service site from their contract.

3. Closure of a residential service site(s):

a. 60 days prior to any planned closure of a residential service site(s) the qualified vendor must:

i. Contact the Network Manager and provide written notification including the reason for the planned closure and release of the capacity for the site(s).

ii. The Network Manager will respond within three business days of this request.

iii. Determine with the Network Manager if the site(s) will:

- Be transitioned to a new vendor through the vendor call process,
- Transition members to sites with a new qualified vendor through the vendor call process, or
- Require a transitional roster and material change analysis with Contracts.

b. The vendor will continue to provide the services until the new Qualified Vendor assumes the site or the members have successfully been relocated.

c. Upon completion of the closure, the Qualified Vendor will remove the service site from their contract.

4. Changing capacity of specific service sites:

a. To increase or decrease the capacity of a single site, the Qualified Vendor must submit a request to increase or decrease existing capacity of an existing site, identifying the reason for the requested change to their Network Manager.

b. The Network Manager will respond within three business days of this request.

c. The Network Manager will notify the Qualified Vendor of the approval or denial of the request before any changes are made to the site.

F. RELOCATION PROCESS

1. Contractors who would like to relocate a currently licensed group home must contact the District Network Manager in writing 60 days prior to a permanent relocation of a current home to:

    a. Notify the District of the relocation within the area as identified in the award letter for which the home was originally awarded, or

    b. Obtain approval for relocation outside of the area where the home was awarded.

2. Confirmation that all affected members and their teams are aware of and in agreement with the move should be provided when contacting the Network Manager or designee prior to the move.

3. The Network Manager will respond within three business days of this request to relocate.

4. Site codes do not follow the home being relocated. A new site code must be issued.

5. Network must provide the Qualified Vendor an award letter for relocation.

6. The Qualified Vendor is required to complete all necessary steps, as directed by Network and the Qualified Vendor's contract specialist, to have the home licensed, certified, monitored, and added to their contract prior to members moving.

G. HOME AND COMMUNITY BASED SERVICES (HCBS) VENDOR SEARCH

1. The online Vendor Search application is located on the DDD website.

2. Qualified Vendors must update and maintain the HCBS Vendor Search Directory when they make changes to services, scope of services, cultural and linguistic capabilities, or special accessibility features. Directions to update this information is in the Qualified Vendor Application and Directory System (QVADS) Provider Instructions – Provider Search Maintenance (DDD-PS-000-002).

H. MAINTENANCE TIMEFRAMES

1. The Qualified Vendor must notify the District Network Manager/designee at least 15 calendar days preceding any changes the Qualified Vendor intends to make which affects the Division's vendor call lists or vendor directories, including changes in linguistic capabilities and special accessibility features.

2. Update the HCBS Vendor Search on the Division's website within 10 calendars days prior to a change in scope of services.

CHAPTER 48 - CREDENTIALING OF CONTRACTED PROVIDERS

REVISION DATE: 7/13/2022
EFFECTIVE DATE: May 26, 2017
REFERENCES: AHCCCS AMPM Policy 950

PURPOSE

This chapter outlines the credentialing process for health care providers.

DEFINITIONS

Provider is any person or entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

Qualified Vendor is a provider that contracts with the Division for the provision of covered services to members or any subcontractor of a provider delivering services to members.

POLICY

The Quality Management Unit of the Division of Developmental Disabilities (Division) completes credentialing functions to ensure compliance with the Arizona Health Care Cost Containment System (AHCCCS) standards set forth in the AHCCCS Medical Policy Manual, Policy 950. The credentialing of health care providers is delegated to the Division's subcontracted health plans and is monitored by the Division at annual operational reviews. The credentialing of Qualified Vendors is completed by the Division.

A. INITIAL CREDENTIALING

Initial Credentialing occurs before a vendor is approved by the Division's Contracts Unit and is issued a Qualified Vendor Agreement, as follows:

1. The Contracts Unit notifies the Quality Management Unit of a new vendor that has met thecriteria.
2. Quality Management Credentialing Unit staff collect the required information as outlined in the Division's Medical Policy Manual Policy 950 (Credentialing and Recredentialing Processes) and create a file.
3. Quality Management staff conduct an on-site assessment.
4. The credentialing file is presented to the Division's Credentialing Committee for approval.
5. Once the vendor has been approved, the Division notifies the vendor within 10 days of the date the Credentialing Committee issues the approval, via letter, that the vendor has been approved and that recredentialing will occur at least every three years thereafter.

B. TEMPORARY/PROVISIONAL CREDENTIALING

If a provider is immediately needed, or meets other criteria in Division's Medical Policy Manual Policy 950 (Credentialing and Recredentialing Processes) for temporary/provisional credentialing and a contract has been issued before the next Credentialing Committee meeting:

1. The Chief Medical Officer, or Medical Director, reviews the initial credentialing file and makes a determination within 14 calendar days from the request.

2. If the vendor has been approved by the Chief Medical Officer or Medical Director, the Division notifies the vendor that it has been provisionally approved and can initiate authorized services.

3. The vendor's credentialing information will be presented at the next Credentialing Committee meeting for final approval in accordance with Division Policy 950.

C. RECREDENTIALING

Recredentialing occurs at least every three years as follows:

1. Quality Management staff collect the required information as outlined in the Division's Medical Policy Manual Policy 950 (Credentialing and Recredentialing Processes) and create a file.

2. The credentialing file is presented to the Division's Credentialing Committee for approval.

3. If the vendor has been approved, the Division notifies the vendor, via letter, that the vendor has been approved and that recredentialing will occur in three years.

D. CREDENTIALING DENIAL, SUSPENSION OR TERMINATION

1. The Division may deny, suspend, or terminate credentialing for the following reasons:

    a. Not having verification of current insurance

    b. Not being in good standing with state, federal and/or accrediting bodies (if applicable)

    c. Not having current licensure, patterns of licensure compliance issues and/or on-site assessment identifies significant issues

    d. Patterns/Trends regarding complaints/grievances, utilization management, quality of care concerns and/or incidents

    e. Program monitoring and/or certification compliance issues and/or trends

    f. Contract actions, corrective action plans

g. Other contractual obligations not met

h. A credible allegation or determination of fraud, abuse or waste

i. Other concerns relevant to vendor performance and compliance.

2. The reason for the denial, suspension, or termination is documented.

3. The vendor's status is communicated to the Assistant Director, Contracts Management Unit staff, and the Assistant Attorney General for appropriate action.

4. AHCCCS and relevant licensing or certifying boards, law enforcement agencies, and/or protective agencies, are notified of credentialing actions.

CHAPTER 49 RESPONSIBLE DRIVING

REVISION DATE: 12/15/2021, 11/24/2021
EFFECTIVE DATE: May 26. 2017

PURPOSE

The Division of Developmental Disabilities (Division) takes member health and safety very seriously and has an initiative called *Responsible Driving…it's more than what's outside the vehicle* to increase awareness about responsible driving and member safety. 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.

POLICY

A. Vendor Requirements

The Division requires vendors to develop and implement policies and procedures, regarding responsible driving and transporting members, that ensure:

1. Current registration, plates, and insurance for each vehicle
2. Ongoing vehicle maintenance that includes the vehicle climate control systems (air conditioner/heater), and log maintenance for two years
3. Periodic reviews of driving records of employees that drive vehicles to transport members
4. Emergency communication (two-way radio or cell phone) is available for transport
5. Preparedness for emergencies (availability of first aid kit, flashlights, emergency numbers)
6. Safe vehicle boarding and exiting of members
7. Vehicle inspection to ensure passenger safety inside and outside the vehicle prior to, during, and after transport
8. Training of staff on transportation policies/procedures.

The Division encourages providers to use the Transportation Section of form (*DDD-2051A*) *Policy Development Tool*, to self-assess policies and procedures in advance of the Division's review.

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

50 VENDOR CALL REQUIREMENTS FOR QUALIFIED VENDORS

REVISION DATES: 05/10/2023, 3/02/22, 3/22/21
EFFECTIVE DATE: February 5, 2018
REFERENCES: A.A.C. R6-6-2101; A.R.S. § 36-551; Qualified Vendor Agreement

PURPOSE

To establish the non-residential and residential Vendor Call requirements for Qualified Vendors and to outline the process for Qualified Vendors to request release from service authorization.

DEFINITIONS

1. "Auto-Assignment" means the process used by the Division to randomly select a Qualified Vendor to provide services to a Member.
2. "Day" means a calendar day unless specified otherwise in this policy. If a due date to complete an action falls on a Saturday or Sunday, the due date is extended to the following Monday. If a due date falls on a state observed holiday, the due date is extended to the following day, excluding weekend days.

3. "Direct Referral" means a phone call, voicemail, and/or email from the Division to one or more Qualified Vendors requesting the Qualified Vendors' availability and ability to provide services for a specific Member or specific group of Members.
4. "Emergency" means an immediate need for services due to an unexpected change in the Member's needs or loss of support system that may result in injury to the Member or exposure to a harmful situation.
5. "Emergency Vendor Call" means a notification sent through Focus inviting Qualified Vendors to submit a response indicating their availability to provide services for a specific Member or specific group of Members, who urgently require services due to an unexpected change in the Member's needs or loss of support system that may result in injury to the Member or exposure to a harmful situation.
6. "Enhanced Behavioral Group Home" means a time-limited service, designed for Members who have been deemed to need intensive behavioral supports, supports the Member's choice to

live in and access opportunities in their communities through services offered in their group home.

7. "Expansion" means adding capacity to the Division's Network of group home services. Expansion capacity is determined by the Division not to exceed six individuals per setting.
8. "Expansion Presentation" means an interview the Division and Members have with a Qualified Vendor(s) that respond to a Vendor Call for Expansion.
9. "Expansion Award Letter" means a written response to the Qualified Vendor from the Division notifying them of the approval to add a new group home with specific parameters to the Division's network.
10. "Focus" means a suite of software applications and programs developed to support the process of delivering ALTCS and State only funded services to eligible Members. Focus includes the management of information regarding Member demographics, service plans, service authorizations, Vendor Calls, and claims. For purposes of this policy, non-residential Vendor Calls are

issued in the Focus Client Application and residential Vendor Calls are issued in the Focus Program Staffing Application (PSA).

11. "Member" means the same as "client" as defined in A.R.S. § 36-551.
12. "Planning Document" means a written statement of services to be provided to a Member, including habilitation goals and objectives, that is developed following an initial eligibility determination and revised after periodic reevaluations.
13. "Planning Team" means a group of people including the Member; the Responsible Person; the Support Coordinator; other State of Arizona Department of Economic Security staff, as necessary; and any person selected by the Member, Responsible Person, or the Department.
14. "Qualified Vendor" means any person or entity that has a Qualified Vendor Agreement with the Division of Developmental Disabilities.
15. "Receiving Group Home" means a Division group home developed using the Vendor Call process to identify vacant

capacity to be used for Members with an Emergency need for group home services.

16. "Residential Services" means, for the purpose of this policy, the same as Community Residential Setting defined in A.R.S. § 36-551 (15), except this policy does not apply to state-operated services.
17. "Responsible Person" means the parent or guardian of a developmentally disabled minor, the guardian of a developmentally disabled adult or a developmentally disabled adult who is a Member for whom no guardian has been appointed.
18. "Vendor Call" means a notification sent through Focus inviting Qualified Vendors to submit a response indicating their availability to provide services for a specific Member or specific group of Members, based on the requirements defined in the Member's Planning Document.

POLICY

A. STANDARD VENDOR CALLS - Non-Residential Services

1. Qualified Vendors shall view Vendor Calls in the Focus Client Application for all services they are approved to provide in their Qualified Vendor Agreements.
2. Qualified Vendors shall designate and authorize staff, with their own individual Focus login, to respond to Vendor Calls within Focus to avoid delays.
3. Qualified Vendors shall respond to each Vendor Call issued in Focus with either a "yes" or "no" response.
4. Qualified Vendors may request additional information about the Member to determine if they can provide the service needed.
    a. Qualified Vendors are not required to respond "yes" to the Vendor Call if they request to review additional information.
    b. If the Member has a current HIPAA release on file, the information will be sent to the Qualified Vendor by secure email within two days by the support coordinator.

c. If the Member does not have a current HIPAA release on file, or the Member does not agree to sign a HIPAA release, the Member's protected health information will be redacted from the Vendor Call (county and zip code will remain).

5. Prior to responding "yes" or "no" to a Vendor Call in Focus, Qualified Vendors shall review the Vendor Call in its entirety to determine if they can meet the needs and preferences of the Member as outlined in the Vendor Call.
   a. If the Qualified Vendor determines that they do have the resources and qualified staff available to meet the Member's needs, the Qualified Vendor shall respond "yes" to the Vendor Call as directed in Focus.
   b. If the Qualified Vendor determines that they do not have the resources or qualified staff available, then the Qualified Vendor shall respond "no" to the Vendor Call.
6. Qualified Vendors may change their response between "yes" and "no" in Focus at any time until the Vendor Call closes.

7. After responding "yes" to the Vendor Call, if a Qualified Vendor determines that they can no longer meet the Member's needs or no longer has qualified staff available, the Qualified Vendor shall change the "yes" response to "no" response in Focus.
8. The Division shall maintain non-Residential Services Vendor Calls as open until the Qualified Vendor is selected or auto-assigned.

B. STANDARD VENDOR CALLS - Residential Services

1. Qualified Vendors shall view Vendor Calls in the Focus PSA for all services they are approved to provide in their Qualified Vendor Agreements.
2. Qualified Vendors shall have designated and authorized staff, with their own individual Focus PSA login, to respond to Vendor Calls.
3. The Division shall ensure standard Vendor Calls remain open for five calendar days.
4. Interested Qualified Vendors that have the available capacity of qualified staff to provide the service as outlined in the Vendor

Call shall respond to the Vendor Call in writing by using the Focus PSA.

5. Prior to submitting a written response to the Vendor Call in the Focus PSA, Qualified Vendors shall review, at minimum, the Planning Document in its entirety to determine if they can meet the needs and preferences of the Member.
6. If the Division has a signed HIPAA release, the Division shall send a secure email with the Member's additional information to the interested Qualified Vendor.
7. If the Division does not have a signed HIPAA release, the Division shall send a secure email to the interested Qualified Vendor with the Member's personal identifiable information redacted.
8. Once the interested Qualified Vendor has reviewed the Member's additional information and determined staff are available and qualified to meet the Member's needs, the Qualified Vendor shall submit a written response to the Division via the Focus PSA as directed in the Vendor Call by the close date.

9. The Qualified Vendor shall respond to the Vendor Call with the following information in the written response to the Division:
    a. Date Qualified Vendor can start services.
    b. Name of the Qualified Vendor.
    c. Contact name.
    d. Contact phone number.
    e. Contact email.
    f. The experience and background to provide the requested services.
        i. The number of years the Qualified Vendor has provided services, or if the Qualified Vendor has not provided services, other pertinent experience; and
        ii. The number and type of homes the Qualified Vendor currently operates for DDD or other state agencies, if applicable.
    g. A written plan to meet identified needs as described in the Member's residential assessment profile.

i. A description of how the Qualified Vendor will provide necessary and Member-specific training to staff.

ii. A description of how the Qualified Vendor will meet the Member’s cultural or linguistic needs.

h. A description of how the Qualified Vendor will meet the Member’s special accommodations, to include:

i. A description of how complex support needs, including medical or behavioral accommodations, will be met, including assurances that the Qualified Vendor will work collaboratively with the Member's health plan to incorporate any required functional behavioral assessment recommendations.

ii. A description of any environmental modifications needed.

i. A time frame by which the service(s) will be delivered.

i. A description of the timeframe that service delivery will begin, which will include the Member or

Responsible Person visiting the residential setting in their preferred geographic location.

ii. A description of all required inspection time frames from the Arizona Department of Health Services (ADHS), the Division's Monitoring, Office of Licensure, Certification and Regulation, and site code issuance not to exceed 90 days, for group home Expansions.

j. Any additional information responsive to the Vendor Call for services.

i. The date by which the Qualified Vendor will offer the Member or Responsible Person a copy of the vendor's policy manual.

ii. A description of how the Qualified Vendor will involve Members in the daily planned activities of the home.

10. The Division may require the Qualified Vendor to provide additional information in the Qualified Vendor's response to

Expansion Vendor Calls for Enhanced Behavioral Group Homes and Receiving Group Homes.

11. After the Vendor Call closes, the Division shall provide the Responsible Person, as applicable, with all responses that meet the needs of the Member as outlined in the Vendor Call.
12. The Division shall notify Qualified Vendors if their written response does not meet the needs specified in the Vendor Call.
13. If a Residential Services Vendor Call closes without identifying a Qualified Vendor, the Division shall conduct Direct Referrals as outlined in Section D. of this policy.

C. AUTO-ASSIGNMENT – Non-Residential and Residential Services

1. If a Member or Responsible Person is unwilling, unable, or does not select a Qualified Vendor from the vendors who respond "yes" to the Vendor Call in Focus for non-Residential Services or submit a written response in the Focus PSA for Residential Services, the Division shall auto-assign the service to a Qualified Vendor.

2. The Division shall include a Qualified Vendor that responds "yes" to the Vendor Call in Focus or submits a written response in Focus PSA in the auto-assignment process as necessary.
3. The Division shall notify the selected Qualified Vendor of the auto-assignment within one business day.
4. The Qualified Vendor shall contact the Member or Responsible Person within one business day of being notified of the Auto-Assignment.

D. DIRECT REFERRALS – Non-Residential and Residential Services

1. The Division shall make Direct Referrals if a Vendor Call does not receive any responses within seven days for non-Residential Services or within five days for Residential Services.
2. The Division shall make Direct Referrals in the Member's preferred geographic area and may extend the search to proximal areas or statewide.
3. The Division shall continue to make Direct Referrals until the service is assigned or is no longer needed by the Member.

4. Qualified Vendors shall respond to the Division's Direct Referrals within one business day.
5. Qualified Vendors who accept the Direct Referral for non-Residential Services shall meet the requirements in Section (A)(5)(a)(b) of this policy.
6. Qualified Vendors who accept the Direct Referral for Residential Services shall meet the requirements in Section (B)(5) of this policy.

E. EMERGENCY VENDOR CALLS – Non-Residential and Residential Services

1. The Division shall issue Emergency Vendor Calls for Members by the using following methods:
   a. Posting the Emergency Vendor Call in Focus for non-Residential Services; or
   b. Posting the Emergency Vendor Call in Focus PSA for Residential Services; and

c. Making Direct Referrals as outlined in Section D(1)(2)(3) of this policy, including contacting Receiving Group homes first for Members needing a group home service.

2. Qualified Vendors shall meet the requirements in D(4)(5)(6) of this policy for responding to Direct Referrals.
3. Qualified Vendors shall respond to Emergency Vendor Calls for non-Residential Services as required in Section A. of this policy.
4. Qualified Vendors shall respond to Emergency Vendor Calls for Residential Services as required in Section B. of this policy.
5. The Division shall maintain Emergency Vendor Calls for Residential Services as open in the Focus PSA for up to three business days.
6. The Division shall maintain Emergency Vendor Calls for non-Residential Services as open until a Qualified Vendor is selected, it is no longer an Emergency need, or the service is no longer needed.
7. Qualified Vendors that respond to the Emergency Vendor Call for Residential Services may meet with the Member or Responsible

Person to coordinate the move if time permits prior to providing Residential Services.

F. SELECTION – Non-Residential and Residential Services

1. The Division shall notify the Qualified Vendor within one business day of being informed of the Member or Responsible Person's selection.
2. The selected Qualified Vendor for non-Residential Services shall complete the following within one business day of being notified of the Member or Responsible Person's selection by the Division:
   a. Acknowledge the service authorization in Focus; and
   b. Contact the Member or Responsible Person to identify a date to start services.
3. The Division shall notify the Qualified Vendors that responded "yes" to Vendor Calls for Residential Services that were not selected within 14 calendar days of the Vendor Call closing.
4. Prior to providing Residential Services, the selected Qualified Vendor shall:
   a. Acknowledge the service authorization(s) in Focus.

b. Verify that the service site is approved by the Division.

c. Attend a meeting with the Member's Planning Team to discuss plans for ensuring a smooth transition for the Member.

5. Following the Member moving into a residential setting, the selected Qualified Vendor shall attend a post-move meeting with the Member's Planning Team to discuss behavioral health supports when necessary, and habilitative outcomes as per timelines required in Division Medical Policy Chapter 1620-E.

G. EXPANSION - All Group Homes

1. The Division shall consider expanding the network when all existing options for identified Member(s) have been exhausted or if a network capacity need has been identified. The Division shall send expansion Vendor Calls to:

a. Meet the needs of a group of Members.

b. Develop new or vacant capacity.

2. The Division shall require new group homes to meet cost effectiveness requirements outlined in the Division's Medical Policy 1620-C.
3. Qualified Vendors shall respond to Expansion Vendor Calls by meeting the requirements as outlined in Section B of this policy.
4. The Qualified Vendor shall participate in Expansion Presentations at the Division’s request.
5. The Qualified Vendor shall develop all materials used in Expansion Presentations, such as brochures, videos, or slide decks, in accordance with Provider Policy Chapter 34.
6. Members shall select the preferred Qualified Vendor based on the collective decision of the Members or Responsible Persons.
7. The Division shall notify the Qualified Vendors that were not selected.
8. The Division shall notify the Qualified Vendor when selected with an Expansion Award Letter.
    a. The Qualified Vendor shall meet all required parameters of the Expansion Award Letter.

b. The Qualified Vendor shall contact the Division with any concerns regarding the parameters of the Expansion Award Letter.

c. The Qualified Vendor Shall provide updates on the status of the Expansion awarded as determined by the Division.

9. The Qualified Vendor shall, within 90 calendar days of receiving the Expansion Award Letter, complete the following:

a. Obtain a home that is owned or leased by the awarded Qualified Vendor within the parameters documented in the expansion award letter.

b. Obtain a license for the group home as required by ADHS.

c. Add the new home address to the service site section in the Division's Contract Administration System.

d. Obtain an HCBS certificate from the Division for the home.

e. Register the home with AHCCCS as a provider type 25-DD group home.

f. Submit an inspection request to DDD Monitoring at DDDMonitoring@azdes.gov and pass the inspection.

g. Obtain a site code by contacting the assigned DDD Contract Specialist.

h. Provide communication at a cadence determined by the Division on recruitment efforts to obtain appropriate staffing levels.

10. The Division may rescind an Expansion Award if the parameters outlined in the Expansion Award Letter are not met, not met timely, or as determined by the Division.

H. REQUEST FOR RELEASE FROM SERVICE AUTHORIZATION – Non-Residential and Residential Services

1. Prior to discontinuing providing services to a Member, the Qualified Vendor shall notify the Planning Team and obtain agreement from the Planning Team.
2. The Qualified Vendor shall submit a request for release from service authorization to the DDD Customer Service Center (CSC) if a request for release is not agreed upon by the Planning Team.
3. The CSC shall process the request and submit it to the District Program Manager (DPM) for resolution.

4. The DPM shall consider the following situations as as applicable when reviewing requests for release of service authorization:
    a. The Qualified Vendor has documented attempts to contact the Member, without success, and services have not been provided.
    b. The Qualified Vendor responded "yes" to the Vendor Call, the Member or Responsible Person subsequently changed the conditions or expectations, and the Qualified Vendor can no longer meet the Member's needs, and services have not been provided.
5. The DPM shall notify the Qualified Vendor of the decision within 21 calendar days.
    a. If the request is denied, the DPM shall include the reasons for denial in the notification.
    b. A Qualified Vendor who disagrees with the decision of the DPM may file a grievance as provided by A.A.C. R6-6-1801 et seq. and A.A.C. R6-6-2201 et seq.

6. The Qualified Vendor shall continue to provide service until a new Qualified Vendor is authorized.

CHAPTER 51 OVERSIGHT AND MONITORING OF DEVELOPMENTAL HOME SERVICES

REVISION DATE: 9/28/22, 2/24/21, 12/26/18

EFFECTIVE DATE: August 8, 2018

REFERENCES: A.R.S. 36-591, 36-592, 36-593.01; A.A.C. R6-6-1001, R6-6-1101

PURPOSE

To outline the roles, responsibilities and requirements of the Division of Developmental Disabilities (Division), Qualified Vendors, and licensees in the provision of Developmental Home Services and Child Developmental Certified Home Services specifically to:

- Outline the experience and expertise, and the training requirements of the Qualified Vendor (agency) staff and licensing workers.
- Establish minimum standards for home studies.
- Provide guidance for entering information into the Division's licensing system, *Quick Connect.*
- Provide guidance for submitting monthly census and changes information.

POLICY

The Division reviews and approves or denies applications and renewals for developmental home licenses to applicants or licensees. The Division contracts with Qualified Vendors for developmental home services and provides monitoring and oversight to ensure compliance with the Qualified Vendor Agreements. Payment for these services are outlined in the Division's Rate Book.

A. DIVISION RESPONSIBILITIES

1. The Division monitors/audits Qualified Vendors at least annually to ensure they have systems in place to provide oversight for compliance to licensing rules, Division Policies and Procedures, Qualified Vendor Agreements, and best practices.
2. New Qualified Vendors are monitored/audited within six months after implementing the service and annually thereafter.
3. The Division shall issue corrective action plans, as necessary, when issues of non-compliance are identified.
4. Protective service agencies (e.g., Department of Child Safety, Adult Protective Services, law enforcement) investigate member abuse, neglect, and exploitation. The Division provides the protective service agencies information to aid in the completion

of an investigation.

5. The Division conducts an onsite visit at each developmental home annually to monitor compliance with health, safety, contractual, programmatic, and quality assurance standards.
6. Prior to initial licensure and annually thereafter, the Division conducts a life-safety inspection. Inspection for an initial license application must occur within nine months of the date the application is submitted to the Office of Licensing, Certification, and Regulation.
7. A new inspection shall be completed if the licensee moves to a new address or completes remodeling.

B. QUALIFIED VENDOR AGENCY RESPONSIBILITIES

1. Through its licensing staff, Qualified Vendors are responsible for recruiting, training, and providing technical assistance and oversight to applicants and licensed providers of developmental home services.
2. Through the established rate model, the Qualified Vendor receives payment from the Division for administrative costs, including but not limited to recruitment, training, technical assistance, and oversight.

a. The Qualified Vendor makes payment(s) to the licensee for direct developmental home services.

b. The licensee may not provide hourly HCBS services to other members while directly responsible for the supervision of members receiving developmental home services.

3. The Qualified Vendor is responsible for reviewing and responding to vendor calls, and once selected by the member/responsible person, assisting with the move in the developmental home.
   a. Up to three Division members or child siblings of members may receive developmental home services in the home.
   b. A license capacity greater than three may only be approved when all children in the home are siblings.
   c. Children deemed likely to be eligible for the DDD program may receive developmental home services upon approval by Division staff.
   d. Qualified Vendors shall ensure new members are not referred to homes with an open licensing investigation, an open protective service investigation, or in a home that has received a notice of an adverse licensing action.

4. The Division pays claims for fingerprinting costs for developmental home license applicants, licensees, and adult household members. Agencies are required to submit information to the Division (using the Fingerprint Clearance Card Tracking Tool) for individuals who have applied for a fingerprint clearance card. The names must be submitted within 10 days of fingerprinting. The name of each applicant, licensee or adult household members should be entered as it appears on their Driver's License or other state or federal identification.

C. EDUCATION AND EXPERIENCE

1. A licensing worker shall have one or more of the following:
   a. A bachelor's degree in a related human services field,
   b. Two years of post-secondary education in a related human services field and two years of directly related work experience, or
   c. A minimum of five years of directly related work experience. Directly related work experience includes work in the field of developmental disabilities, family home licensing, or child welfare.
2. A licensing supervisor shall meet the requirements of a licensing

worker and have two years of supervisory experience or demonstrated leadership experience.

3. A licensing supervisor who is completing the duties of supervisor and licensing worker shall meet the higher requirements of the supervisor.

D. CASELOAD RATIO

A full-time licensing worker may not be responsible for more than 20 licensed homes for training, technical assistance, and oversight.

E. TRAINING

1. Licensing workers and supervisors must have a current Level I Fingerprint Clearance Card and within the first 90 days of employment complete all of the following training areas:
   a. Article 9 (*Requires a certified instructor*)
   b. Articles 10 and 11, as applicable to service delivery to children or adults
   c. Mandated reporting
   d. Incident reporting
   e. Cultural Competency
   f. HIPAA
   g. Provider Manual Chapter 51, Oversight and Monitoring of

Developmental Home Services

h. Prevention & Support (*Requires a certified instructor*)

i. The move process

j. The planning process

k. Introduction to the four developmental disabilities

l. Licensing forms & *Quick Connect*

m. Record keeping

n. Behavior planning

o. Positive behavior support

p. Medication management

q. Life safety rules

r. Member fund management

s. Investigations

t. Guardianship and legal issues

u. The Child and Family Team Process

2. Licensing workers and supervisors are required to attend the Division's Home Studies and Family Assessment Seminar within six months of being assigned to a licensee. In addition, a licensing worker or supervisor is required to complete a minimum of 10 hours of training per year.

3. Licensing seminars sponsored by the Division may be retaken for training credit every three years and count towards the annual training requirements.

F. RECORDS FOR CHILD AND ADULT DEVELOPMENTAL HOMES

1. The Qualified Vendor shall have an organized system to maintain all licensing documents. The licensing file includes training certificates, Department of Economic Security forms, and documentation to verify licensing compliance where applicable. The licensing file shall be kept in locked storage or secure electronic storage when not in use and made available to the Division upon request.
    a. If a licensed provider transfers from one Qualified Vendor to another Qualified Vendor, the sending agency shall provide a copy of the provider's licensing file as outlined in this policy.
    b. The receiving Qualified Vendor shall update any missing items within 30 days of the transfer.
2. The licensing file shall include the following Department of Economic forms:
    a. LCR-1056A, Applicant Statement of Understanding

b. LCR-1040A, Health Self-Disclosure/Physician Statement

c. LCR-1034A, Criminal History Self-Disclosure Affidavit

d. DD-289 or DD-281, Child or Adult Developmental Home Agreement

e. LCR-1031B, Child or Adult Developmental Home Caregiver Assessment Guide (for persons licensed after implementation of this policy)

f. LCR-1054A, signed Initial Application Worksheet

g. LCR-1053A, signed Renewal Application Worksheet

h. Signed Developmental Home Third-Party Agreement, Section 9 F of the Qualified Vendor Agreement

i. LCR-1078A, Developmental Home Application Cover Page

3. The licensing file shall include the following documents as applicable:

a. Training Certificates

b. Fingerprint Clearance Documentation

c. Interstate Central Registry clearance (For child developmental homes; for applicants and household members who have resided outside of Arizona within the prior five years)

d. Three References

e. Marriage License

f. Divorce Decree(s) for the current 10-year period prior to application

g. Birth Certificates (or proof of legal residency)

h. Valid Driver's License for any individuals providing transportation

i. Current vehicle registration for any vehicles regularly used to provide transportation

j. Current vehicle insurance for any vehicles regularly used to provide transportation

k. Verification of income

l. Immunization records for children

m. Interview documentation, pre-licensure and renewal

n. Office of Licensing, Certification, and Regulation (OLCR) Inspection Report

o. Evacuation plan

p. Rabies vaccinations for dogs

q. Copy of the actual license

r. Monitoring Forms

s. Incident Reports

t. Licensing investigations and any corrective action plans

u. Documentation verifying qualifications of any alternate caregivers (Level 1 Fingerprint Clearance Card, CPR, First Aid, Article 9, orientation to member, APS Registry check, and Department of Child Safety (DCS) Central Registry check)

G. POTENTIAL APPLICANTS FOR DEVELOPMENTAL HOME LICENSURE

1. A Qualified Vendor shall inform a potential applicant of the developmental home 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 Division for a developmental home license.
2. If the Qualified Vendor determines it is not able to work with an applicant who wishes to apply for a license, the determination shall not be based on race, religion, national origin, sex, sexual orientation, gender identity, or a similar protected class.
3. A Qualified Vendor shall assist any applicant it declines to work

with to find an alternative vendor, or if no alternative vendor is available, refer the applicant to the Division. The Qualified Vendor shall transfer any application information to the alternative vendor or Division, as applicable.

4. Applicants for licensure may be married or unmarried persons. No more than two single individuals shall be licensed at the same address if they both plan on providing care. This could include a cohabiting couple, a set of adult siblings, a parent and adult child, or roommates who wish to be licensed together. Married applicants shall be licensed jointly unless a married applicant applies to be licensed individually and one or more of the following applies to the applicant's spouse:
    a. Expected to be absent from the household for nine or more of the following 12 months due to employment, military service, or other planned absence;
    b. Legally separated and living in another residence and the applicant has the right to exclusive use of the residence; or
    c. Medically or physically incapacitated to the degree that the spouse is unable to provide care for a member.
5. The Qualified Vendor is responsible to provide or arrange

pre-licensure and annual training for applicants. Pre-licensure training must meet the specific content requirements outlined by the Division. The Qualified Vendor is responsible to ensure that the licensee receives a pre-move orientation to each member's needs and planning documents.

H. HOME STUDY, HOME VISITS, AND TECHNICAL ASSISTANCE

1. Prior to licensure, the applicant and household members shall participate in interviews and assist the licensing worker to evaluate the applicant with respect to character, family stability, and the ability to care for individuals with developmental disabilities. Each applicant and household member should be interviewed individually. Married or cohabiting couples should be interviewed at least once together. If the applicant has children in the home, children should be interviewed, if possible. All interviews should be conducted by the licensing worker in person. Information gathered during the interviews is summarized and included in the Home Study submitted through *Quick Connect*.
2. The licensing worker shall visit the home monthly to provide technical assistance, support to the licensee, and ensure

compliance with licensing rules, Division policies and procedures, the Qualified Vendor Agreement, the Third-Party Developmental Home Agreement, and best practices. The licensing worker shall document all visits in the Division's licensing data system, *Quick Connect.* If there are no members placed in the home, only quarterly (in person or virtual) visits are required.

Note: New move visits shall be completed within seven days. For licensees providing care for the first time, a licensing worker shall visit the home once per week during the first four weeks of move.

3. A comprehensive licensee visit shall be completed every quarter using the Developmental Home Compliance Review form (LCR-1079A). A visit includes the following:
   a. A review of any expiring certifications or documents,
   b. An inspection of the premises to ensure compliance with the licensing and life-safety rules,
   c. A review of the file (progress reports, medication logs),
   d. A discussion of any move challenges including methods used for managing inappropriate behaviors,

e. A discussion about the progress of the member on their habilitation goals,

f. A discussion of any changes or upcoming changes in the household,

g. A discussion of past or upcoming appointments,

h. A review of transportation arrangements,

i. A review of any alternate supervision plans,

j. A discussion of member funds,

k. A discussion of member choice,

l. A discussion of member social and recreational activities, and

m. Interaction or observation of the member in the home setting.

4. Quarterly visits are based on a calendar year. Quarterly visits shall be completed by March 31, June 30, September 30, and December 31. At least one unannounced home visit shall be completed each calendar year using the Abbreviated Developmental Home Compliance Review form (LCR-1079B).

5. Visits shall be documented in *Quick Connect* within 10 business days of the visit. Documentation shall include:

a. Date of the visit,

b. Type of visit (scheduled or unannounced),

c. Length of the visit,

d. Location, and

e. Individuals contacted during the visit.

f. A general visit summary that includes:

i. A summary of key discussion points during the visit,

ii. A statement identifying the monitoring tool used during the visit,

iii. A statement of whether there were any licensing violations noted and a statement indicating any calls to protective services as a result of the visit,

iv. A statement of any corrective actions needed including a notation of any repeat issues,

v. A summary of any items requiring follow-up, and

vi. Verification that the follow-up was completed from the last review.

6. Annual renewal is an annual reassessment of character, family stability, and the ability to care for individuals with developmental disabilities. The annual renewal may be combined

with a quarterly monitoring visit. A renewal visit includes interviews with licensees. During the renewal visit, the licensing worker collects or reviews documents needed for the renewal application. Members should not be identified by name in licensing home studies. Members should be identified by initials and Assists ID only. Renewal applications must be submitted through *Quick Connect* at least 30 days prior to the expiration of the license.

7. A renewal application and home study may be submitted for a license applicant whose license has been voluntarily closed or expired for less than one year. An applicant whose license has expired or voluntarily closed for more than one year must submit an initial application and home study.
8. If a licensing investigation is requested by the Division due to a complaint or significant compliance concern, the Qualified Vendor shall contact the licensee and initiate an investigation within 10 days. The Qualified Vendor shall submit a report to OLCR within 21 days using the Licensing Investigation Template form (LCR-1080A).
9. At all visits a Notice of Inspection Rights form (LCR-1005A) shall

be reviewed and completed. The licensee shall receive a copy of any monitoring forms completed during the visit.

I. DEVELOPMENTAL HOME CENSUS AND REPORTING CHANGES

The Division manages the Network capacity to support its membership. In order to ensure that the capacity is accurate, the Qualified Vendor shall submit a monthly census of each developmental home it has an agreement with no later than the last day of the reporting month. The census shall be on the Division's approved Developmental Home Census Report form and submitted through secure email to DDDDevelopmentalHomeCensus@azdes.gov. The Developmental Home Census Report form may be found here: https://des.az.gov/sites/default/files/Developmental_Home_Census_Template_100920.xlsx Additionally, the Qualified Vendor shall notify the Division of all changes in member moves, including internal moves (within the agency) or external moves (to another vendor). The moves shall be reported on the same form as the monthly census and submitted to the same email address.

J. LICENSEE

1. The licensee is required to maintain a license issued by the Division and ensure that the licensee maintains compliance with

the terms of the license and with applicable rules. The licensee provides direct care to Division member(s) as outlined in the member's planning documents and under the Third-Party Developmental Home Agreement.

2. The licensee selects a Qualified Vendor based on individual preference; however, licensee may not transfer from one Qualified Vendor to another if the license is within 60 days of expiration. If the licensee is on a corrective action plan, a transfer requires written approval of the sending Qualified Vendor, the receiving Qualified Vendor, and the Division.
3. The licensee shall comply with all home visits conducted by the licensing worker or the Division.
4. Prior to initial licensure, all child and adult developmental home applicants must have CPR and First Aid training, taught by an instructor certified by a nationally recognized entity such as the American Red Cross, the American Heart Association, or the National Safety Council, that requires the applicant to demonstrate mastery of skills in person to the instructor. In addition, receive training (with supporting documentation verifying completion) in all of the following core topics and

subtopics, totaling a minimum of 18 hours of course or instruction time (Courses marked with an asterisk [*] are available on the Division's website):

a. Article 9, including member rights, taught by a certified instructor.

b. DDD Philosophy and Mission Statement*

   i. DDD Mission Statement.

   ii. Individual and family involvement in making choices and expressing preferences.

   iii. Equal access to quality services and supports for all individuals.

   iv. Individuals as welcomed, participating, and contributing members in all aspects of family and community life.

   v. The rights of all individuals and the preservation of their worth, value, and dignity.

c. Introduction to the Four Developmental Disabilities*

   i. What are the Four Developmental Disabilities?

      - Cognitive/ Intellectual Disability
      - Epilepsy

- Cerebral Palsy
- Autism

ii. Diagnostic Criteria

iii. Functional Criteria

iv. Substantial Functional Limitation(s)

v. Treatment

d. The planning process and skill building*

i. The planning process

ii. Components of a plan

iii. Long- and short-term goals

iv. Measurable objectives

v. Data collection procedures and systems

vi. Progress reports

vii. Assessing strengths and needs

viii. Methods of teaching

ix. Types of reinforcement

x. The use of teaching strategies/plans

e. Medication Administration*

i. Medication storage

ii. Medication container and label

iii. The medication logs

iv. Correct dosage

v. Forms of medication

vi. Routes of medication administration

vii. Medication error procedures

f. Incident Reporting and Reporting Abuse, Neglect, or Exploitation*

i. Understanding the incident reporting process.

ii. Identifying emergency situations and signs of abuse.

iii. Understanding mandatory reporting requirements.

iv. Demonstrating how to complete an incident report.

g. Confidentiality/HIPAA*

i. Limits to access to member records and personally identifiable information.

ii. Agency procedures designed to protect/safeguard member confidentiality.

iii. Procedures for obtaining consent prior to the release of information.

iv. Review of ARS 36-568.01.

h. Choking and Aspiration*

i. Preventing aspiration and choking

ii. Common issues

iii. Assessment

iv. Intervention and prevention strategies

i. Principles of Positive Behavior Support

i. Prevention vs. intervention

ii. Recognizing cues

iii. Reinforcing appropriate behavior

iv. Redirection

v. Consistency

vi. Clear communication

vii. Evaluating the environment

viii. Defensive positioning

ix. Providing opportunities for choices and decision-making

j. Cultural Competency (covered for child developmental home applicants in the ADCS/Foster Parent College Based Pre-Service Training Program).

k. Client Funds Training*

L. Documentation and Progress Reporting Requirements and

vendor policies.

l. Review Article 10 or 11, as applicable to the populations served.

m. Review of the Child or Adult Developmental Home Third-Party Agreement.

n. Supporting positive relationships with family members, schools, or day programs, and professional communication (covered for child developmental home applicants in the ADCS/Foster Parent College Based Pre-Service Training Program).

5. In addition to the DDD specific training noted above:

a. Applicants for a child developmental home license must complete the DCS/Foster Parent College-Based Pre-Service Training Program.

b. If required in a member's planning documents, applicants must complete the training in Prevention and Support.

6. Licensees are required to complete 10 hours of training annually. Training required to maintain certifications (CPR, First Aid, and Article 9) may be counted for up to four hours of the annual training.

7. When reopening a license that has been closed for one year or less, applicants must complete a minimum of 10 hours of training. If the license has been closed for over one year, applicants must complete a minimum of 18 hours of training covering the topics required for initial applicants.

K. CHILD DEVELOPMENTAL CERTIFIED HOMES

1. A Child Developmental Certified Home (CDCH) is a foster home licensed by the DCS that has been certified by the Division to provide care for a specific child or children with developmental disabilities. A CDCH must meet the same requirements as a child developmental home and maintain compliance with foster care licensing rules. When a Child Developmental Home Certification is issued, the foster care license is restricted to the specific child or children placed in the home. Additional children may only be placed in the home with the approval of DCS and DDD. A CDCH may provide care for up to five children in care with no more than three children with developmental disabilities.
2. Once the certification is issued, the DDD qualified vendor (certifying agency) is responsible for monitoring compliance with child developmental home requirements outlined in A.A.C

R6-6-1001 et. seq. (Article 10). The DCS licensing agency is responsible for monitoring compliance with foster care licensing rules. A CDCH provider may be supported and monitored by a single agency responsible for both DDD and DCS requirements or a CDCH provider may be monitored by a DDD qualified vendor for the DDD certification requirements while a different agency monitors the DCS licensing requirements. The DDD qualified vendor is required to conduct monitoring visits to the home according to the same requirements outlined in this chapter for child developmental homes.

3. Prior to applying for a CDCH, the DDD certification worker must confirm that the child is eligible for DDD services and approved for Child Developmental Certified Home Services. This must be confirmed by contacting DDD Network staff in the District responsible for support coordination for the child.

L. INITIAL APPLICATION FOR CDCH CERTIFICATION

1. Initial CDCH applicants must complete 18 hours of training covering the topics required for a child developmental home as listed in this policy. To apply for a CDCH certification, the following documents shall be submitted to OLCR:

a. LCR-1086A, Application for Child Developmental Home Certification,

b. LCR-1087A, Child Developmental Certified Home Application Cover Page,

c. LCR-1056A, Applicant Statement of Understanding signed by the applicants and all adult household members,

d. LCR-1085A, Adult Protective Services Records Check Request for the applicants and all adult household members,

e. CSO-1232A (DCS form), a copy of the most recent health self-disclosure for the applicants and all adult household members,

f. CSO-1269A (DCS form), a copy of the most recent physician statement for the applicants and all adult household members,

g. CSO-1229 (DCS form), a copy of the most recent Criminal History Self-Disclosure for the applicants and all household members,

h. LCR-1033A, Life-Safety Inspection Request, and

i. Certification Study.

2. For DDD vendors who are also responsible for the foster care license, the CDCH study may be submitted through *Quick Connect*. In all other circumstances, the CDCH study shall be submitted to OLCR via email. The CDCH study shall contain the following:
    a. A statement of the circumstances of the request, including a statement that DDD/Network has approved certification for the specific child. Identify the child by initials and Assists ID only.
    b. A summary of the training completed. Training must reflect the minimum of 18 hours of child developmental home training requirements outlined in this policy.
    c. A summary of the child's needs.
    d. A summary of how the family will meet the child's needs including:
        i. A description of the applicant's work hours.
        ii. Alternative supervision plan which includes only caregivers meeting HCBS requirements.
        iii. Transportation plan including a vehicle inspection.
        iv. A summary of any special care needs for other

members of the household including placed or biological children.

e. A description of the home, sleeping arrangements, and a summary of the OLCR inspection.

f. A summary of the fingerprint clearance card status and protective service checks completed on the applicants and household members.

g. Recommendation for Child Developmental Home Certification.

M. RECORDS FOR CHILD DEVELOPMENTAL HOME CERTIFICATION

1. The Qualified Vendor shall have an organized system to maintain all certification documents. The licensing file includes training certificates, Department of Economic Security forms, Department of Child Safety forms, and documentation to verify certification compliance where applicable. The licensing file shall be kept in locked storage or secure electronic storage when not in use and made available to the Division upon request.

2. Forms:

   a. LCR-1086A, signed Application for Child Developmental Home Certification

b. LCR-1056A, signed Applicant Statement of Understanding

c. LCR-1085A, Request for Adult Protective Services Records Check

d. LCR-1033A, Request for Life Safety Inspection

e. CSO-1232A (DCS form), Health Self-Disclosures obtained from the DCS licensing file

f. CSO-1269A (DCS form), Physician Statements obtained from the DCS licensing file

g. CSO-1229A (DCS form), Criminal History Self-Disclosure forms obtained from the DCS licensing file

h. LCR-1087A: Child Developmental Certified Home Application Cover Page

i. Signed Developmental Home Third Party Agreement, Section 9 F of the Qualified Vendor Agreement

3. Verification documents and other requirements:

a. Training Certificates

b. Fingerprint Clearance Documentation

c. Three References (copies of references may be obtained from the foster care licensing file)

d. Valid Driver’s License for any individuals providing

transportation

e. Current Vehicle Registration for any vehicles regularly used to provide transportation

f. Current Vehicle Insurance for any vehicles regularly used to provide transportation

g. Immunization records for non-placed children

h. OLCR inspection report

i. Evacuation plan

j. Rabies vaccinations for dogs

k. Copy of the actual license

l. Monitoring Forms

m. Incident Reports

n. Licensing/Certification investigations and any corrective action plans

o. Documentation verifying qualifications of any alternate caregivers (Level 1 fingerprint clearance card, CPR, First Aid, Article 9, orientation to member, APS Registry check and DCS Central Registry check)

N. RENEWING THE CERTIFICATION

1. A foster care license is issued for a two-year period. The initial

certification will be in effect for a minimum of one year, and then expire on the same day and month as the foster care license expiration. The certification will expire annually thereafter.

2. The DDD certifying agency is responsible for monitoring renewal timeframes and renewing the certification as needed.
3. To renew the certification:
    a. A renewal application must be submitted at least 30 days prior to the expiration of the certification.
    b. 10 hours of training must be completed. Training required to maintain certifications (CPR, First Aid and Article 9) may be counted for up to four hours of the annual training.
    c. A Life-Safety Inspection must be conducted annually prior to each renewal.
4. To renew the CDCH, the following documents shall be submitted to OLCR:
    a. LCR-1086A, Application for Child Developmental Home Certification,
    b. LCR-1087A, Child Developmental Certified Home Application Cover Page,
    c. LCR-1056A, Applicant Statement of Understanding, signed

by the applicants and all adult household members,

d. CSO-1232A (DCS form), a copy of the most recent health self-disclosure for the applicants and all adult household members, if updated during the certification period,

e. CSO-1269A (DCS form), a copy of the most recent physician statement for the applicants and all adult household members, if updated during the certification period,

f. CSO-1229 (DCS form), a copy of the most recent Criminal History Self-Disclosure for the applicants and all household members, if updated during the certification period, and

g. LCR-1033A, Life-Safety Inspection Request (60 days prior to expiration).

5. Certification Home Study:

a. For DDD vendors who are also responsible for the foster care license, the CDCH study may be integrated into the license renewal and submitted through *Quick Connect*.

b. For DDD vendors responsible for the certification only, the CDCH study is submitted to OLCR via email and the foster

care licensing agency enters that data into *Quick Connect* once reviewed and approved by OLCR.

c. The certification renewal study should follow the same general format as the initial study outlined above.

O. TERMINATING A CERTIFICATION

A CDCH is terminated when the child for whom the CDCH certification was issued moves from the home or if the foster care license is terminated. After a child leaves the home an amendment must be completed to close the certification.

CHAPTER 52 HABILITATION STAFFING SCHEDULE REQUIREMENTS AND ANNUAL REVIEW

REVISION DATE: 8/10/22

EFFECTIVE DATE: April 3, 2019

REFERENCES: Division Medical Policy 1620-C

PURPOSE

To establish the duties and responsibilities of Qualified Vendors regarding the preparation and submission of Daily Habilitation Staffing Schedule for Group Homes and Individually Designed Living Arrangements/Supported Living (IDLA) unless otherwise noted.

POLICY

A. CRITERIA

1. Qualified Vendors are responsible for the following:

    a. Maintaining the staffing level as indicated in the approved staffing schedule, and

    b. Submitting all staffing schedules to the Division for review and approval through the Program Staffing Application in Focus.

B. CREATING AND SUBMITTING STAFFING SCHEDULES

1. Qualified Vendors are responsible for creating and submitting all staffing schedules that are determined based on the collective needs of all members at that site as follows:

    a. Five business days prior to all known or planned events (e.g., members moving in/out, school breaks, holidays).

    b. Within two business days of all unplanned events (e.g., member

hospitalized, illness, or vacation).

2. Submit a new Master Schedule for changes in:

   a. Occupancy. The number of Division members or other individuals with developmental disabilities who currently live in the home.

   b. Capacity (requires Network pre-approval) for group homes only.

   c. Site Code and/or address.

   d. Any modifications to the staffing schedule exceeding 30 days resulting in a change to the range as outlined in the Division's Rate Book.

   e. Home closure.

3. Submit a new temporary schedule for any modifications to the staffing schedule for less than 30 days resulting in a change to the range as outlined in the Division's Rate Book, including but not limited to:

   a. Acute behavioral health need(s).

   b. Acute physical health need(s).

   c. School/holiday breaks.

   d. Short-term absence from a day or work program.

   e. Scheduled or unscheduled short-term absence from the home.

4. If there is an emergency:

   a. Staff the home as appropriate for the immediate circumstance.

   b. When the emergency event modifies the staffing range notify:

i. Network Manager and/or designee by the next business day and submit a revised staffing schedule with a detailed explanation.

ii. Member's support coordinator as soon as possible, but no later than the next business day.

5. Complete Summary Comments:

a. Identify the member(s) by first and last name.

b. Indicate member(s) who:

i. Have an approved behavior plan,

ii. Have a work and/or day program schedule,

iii. Need additional staffing supports, as outlined in the Planning Documents, for needs including but not limited to:

1) Behavioral Health

2) Physical Health

3) Community

4) Overnight

c. Explain the reason for the schedule change, and

d. Provide specific details regarding the members' staffing needs.

C. ANNUAL RESIDENTIAL REVIEW

1. Annually the Qualified Vendor shall, upon invitation, meet with Network to review daily habilitation staffing schedules and includes the following:

a. Vacancies and Placement Profiles.

b. Review information regarding potential housemates.

c. Additional staffing supports:

i. Compare census to the schedule to ensure it is accurate.

ii. Review the information in the comment section regarding additional staffing supports.

iii. Verify documentation that the additional staffing supports are approved by the planning team, including any behavioral health supports.

d. Capacity.

e. Residents not funded through the Division, including individuals who are involved with the Department of Child Services.

f. Cost effectiveness. The review should result in mutually agreed upon appropriate and cost-effective supports that meets the physical health, functional, social, and behavioral health needs of the member in the most integrated and least restrictive setting; and

g. Summary comments.

2. Within 14 calendar days following the annual review, submit all agreed upon updates to the Division.

3. Maintain all approved staffing schedules.

D. NETWORK APPROVAL

1. The Network is responsible for the following:

a. Create or revise a staffing schedule.

b. Review staffing schedules submitted by the Qualified Vendor.

c. Approve each staffing schedule as appropriate.

d. Upon approval of an IDLA – HID Staffing Schedule:

    i. Keep the signed documents with original signatures, and

    ii. Provide a copy to the Qualified Vendor.

CHAPTER 53 SUPPORTING CHILDREN IN CARE OF THE DEPARTMENT OF CHILD SAFETY IN COMMUNITY RESIDENTIAL SETTINGS

REVISION DATE: 1/10/2024

REVIEW DATE: 5/12/2023

EFFECTIVE DATE: December 7, 2022

REFERENCES: A.R.S. 36-551(12), (15), (23), (33) (Version 2)

PURPOSE

To outline the roles and responsibilities of Qualified Vendors, the Department of Economic Security, Division of Developmental Disabilities (DDD or Division), and the Department of Child Safety (DCS) for supporting children in care of DCS in Community Residential Settings. This includes providing access to Community Residential Settings to children with intellectual and developmental disabilities who are likely eligible for DDD and their siblings.

DEFINITIONS

1. **"**Child Developmental Home**"** means the same as defined in A.R.S. 36-551(12).
2. **"**Community Residential Setting" means the same as defined in A.R.S. 36-551(15).
3. "Group Home" means the same as defined in A.R.S 36-551(23).
4. "Likely Eligible Child**"** means a child screened by DCS, using a tool

developed by the Division, and determined likely eligible for the Division based on that tool.

5. "Member" means the same as "Client" as defined in A.R.S. § 36-551.
6. "Nursing-Supported Group Home" means the same as defined in A.R.S. 36-401 and 36-551 (33) (Version 2).

POLICY

A. QUALIFIED VENDOR ROLES AND RESPONSIBILITIES

Qualified Vendors shall do the following:

1. Accept referrals in community residential settings for Members, Likely Eligible Children, and siblings of Members and Likely Eligible Children, from the Division during business hours and from DCS after business hours or as authorized by the Division.
2. Ensure Members and Likely Eligible Children receive developmental home services in the same setting as their siblings, when possible.
3. Do not permit siblings to reside in DDD Group Homes or Nursing-Supported Group Homes.
4. Follow the requirements in the Qualified Vendor Agreement and Division Policy when delivering services to children in care of

DCS.

5. Do not make referrals to licensees of child developmental home services with open DCS investigations, licensing concerns, or do not have existing licensed capacity.
6. Only accept referrals in Group Homes or Nursing-Supported Group Homes where there is current existing capacity approved by the Division.
7. Submit claims to DCS for services in Community Residential Settings for:
    a. Members who are not eligible for ALTCS;
    b. Likely Eligible Children; and
    c. Siblings of Members and Likely Eligible Children.
8. Submit claims for authorized services as outlined in the Division's rate book and billing manual for Members who are eligible for ALTCS.
9. Submit non-Member incident reports to dddolcr@azdes.gov.
10. Submit Member incident reports in accordance with Provider Policy Chapter 70.

B. DEPARTMENT OF CHILD SAFETY ROLES AND RESPONSIBILITIES

Pursuant to intergovernmental agreement, DCS shall do the following:

1. Screen children in care of DCS for signs of possible intellectual or developmental disabilities using the Division's Likely Eligible Tool (LET) available in the DES Document Center.
2. Provide the completed LET, a signed Authorization for Disclosure of Protected Health Information, any records that demonstrate potential signs of an intellectual or developmental disability, any identified specialized care needs, and request assistance from the Division within one business day of completing the LET.
3. Notify the Division of the Community Residential Setting selected within one business day of receipt of the residential services options.
4. Be responsible for identifying residential services options for all DCS involved children after business hours and notifying the Division by the next business day of the child moving into the residential setting.
5. Ensure Likely Eligible Children receive developmental home services in the same setting as their siblings and do not permit siblings to reside in DDD Group Homes or Nursing-Supported Group Homes.
6. Be responsible for identifying residential service options for

siblings of Division Eligible or Likely Eligible Children who require a new living arrangement due to disruption of a Community Residential Setting, including when a Likely Eligible Child is found ineligible and needs a new living arrangement due to disruption.

7. Coordinate all physical and behavioral health services necessary to support non-ALTCS children in the Community Residential Setting.
8. Pay claims for services in Community Residential Settings that meet DCS payment standards submitted by Qualified Vendors for:
    a. Members not eligible for ALTCS,
    b. Likely Eligible Children, and
    c. Siblings of members and Likely Eligible Children.
9. Visit the child(ren) monthly in the Community Residential Setting.
10. Report any potential licensing or contractual violations to the Division's Office of Licensing, Certification and Regulation (OLCR) or the Arizona Department of Health Services (ADHS) as appropriate to the setting.
11. Submit Division and or AzEIP eligibility application within 90 days

of the Likely Eligible Child moving into a Community Residential Setting.

12. Report updates on the DCS LET tracking form for Likely Eligible Children.

C. DIVISION ROLES AND RESPONSIBILITIES

Pursuant to intergovernmental agreement with DCS, the Division shall do the following:

1. During business hours, on behalf of DCS, identify Community Residential Settings for Members, Likely Eligible Children, and siblings of Members and Likely Eligible Children, as allowable in this policy.
2. Monitor compliance of Community Residential Settings as required and report issues or concerns to DCS, OLCR, and ADHS as appropriate.
3. Report any licensing issues to ADHS for children residing in Group Homes and Nursing-Supported Group Homes and to OLCR for children in DCS care who reside in Child Developmental homes.
4. Restrict a Child Developmental Home license if a Likely Eligible Child is found to be ineligible for the Division.

54 GROUP HOME REQUIREMENTS

REVISION DATE: 2/7/2024
REVIEW DATE: 8/30/2023
EFFECTIVE DATE: July 19, 2023
REFERENCES: 42 § C.F.R. 441.300-441.310; A.R.S. § 13-3602; A.R.S. § 36-401; A.R.S. §§ 36-501 et seq.; A.R.S. § 36-551; A.A.C. R9-10-2206; A.A.C. R9-10-101; A.A.C. R6-6-101; A.A.C. Title 6, Article 8; A.A.C. Title 6, Article 9; A.A.C. Title 6, Article 15; A.A.C. Title 6, Article 21; Qualified Vendor Agreement; Behavior Supports Manual Chapter 400; Behavior Supports Manual Chapter 500

PURPOSE

The purpose of this policy is to outline the requirements for Qualified Vendors when providing Group Home services for Division Members.

DEFINITIONS

1. "Acuity" means a patient's need for medical services, nursing services, or behavioral health services based on the patient's medical condition or behavioral health issue.
2. "Acuity plan" means a method for establishing nursing personnel requirements by unit based on a patient's acuity.
3. "Adult" means a person aged 18 years or above.
4. "Behavior Plan" means a written plan of services and therapeutic interventions based on a complete assessment of a Member's developmental and health status, strengths and needs

that are designed and periodically updated by the multispecialty, interdisciplinary team.

5. "Behavioral Health Professional" means
   a. An individual licensed under A.R.S. § 32, Chapter 33, whose scope of practice allows the individual to:
      i. Independently engage in the practice of behavioral health as specified in A.R.S. § 32-3251, or
      ii. Except for a licensed substance abuse technician, engage in the practice of behavioral health as specified in A.R.S. § 32-3251 under direct supervision as specified in A.A.C. R4-6-101.
   b. A psychiatrist as specified in A.R.S. § 36-501.
   c. A psychologist as specified in A.R.S. § 32-2061.
   d. A physician.
   e. A behavior analyst as specified in A.R.S. § 32-2091.
   f. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse, or
   g. A registered nurse:
      i. A psychiatric-mental health nursing certification, or

ii. One year of experience providing behavioral health services.

6. "Behavioral-Supported Group Home" or "BSGH" means a time-limited service, designed for Members who have been deemed to need intensive behavioral support that supports the Member's choice to live in and access opportunities in their communities through services offered in their Group Home.
7. "Business Hours" means the office hours that state offices are kept open for transaction of business from 8:00 a.m. to 5:00 p.m., from Monday through Friday, excluding holidays, furlough closure; or otherwise required by law, as per A.R.S. § 38-401.
8. "Child" means a person under the age of 18.
9. "Clinical Oversight" means monitoring provided by an independently licensed BHP, by virtue of education, training and experience, is capable of assessing the behavioral health history of a Member to determine the most appropriate treatment plan.
10. "Clinical Oversight Meeting" means a professional staffing that occurs at least monthly, for the purposes of monitoring the

Member's progress and the Qualified Vendor's compliance with Division policy and BSGH service specifications.

11. "Court-Ordered Evaluation" or "COE" means an evaluation ordered by the court as per A.A.C. R9-21-101.
12. "Court-Ordered Treatment" or "COT" means treatment ordered by the court as per A.A.C. R9-21-101.
13. "Direct Support Professional" or "DSP" means a person who delivers direct support in Home and Community-Based Services with current training according to the training and/or certification or licensing requirements of the Home and Community-Based Service(s) they provide. DSPs support Members to develop independent skills and be included in their communities. DSPs may include Developmental Home Providers and therapists who provide direct support.
14. "Emergency Receiving Home" means a Division Group Home developed using the Vendor Call process to create vacant capacity to be used for Members with an emergency need for Group Home services.

15. "Functional Behavior Assessment" means a comprehensive assessment consisting of different observations of the member in one or more settings, with one or more caregivers; and includes a comprehensive review of historical documents (e.g., Planning Documents, evaluations, progress reports, Individualized Education Program, data collection), indirect and direct assessment, and recommendations for treatment.
16. "Group Home" or "Home" for the purposes of this policy means the same as defined in A.R.S. § 36-551.
17. Home and Community-Based Services Settings Final Rule means the requirements set forth by 42 C.F.R. §§ 441.300-441.310 for HCBS settings to ensure individuals have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate.
18. "Member" means the same as "client" as defined in A.R.S. § 36-551.
19. "Nesting" means a period of independent caregiving, usually 24 to 48 hours for the Member while they are in the Developmental Home, Nursing Supported Group Home, or Intermediate Care

Facility and the parent or caregiver has the oversight of medical staff during that time period.

20. "Nursing Supported Group Home" means the same as defined in A.R.S. § 36-401.
21. "Order of Protection" means any injunction or other court order that is issued for the purpose of preventing violent or threatening acts or harassment against, contact or communication with or physical proximity to another person.
22. "Person-Centered" means an approach to planning designed to assist the Member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.
23. "Planning Document" means a written plan developed through an assessment of functional needs that reflects the services and supports, paid and unpaid, that are important for and important to the Member in meeting the identified needs and preferences for the delivery of such services and supports.
24. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member,

and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

25. "Predictable Staffing" means a consistent schedule of direct support professionals that meets the needs of the Member(s) and the Member(s) know and expect to be working with them.
26. "Program Review Committee" or "PRC" means the assembly of designated individuals that review and approve Behavior Plans meeting the criteria outlined in Article 9 prior to implementation.
27. "Qualified Vendor" means any person or entity that has a Qualified Vendor Agreement with the Division of Developmental Disabilities.
28. "Residential Services" means the same as Community Residential Setting defined in A.R.S. § 36-551 (15), except this policy does not apply to state-operated services.
29. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a

developmental disability or an adult with a developmental disability who is a Member or an applicant for whom no guardian has been appointed as per A.R.S. § 36-551 (39).

POLICY

A. REQUIREMENTS FOR ALL GROUP HOMES

1. The Qualified Vendor shall provide a safe, stable, individualized environment that is Person-Centered with:
   a. Predictable staffing;
   b. Daily routines;
   c. Promotes independence, autonomy, Member choice and control as much as possible while assuring Member health and safety; and
   d. Offers and supports social and leisure activities based on what the Member likes to do, supports relationships that are important to the Member by enabling frequent contact with people who care about the Member, and supports Members with integrating into their communities.
2. Qualified Vendors shall only accept Member referrals for Residential Services from the Division.

3. Qualified Vendors operating standard Group Homes, Emergency Receiving Homes, and Nursing Supported Group Homes in which a Member resides shall ensure:
    a. An approved Behavior Plan is in place for Members as outlined in the Division Behavior Support Policy Manual and A.A.C. R6-6-904 within 90 days of move-in and approved annually; and
    b. Have staff that are trained and monitored to implement a Member's Behavior Plan as written.
4. Qualified Vendors shall ensure all Group Homes operated by the Qualified Vendor in which Members reside are:
    a. Licensed by the Arizona Department of Health Services (ADHS) and approved by the Division;
    b. Assigned a site code by the Division for each Group Home;
    c. Meet the requirements of the Home and Community Based Services Final Rule; and
5. Qualified Vendors shall allow adult and child Members to live in the same Group Home operated by the Qualified Vendor if:

a. Approved by the Responsible Person(s) of the child and adult; and

b. Documented in the Planning Document of both the child and adult.

6. Staff of all Group Homes operated by the Qualified Vendor shall accompany and provide support to Members until admitted as inpatient to a hospital.

7. The Qualified Vendor providing Group Home services shall ensure Members are accompanied by Group Home staff during emergency transport if available.

8. Qualified Vendors shall participate in discharge planning and all staffings with the hospital or crisis facility while a Member is inpatient.

9. Qualified Vendors shall participate in transition meetings for Members moving into or from a Group Home.

10. The Qualified Vendor shall accept the Member back to the Group Home as determined by the Planning Team upon discharge from the hospital or crisis facility.

11. The Qualified Vendor shall not delay the Member's return to the Group home upon discharge from the hospital or crisis facility.
12. Qualified Vendors shall assist with the petition for Court Ordered Evaluation (COE) or Court Ordered Treatment (COT) upon witnessing an event that impacts the safety of the Member or others, when necessary in accordance with A.A.C. R9-21-101 and A.R.S. § 36-520.
13. Qualified Vendors shall continue to provide support to the Member until the petition is accepted by the court and the Member is admitted to a facility for COE or COT.
14. If the petition for COE or COT is not accepted by the court, the Qualified Vendor shall transport the Member back to the Group Home.
15. The Qualified Vendor operating a Group Home in which Members reside shall notify the Division's Statewide Residential Network team within 24 hours if a Member:
    a. Is unable to return to the Group Home due to the Member having been served an Order of Protection; or

b. Requires emergency relocation to an alternative Group Home.

16. Qualified Vendors who have service authorizations for Members served with an Order of Protection shall continue to serve those Members as allowed for in 6 A.A.C. 6 Article 21.
17. Qualified Vendors shall maintain an after business hours contact and provide the after business hours contact information to the Division.
18. The Qualified Vendor operating a Group Home in which Members reside shall not restrict a Member's ability to access their community and common areas within the Group Home environment unless the restriction is approved in the Member's Behavior Plan.
19. Qualified Vendors operating a Group Home in which Members reside shall maintain at least three days worth of meals and snacks based on:
    a. The menu for each Group Home; and
    b. Special dietary needs.

20. Qualified Vendors operating a Group Home in which Members reside shall participate in Member meetings as outlined in Provider Manual Chapter 2.
21. Qualified Vendors providing Group Home services shall obtain and maintain the following records of Members who reside in the Group Home:
    a. Vital information documentation
        i. The name, address, and telephone numbers of the health care provider for each Member;
        ii. 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 Member;
        iii. Guardianship status for each Member, if applicable;
        iv. The name and telephone number of the Responsible Person;
        v. The person to be contacted in case of emergency for each Member;
        vi. Member funds ledger;

vii. Member's Group Home attendance records;

viii. Member's behavioral health documentation:

(a) Pre-move Behavior Plan;

(b) Post-move Behavior Plan; and

(c) Data collected from behavioral observations from the last 30 days.

b. Documentation of individualized needs

i. Completed Pre-service Provider Orientation (DDD-097A) form;

ii. Nutritional needs or special diets with parameters;

iii. Special fluid intake needs;

iv. Prescriptions for dietary needs or holistic medication;

v. Seizure activity information:

(a) Type and characteristics;

(b) Frequency and duration;

(c) Instructions for staff response; and

(d) Records of seizure activity.

vi. Adaptive equipment, protective devices, and facility adaptations;

vii. Required medical monitoring, including blood glucose testing, blood pressure checks, and lab work;

viii. Reference to the Behavior Plan or Planning Document if health care related issues are addressed;

ix. Special instructions for carrying, lifting, positioning, bathing, feeding, or other aspects of personal care;

x. Any known allergy to food, medication, bite or stings, or pollen and steps to be taken when an allergic reaction occurs; and

xi. Other individualized healthcare routines.

c. Complete medical history

i. Physical examination;

ii. Immunization records;

iii. Tuberculosis screening;

iv. Hepatitis B screening;

v. Type of developmental disability;

vi. Medication history;

vii. History of allergies;

viii. Dental history;

ix. Seizure history;

x. Developmental history; and

xi. Family medical history.

d. Medications

i. Copies of prescriptions or documentation of any verbal or written medical orders from a medical practitioner;

ii. Copies of the medication list provided upon discharge from an inpatient or skilled nursing facility;

iii. A current medication log for each Member with the following information:

(a) List of all prescription and nonprescription medications administered to a Member by or under the supervision of a direct care staff;

(b) The name of the Member who received the medication;

(c) The name of the medication;

(d) The medication dosage;

(e) The date and time of administration;

(f) The route of administration;

(g) Special instructions for administration of the medication; and

(h) Signature and initials of the direct care staff who administered or supervised the administration of the medication.

22. The Qualified Vendor providing Group Home service shall verify that the Member's medication log matches with:

    a. Current prescriptions;

    b. Current medical orders; and

    c. Discharge instructions upon discharge from a hospital or facility.

23. The Qualified Vendor providing Group Home service shall notify the Member's prescribing practitioner if any discrepancies are identified between prescriptions, medical orders, discharge instructions, or the medication log.

24. The Qualified Vendor providing Group Home service shall update the Member's medication log upon changes to the prescriptions or non-prescription orders from a medical practitioner.

B. BEHAVIORAL-SUPPORTED GROUP HOME (BSGH) ADDITIONAL REQUIREMENTS

1. Qualified Vendors operating a BSGH shall:
   a. Accept any Member referred by the Division; and
   b. Provide BSGH service for the referred Member.
2. The Qualified Vendor providing BSGH services shall, within 45 days of the Member's move-in to the BSGH, submit a Behavior Plan to:
   a. The Division's Behavioral Health Administration; and
   b. The Program Review Committee.
3. The Qualified Vendor providing BSGH services shall provide a minimum of ten hours of Clinical Oversight each week per BSGH setting, with a minimum of 50% of the hours provided onsite in the BSGH.

4. The Qualified Vendor providing BSGH service shall submit the Clinical Oversight Standard Agenda form to the Division two business days prior to the Clinical Oversight Meeting.
5. The Qualified Vendor providing BSGH service shall participate in Clinical Oversight Meetings.
6. The Qualified Vendor providing BSGH service shall ensure the following staff attend Clinical Oversight Meetings at minimum:
    a. The Behavioral Health Professional (BHP) employed by the Qualified Vendor; and
    b. A Qualified Vendor representative.
7. The Qualified Vendor providing BSGH service shall require the following when a Member transitions from the BSGH to a new setting:
    a. Current leadership, house supervisor, and BHP to tour the potential receiving setting at the request of the Responsible Person.
    b. The receiving Qualified Vendor and Planning Team, with input from both the BSGH and Division’s clinician, shall

develop a transition plan that includes the following, but is not limited to:

i. Member visit(s) to the new setting;

ii. The Member being observed by the receiving setting staff and DSPs;

iii. Training of staff and DSPs at the new setting by the BSGH; and

iv. Documenting the required training of staff and DSPs at the new setting on the Behavior Plan.

v. Training of Employment Services or Day Program staff, as applicable.

vi. Using the Residential Pre-Move Checklist for developing the transition plan.

c. BSGH clinical staff, with the Responsible Person's agreement, shall provide Clinical Oversight and support to the Member and the receiving Qualified Vendor for up to two months after the Member moves in as determined by the transition plan.

d. The BSGH clinical staff shall:

i. Participate in all transition and post transition meetings (i.e. medication reviews, Planning Document, etc.) while providing the agreed upon Clinical Oversight as outlined in the transition plan;

ii. Document all transition activities as outlined in the Member's transition plan; and

iii. Provide documentation on transition activities during all transition and post transition meetings.

e. The existing Qualified Vendor shall consult with the new Qualified Vendor to update the Member's Behavior Plan.

C. EMERGENCY RECEIVING HOME ADDITIONAL REQUIREMENTS

1. The Division may change the designation of the Emergency Receiving Home to a standard Group Home, if the Division deems it necessary.
2. The Qualified Vendor providing Emergency Receiving Home services shall accept any emergency Member referrals from the Division.

3. The Qualified Vendor shall ensure all Emergency Receiving Homes operated by the Qualified Vendor in which Members reside:
    a. Have sufficient staff immediately available to support the Member; and
    b. All DSPs have Prevention & Support training.
4. Qualified Vendors providing Emergency Receiving Home services shall adhere to the requirements in Section (A). of this policy.
5. The Qualified Vendor shall ensure all Emergency Receiving Homes operated by the Qualified Vendor in which Members reside are fully furnished, including bedrooms.

D. NURSING SUPPORTED GROUP HOMES (NSGHs) ADDITIONAL REQUIREMENTS

1. Qualified Vendors operating a NSGH in which Members reside shall submit a monthly census of the NSGH no later than the last day of the reporting month.
    a. The Qualified Vendor operating a NSGH shall submit the census through secure email to DDDResidentialunit@azdes.gov; and

b. The Qualified Vendor operating a NSGH shall notify the Division of all changes in Member moves, including internal moves or external moves within two business days.

2. The Qualified Vendor operating a NSGH in which Members reside may provide Nesting when requested by the Division's Health Care Services Department.
3. Qualified Vendors who operate a NSGH and provide Nesting shall develop, implement, and submit Nesting policies and checklists for review and approval by the Division's Network and Health Care Services Department.
4. Qualified Vendors who operate a NSGH shall ensure that the types and amount of nurses and other direct care workers as required by the Acuity Plan are present in the NSGH.

57 THIRD PARTY LIABILITY WAIVER REQUESTS

REVISION DATE: 10/25/2023, 9/7/2022, 4/25/2018
EFFECTIVE DATE: August 5, 2016
REFERENCES: 42 C.F.R. § 433.136; 42 C.F.R. § 433.138; 42 C.F.R. § 433.139; Deficit Reduction Act (DRA) of 2005; A.R.S. § 36-2903; A.R.S. § 36-2904; A.R.S. § 36-2923; A.R.S. § 36-596; A.R.S. § 36 Chapter 5.1; A.A.C. R6-6-1303; A.A.C. R6-6-2101; A.A.C. R9-22-1001; A.A.C. R9-22-1002; A.A.C. R9-22-1003; ACOM 201; ACOM 416; ACOM 434; CMS 1500

PURPOSE

This policy establishes requirements for Qualified Vendors when coordinating benefits and requesting Third Party Liability waivers for therapy and nursing services claims.

DEFINITIONS

1. "Coordination of Benefits" or "COB" means 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.
2. "Cost Avoidance" means the process of identifying and utilizing all confirmed sources of first or third-party benefits before payment is made by the Division.
3. "Explanation of Benefits" or "EOB" means a document that states the Third Party insurance company's potential liability

for a claim that arises out of a contract of insurance. An EOB indicates how the payment was calculated and any reasons for non-payment.

4. "Qualified Vendor" or "QV" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Division.
5. "Third Party" means an individual, entity or program that is, or may be, liable to pay all or part of the expenditures for medical assistance furnished under a State plan as defined in 42 C.F.R. § 433.136.
6. "Third Party Liability" or "TPL" means the legal obligation of the third parties (e.g. certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

POLICY

A. QUALIFIED VENDOR TPL RESPONSIBILITIES

1. The QV shall coordinate benefits with Third Parties to ensure

costs for services otherwise payable by the Division are Cost Avoided or recovered from a liable Third Party.

2. The QV shall create appropriate methodologies and processes for obtaining documentation and payment from Third Parties, as required by the Division, to include, but not limited to:
   a. Resubmitting claims,
   b. Making follow-up phone calls, and
   c. Submitting additional requested information.
3. The QV shall bill the TPL(s), including High Deductible Health Plans that are associated with Health Savings Accounts (HSAs), before submitting claims to the Division.
4. The QV shall report to TPLBenefits@azdes.gov any updates to the member-specific TPL information within ten (10) business days of learning of the new information.
5. If a QV has been paid by the Division and subsequently receives reimbursement from a TPL, the QV shall submit a claim correction or claim reversal and report the TPL payment to the Division.
6. When a QV receives payment from a TPL in an amount that meets or exceeds the published rate, the QV shall report the

provision of service on the claim document indicating no amount due from the Division.

7. When a QV receives payment from a TPL in an amount that is lower than the published rate, the QV shall report the provision of service on the claim document up to the Division's contracted rate. The QV shall bill the Division for the difference between the TPL paid amount and the Division's contracted rate.

B. CLAIMS AND EXPLANATION OF BENEFITS

1. Prior to submitting a claim to the Division, the QV shall obtain an EOB that indicates denial of the claim from the member's TPL. If the TPL has not adjudicated the claim within six months, the QV shall submit the claim to the Division to preserve timely filing.
2. If the Division member is covered by more than one TPL, the QV shall obtain an EOB from each TPL.
3. When submitting a claim to the Division, the QV shall include the EOB and supporting documentation if necessary, verifying the rejection or non-payment of the claim by the TPL.
4. The QV shall ensure the billed service code reflected on the EOB corresponds to AHCCCS-approved Current Procedural

Terminology codes (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes.

C. APPLYING FOR A TPL WAIVER

1. Upon receiving an EOB with a denial of payment from the TPL, the QV shall request a TPL waiver from the Division to receive payment for the claim and to meet COB requirements.

2. The QV shall submit TPL waiver requests by email to TPLWaiver@azdes.gov; with the following required documents:
   a. A completed COBV Waiver Request form, and
   b. Each corresponding EOB.
   c. If the EOB does not contain the procedure codes (CPT/ HCPCS), the QV shall include the CMS 1500 form (if applicable).
   d. Other supporting documentation may be submitted with the COBV waiver request.

3. The Division shall deny TPL waiver requests if unapproved or incorrect procedure codes are submitted by the QV.

4. The Division shall deny TPL waiver requests when the EOB from the TPL is denying the claim for additional information or

corrected information.

5. The Division shall request additional information from the QV and or TPL carrier, if required.
6. The QV shall meet the criteria below to obtain a TPL waiver when billing for services covered under Medicare Part B:
   a. Be a certified Medicare provider.
   b. Submit a COBV Waiver Request and a Medicare Part B EOB.
7. The QV shall not submit a TPL waiver to the Division for billing pertaining to Medicare Parts A, C, and D.
8. The Division shall review all TPL waiver requests and provide the QV with an approval or denial status.
9. The QV may view approved waivers under "Waivers" in the Professional Billing System (PBS).
10. The Division shall email denied waivers to the QV.

D. THIRD PARTY LIABILITY EXCLUSIONS

The Division shall not require the QV to bill the following accounts, as they are not considered as liable Third Party resources:

1. Medical Savings Account (MSA);
2. Health Flex Spending Arrangement (FTA); and

3. Health Savings Account (HSA).

Chapter 58 MEDICATION MANAGEMENT SERVICES

REVISION DATES: 7/01/2020, 2/28/2019
EFFECTIVE DATE: March 29, 2013

Primary Care Provider (PCP) Medication Management Services

In addition to treating physical health conditions, the Division allows Primary Care Providers (PCPs) to treat behavioral health conditions within their scope of practice. Such treatment shall include but not be limited to substance use disorders, 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 includes the AHCCCS preferred drugs on the AdSS's drug list for the treatment of these disorders. The AdSS is responsible for these services both in the prospective and prior period coverage timeframes.

A. Medication-Assisted Treatment (MAT): The AdSS shall reimburse PCPs who are providing medication management of opioid use disorder (OUD) within their scope of practice. The PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the medication assisted treatment (MAT) model and coordinate care with the behavioral health provider. The AdSS shall include the AHCCCS preferred drugs on the AdSS drug list for the treatment of OUD.

B. Step Therapy: The AdSS may implement step therapy for behavioral health medications used for treating anxiety, depression, and ADHD disorders. The AdSS shall provide education and training for providers regarding the concept of step therapy. If the T/RBHA/behavioral health provider provides documentation to the AdSS that step therapy has already been completed for the conditions of anxiety, depression or ADHD, or that step therapy is medically contraindicated, the AdSS shall continue to provide the medication at the dosage at which the member has been stabilized by the behavioral health provider. In the event the PCP identifies a change in the member's condition, the PCP may utilize step therapy until the member is stabilized for the condition of anxiety, depression, or ADHD. The AdSS shall monitor PCPs to ensure that they prescribe medication at the dosage at which the member has been stabilized.

C. Tool Kits: Clinical tool kits for the treatment of anxiety, depression, and ADHD are available in the AHCCCS Medical Policy Manual (AMPM). Refer to AMPM Appendix E, Childhood and Adolescent Behavioral Health Tool Kits and Appendix F, Behavioral Health Tool Kits. These tool kits are a resource only and may not apply to all patients and all clinical situations. The tool kits are not intended to replace clinical judgment. The AdSS shall ensure that PCPs who have an interest or are actively treating members with these disorders are aware of these resources and/or are utilizing other recognized, clinical tools/evidence-based guidelines. The AdSS shall develop a monitoring process to ensure that PCPs utilize evidence-based guidelines/recognized clinical tools when prescribing medications to treat depression, anxiety, and ADHD.

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

REVISION DATE: 6/24/2022, 10/1/2021, 5/24/2021, 10/1/2018, 5/30/2018, 5/26/17 EFFECTIVE DATE: May 13, 2016

REFERENCES: 42 CFR 433.135, 42 CFR 438.114; A.R.S. §§ 36-2904 and 2905.01; A.A.C. R9-22 A.A.C. R9-28 42 A.A.C. R9-22-1003; AHCCCS Contractor Operations Manual (ACOM) 423, ACOM 437

PURPOSE

The purpose of this policy is to provide guidance to Qualified Vendors/providers regarding the limited situations when ALTCS eligible members enrolled in one of the Division's Administrative Services Subcontractors (AdSSs) or Tribal Health Program (THP) has chosen to receive behavioral health services through a Tribal Regional Behavioral Health Authority (TRBHA), and the member is not receiving all of the physical and behavioral health services through one entity.

DEFINITIONS

1. "Acute Care Hospital" means a general hospital that provides surgical services and emergency services.
2. "DDD Tribal Health Program (THP)" means an acute care Fee-For-Service (FFS) program administered by AHCCCS for eligible American Indians which reimburses for services provided by and through the Indian Health Service (IHS), Tribal Health

Programs operated under 638 or any other AHCCCS registered provider.

3. "Behavioral Health Diagnosis" means diagnoses listed in the Standard Service Set in AHCCCS Reference File (RF) 724.
4. "Behavioral Health Entity" means the TRBHA, with which the member is enrolled/assigned for the provision of and/or coordination of behavioral health services.
5. "Enrolled Entity" means the AdSS or THP with which the member is enrolled for the provision of physical health services.
6. "Primary Care Provider (PCP)" means an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP shall be an individual, not a group or association of persons, such as a clinic.

7. "Principal Diagnosis" means the condition established after study to be primarily responsible for occasioning the admission or care for the member, as indicated by the Principal Diagnosis on a UB claim form from a facility or the first-listed diagnosis on a CMS 1500 claim line.

POLICY

A. Payment for Division covered behavioral health and physical health services is determined by the Principal Diagnosis appearing on a claim, except in specific circumstances as described below. This policy is not intended to address all scenarios involving payment responsibility. The Principal Diagnosis should not be confused with the admitting diagnosis or any other diagnoses on the claim. Neither the admitting diagnosis nor any other diagnoses on the claim should be used in the assignment of payment responsibility.

B. GENERAL REQUIREMENTS REGARDING PAYMENT FOR PHYSICAL AND BEHAVIORAL HEALTH PAYMENTS

1. AHCCCS DFSM shall process payment of claims on behalf of THP when payment of physical and behavioral health services is a THP responsibility as the Enrolled Entity.
2. AHCCCS DFSM shall process payment of claims when payment of services is noted as a TRBHA responsibility as the Behavioral

Health Entity.

3. AHCCCS DFSM shall pay claims for physical and health services that are provided by an IHS or tribally owned and/or operated facility to Title XIX members.
4. Regardless of setting, if physical health services are listed on a claim with a behavioral health Principal Diagnosis, the AHCCCS DFSM (for members enrolled with a TRBHA) shall process payment of covered physical health services and behavioral health services.
5. Regardless of setting, if behavioral health services are listed on a claim with a principal diagnosis of physical health, the AdSS or AHCCCS DFSM (on behalf of THP) shall process payment of covered behavioral health services and physical health services.
6. Payment responsibility for professional services associated with an inpatient stay shall be based on the Principal Diagnosis on the professional claim. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services may not necessarily be the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of authorization/notification of the inpatient stay regardless

of the entity which authorized the inpatient stay.

7. The AdSS or AHCCCS DFSM (on behalf of THP) shall process payment for an emergency department facility claim of an acute care facility including triage and diagnostic tests, when there is no admission to the facility, regardless of the Principal Diagnosis on the facility claim. Payment responsibility for professional services associated with the emergency department visit shall be determined by the Principal Diagnosis on the professional claim. Payment responsibility for the emergency department visit and payment responsibility for the associated professional services may not necessarily be the same entity. Payment of the professional claim shall not be denied by the responsible entity due to lack of notification of the emergency department visit.
8. The AdSS or AHCCCS DFSM (on behalf of THP) shall coordinate with the TRBHA Behavioral Health Entity when both physical and behavioral health services are rendered during an inpatient stay and the AdSS is notified of the stay. Such coordination shall include, but is not limited to, communication/collaboration of authorizations, determinations of medical necessity, and concurrent reviews.
9. All Division services shall be medically necessary, cost effective, and

federally and state reimbursable. For specific information on inpatient reimbursement rates refer to A.A.C. R9-22-712.60 et seq.

C. SPECIFIC CIRCUMSTANCES FOR PAYMENT RESPONSIBILITIES

1. The AdSS or AHCCCS DFSM (on behalf of THP), as the Enrolled Entity, shall process payment for the following:
   a. Services associated with a PCP visit for the diagnosis and treatment of behavioral health conditions within the PCP's scope of practice. Such treatment shall include but not be limited to substance use disorders, depression, anxiety, and/or ADHD. 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.
   b. Medication management services provided by the PCP while the member may simultaneously receive counseling and other medically necessary rehabilitative services from the TRBHA. The PCP shall not be required to be the member's assigned PCP, for purposes of medication management.
   c. Claims with behavioral health Principal Diagnoses that are related to communication disorders usually diagnosed in

infancy, childhood, or adolescence. These behavioral health conditions require services from non-behavioral health provider types such as speech therapists or other physical health providers, and are therefore considered physical health services.

d. Transportation for the member to the initial behavioral health appointment regardless of whether the Enrolled Entity or the Behavioral Health Entity scheduled that appointment.

e. Transportation for the member to the emergency department of an acute care hospital when the transport is emergent, including inter-facility transfers to the emergency department.

f. Occupational Therapy claims regardless of Principal Diagnosis.

g. Professional fees with a physical health Principal Diagnosis, regardless of setting.

h. Inpatient facility services to hospitalized members with a physical health Principal Diagnosis. Reimbursement shall not be related to the bed or floor where the member is placed.

i. Outpatient observation services with a physical health Principal Diagnosis.

2. AHCCCS DFSM (for members enrolled with a TRBHA), as the

Behavioral Health Entity, shall pay for the following:

a. Medically necessary transportation services for members enrolled with a TRBHA (emergent and non-emergent) when the diagnosis code on the claim is ICD-10 R68.89.

b. An inpatient claim with a behavioral health Principal Diagnosis. AHCCCS DFSM shall not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the AdSS or AHCCCS DFSM (on behalf of THP) authorized and/or determined medical necessity of the stay through concurrent review, such as when the admitting diagnosis is a physical health diagnosis.

c. Inpatient facility services to hospitalized members with a behavioral health Principal Diagnosis. Reimbursement shall not be related to the bed or floor where the member is placed.

d. Professional fees with a behavioral health Principal Diagnosis, regardless of setting including, but not limited to, diagnosis and treatment of depression, anxiety, and/or opioid use disorder, and/or attention deficit hyperactive disorder except when depression, anxiety opioid use disorder and/or attention deficit hyperactive disorder treatment is provided by a PCP.

e. Outpatient observation services with a behavioral health Principal Diagnosis.

3. Payment of pre-petition screening and court ordered evaluation services is the fiscal responsibility of a county (refer to ACOM Policy 437). For payment responsibility for other court ordered services such as driving under the influence and domestic violence refer to ACOM Policy 423.

D. RBHA Contractors are responsible for the payment of crisis stabilization services for all individuals within their assigned GSA(s), including individuals in the Federal Emergency Services Program (FESP). Crisis services include telephone, community based mobile response, and facility-based stabilization (including observation and detox not to exceed 24 hours) along with payment for non-emergent medical transportation (NEMT) to a crisis stabilization provider and any associated covered services delivered by the crisis provider in these settings during the first 24 hours. The AdSS or AHCCCS DFSM (on behalf of THP) shall pay for all medically necessary services related to a crisis episode after the initial 24 hours covered by the RBHA Contractor (which may include follow up stabilization services). The AdSS or THP shall ensure timely follow up and

care coordination, whether the member received crisis services within or outside of the GSA served by the AdSS or THP. The AdSS or AHCCCS DFSM (on behalf of THP) shall pay for all emergent transportation provided during the initial 24 hours of a crisis episode. The AdSS or AHCCCS DFSM (on behalf of THP) shall pay for NEMT from a crisis service provider to another level of care, regardless of the timing within the crisis episode.

CHAPTER 60 NOTIFICATION TO QUALIFIED VENDORS

REVISION DATE: 11/24/2021
EFFECTIVE DATE: May 13, 2016

PURPOSE

To outline processes used to distribute information to the Division's Qualified Vendor Network.

DEFINITIONS

Material Change to Provider Network – Any change in composition of or payments to the Division's provider network that affects, or can reasonably be foreseen to affect, the Division's capacity and adequacy of services necessary to meet the performance and/or provider network standards as required by AHCCCS. Changes to provider network may include, but are not limited to:

1. A change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.

2. A change impacting 5% or less of the membership but involving a provider or provider group who is the sole provider of a service in a service area or operates in an area with limited alternate sources of the service.

Material Change to Business Operations - Any change in overall operations that affects, or can reasonably be foreseen to affect, the Division's ability to meet the performance standards as required in its contract with AHCCCS including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or its provider network in a specific Geographic Service Area (GSA). Changes to business operations may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review.

Material Event – An event that could prevent or impede the vendor's ability or legal authority to perform its duties under this Agreement, including but not limited to the duty to render services in a manner that protects the health and safety of DDD members.

Provider - Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services as specified in 42 CFR 457.10 and 42 CFR 438.2. This includes Service Providers as defined at ARS 36-551 also called Qualified Vendors.

POLICY

The Division provides information to the Qualified Vendor network on its webpage and through various electronic communications including email and newsletters, and through scheduled provider meetings. Qualified Vendors are responsible to ensure the Division's contracting system has updated contact information in order to receive the Division's notifications.

A. Material Changes/Material Events

1. The Division communicates to Qualified Vendors, any Material Change 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.

2. Qualified Vendors are required to report to the Division any Material Event as required in the DES/DDD Standard Terms and Conditions for Qualified Vendors. The Qualified Vendor must notify the Division's Contract Administrator at DDDContractsmanager@azdes.gov within 24 hours of a material event.

B. Policy Changes

1. The Division notifies Qualified Vendors of Policy changes in advance of the change by posting all proposed new policies and major policy changes to its website for public comment. Qualified Vendors are responsible to review potential changes and provide comments. Final changes are communicated to Qualified Vendors through the Division's electronic notification and in provider meetings. Additionally, Qualified Vendors and their employees or subcontractors may sign up for automatic policy notification on the Division's website. Qualified Vendors are responsible to update their policies and procedures within 6 months of the final publication of the Division's policy change or sooner if outlined in a specific policy.

2. The Division notifies Qualified Vendors of AHCCCS Guidelines, Policy, and Manual Changes through electronic notification. Qualified Vendors are also encouraged to sign up for notification directly on the AHCCCS website.

C. Contract Notifications

The Division provides contract notifications for the following circumstances:

1. Exclusion from the Network: The Division provides applicants for Qualified Vendor Agreements notification in writing with the reason for declining any written request for inclusion in the network.

2. Contract Action: The Division provides written documentation of any progressive contract action, including termination actions. Qualified Vendors must develop plans and implement actions to come into compliance with contract requirements.

D. General Notifications

1. The Division provides notification and a schedule of provider meetings and documentation from past meetings on its website. Qualified Vendors are expected to attend provider meetings to receive updates and technical assistance regarding service delivery to Division members.

2. The Division provides information about Disease/Chronic Care Management on its website. Qualified Vendors should review and distribute information if pertinent to authorized members.

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

REVISION DATE: 11/4/2020, 8/21/2019, 06/20/2018

EFFECTIVE DATE: June 17, 2016

REFERENCES: A.R.S. § 36-594.01, 42 CFR 431.107

All providers of AHCCCS-covered Home and Community Based Services must be HCBS certified by the Division of Developmental Disabilities (Division). The Division's Office of Licensing, Certification, and Regulation (OLCR) assists vendors and providers with this process. HCBS Certification provides a uniform standard for worker qualifications and site safety. Home and Community Based Services allow members of the Division to receive services in their own home or community rather than in institutions or isolated settings.

The Division certifies Independent Providers, Specialty Contractors, Qualified Vendors and, effective 10/1/2019, DD Health Plan Providers.

- Independent Providers (IPs) are individuals that have an Independent Provider Agreement with the Division.
- Qualified Vendors (QVs) are agencies that have been awarded a Qualified Vendor Agreement from the Division.
- DD Health Plan providers are contracted by a Managed Care Organization (MCO) to provide HCBS services to Division members.
- Specialty Contract/AZEIP providers provide HCBS services to DD ALTCS eligible members through the Arizona Early Intervention Program.

HCBS Certification Requirements

The rules governing HCBS Certification are found in the Arizona Administrative Code (A.A.C.) R6-6-1501 et. seq. HCBS requirements vary depending on the employee type and type of service provided. HCBS requirements for direct service providers include, but are not limited to:

A. Possession of a valid Level One Fingerprint Clearance Card, except when exempted by A.R.S. § 36-594.01(D). If services are delivered in the private home of a direct care worker, all adult household members of the home must also have a Level One Fingerprint Clearance card.

B. Completion of a Criminal History Self-Disclosure affidavit (LCR-1034A).

C. Identification of three references.

D. Proof of age (providers must be at least 18 years old).

E. Submission of an application or resume attesting to the qualification or experience requirements specific to each service.

F. Orientation to member's needs.

G. Possession of Cardio-Pulmonary Resuscitation (CPR) certification.

H. Possession of First Aid certification (professionally licensed providers are exempt).

I. Completion of Article 9 training.

J. Submission to a Department of Child Safety Central Registry check.

K. Submission to an Adult Protective Services Registry Check.

L. Possession of a valid Driver License (if transporting members).

M. Possession of a valid auto registration and insurance if transporting members in a personal vehicle.

N. Completion of Prevention and Support (if required by the member's planning document).

O. Verification of professional licensure (if providing professionally licensed services).

If services are delivered in a setting owned, leased, or controlled by the provider, the setting must pass a safety inspection by the Division prior to use for service delivery. The Division will reinspect the setting every two years thereafter.

HCBS certified providers are required to maintain documentation attesting to compliance with HCBS requirements for all staff. The Division conducts a file audit at least every two years.

HCBS Certification for Independent Providers

Independent Providers apply for certification with the assistance of an Independent Provider Coordinator (IPC) assigned by the Division. The IPC provides required forms including an initial application and an applicant Statement of Understanding. The IPC also collects documentation attesting to compliance with all HCBS requirements.

Individuals with an Independent Provider Agreement must submit an initial application.

A. Include in the application packet:

1. Application for Initial HCBS Certification (LCR-1025A)

2. A copy of a Level One Fingerprint Clearance Card (FCC), issued by the Arizona Department of Public Safety (DPS), unless the applicant is exempted per A.R.S. § 36-594.01

3. A copy of the *Criminal History Self Disclosure Affidavit (LCR-1034A)*

4. Applicant Statement of Understanding (LCR-1064A)

5. Statement of Lawful Presence (LCR-1075A)

6. Three reference letters

7. Proof of successful completion of training for CPR, First Aid, and Article 9

B. All application documents must be provided to the IPC who will forward the documents to OLCR for processing.

The Independent Provider must contact the assigned IPC to initiate any amendments to the HCBS certificate. An amendment is needed for a change of address, contact information or name. An amendment is also needed for the addition or removal of services.

HCBS Certification for Qualified Vendors

Qualified Vendor Agencies or individuals with a Qualified Vendor Agreement must complete the HCBS Certification process online through the Division's Focus application. Once a QVA with the Division has been approved, the vendor should refer to OLCR Tracking Application Provider Reference Guide (DDD-OLCR-040-001_Provider) for instructions on how to submit an application for HCBS certification. An initial HCBS Certification application cannot be completed until a Qualified Vendor Agreement (QVA) with the Division has been approved.

The online HCBS Certification initial application includes:

A. An Application for Initial Certification (LCR-10-83A).

B. A staff roster of all direct care employees or contractors, including the CEO/President/Owner and authorized signatory as listed in the Qualified Vendor contract application. The roster must indicate compliance with all applicable HCBS training and background check requirements.

C. Criminal History Self Disclosure Affidavit (LCR-1034A) for the CEO/President/Owner(s) of the agency and all contract signatories.

D. Proof of successful completion of training for CPR, First Aid, and Article 9 (if the owner/applicant is providing direct services).

Once the HCBS Certificate is issued, the vendor must keep the staff roster up to date. New employees must be added to the roster within 30 calendar days of hire. Employees must be removed from the roster within 30 calendar days of separation from employment. All other updates to the roster must be made within 30 calendar days of a change. The staff roster is reviewed by a certification specialist at each renewal. The roster is considered compliant when the OLCR Tracking Application indicates a 95% or higher compliance rating.

Qualified Vendors providing group home services must provide a copy of a current license or proof of inspection provided by the Arizona Department of Health Services to apply for an HCBS Certificate for each group home. The expiration date on a group home HCBS certificate is aligned with the expiration date on the agency's HCBS certificate.

For Qualified Vendors providing other types of site based HCBS services, a Life Safety inspection must be completed prior to using a site for services. A Life Safety Inspection must be completed every two years thereafter. It is the responsibility of the vendor to track inspection due dates and ensure service site information is up to date.

HCBS Certification for Providers Contracted with a Managed Care Organization (MCO)

DD Health Plan Providers who are contracted with both an MCO and DDD (as a Qualified Vendor) only need one HCBS certificate. These providers must complete the certification

process through the OLCR Tracking Application as outlined in this policy under HCBS Certification for Qualified Vendors.

DD Health Plan only providers must contact OLCR directly for certification instructions. Certification requires submitting an application form and documentation attesting to compliance with HCBS rules.

The required submission includes:

A. An Application for Initial HCBS Certification (LCR-1083A)

B. A copy of the Level One Fingerprint Clearance Card (FCC), issued by the Arizona Department of Public Safety (DPS) for the CEO/Owner

C. A copy of the Criminal History Self Disclosure Affidavit (LCR-1034A) for the CEO/Owner

D. Three reference letters for the individual or agency

E. Proof of successful completion of training for CPR, First Aid, and Article 9 (if the owner/applicant is providing direct services)

F. A completed agency roster listing all staff providing direct services to members (LCR-1028A)

If services are delivered in a setting owned, leased, or controlled by the provider, a setting inspection must be completed by OLCR prior to services being delivered in this setting.

HCBS Certification for Specialty Contract/AZEIP Providers

Specialty Contract/AZEIP who are contracted with both an AzEIP and DDD (as a Qualified Vendor) only need one HCBS certificate. These providers must complete the certification process through the OLCR Tracking Application as outlined in this policy under HCBS Certification for Qualified Vendors.

Specialty Contract/AZEIP only Providers must contact OLCR directly for HCBS certification instructions. Certification requires an application form and documentation attesting to compliance with HCBS rules. The required submission includes:

1. Application for Initial HCBS Certification (LCR-1083A)

2. A copy of the Fingerprint Clearance Card (FCC), issued by the Arizona Department of Public Safety (DPS) for the CEO/Owner

3. A copy of the Criminal History Self Disclosure Affidavit (LCR-1034A) for the CEO/Owner

4. Three reference letters for the individual or agency

5. Proof of successful completion of training for CPR, First Aid, and Article 9 if the owner/applicant is providing direct services

6. A completed agency roster listing all staff providing direct services to members (LCR-1028A)

If services are delivered in a setting owned, leased, or controlled by the provider, a setting inspection must be completed by OLCR prior to services being delivered in this setting.

Amending the HCBS Certificate

Any of the following changes requires an amendment to the certificate:

1. Address
2. Addition/deletion of services
3. Ownership
4. FEI
5. Contact information
6. Provider name

Qualified Vendors must submit an amendment request to the Qualified Vendor Agreement (QVA) in the contract application of the Division's Focus system. Once the contract amendment is approved, a certificate amendment is sent to in the OLCR Tracking Application.

Providers contracted with an MCO and AZEIP/Specialty Contractors must notify OLCR directly of the amendment request.

Independent providers must contact the Independent Provider Coordinator (IPC).

AHCCCS Enrollment

A. AHCCCS enrollment is mandatory. It is required for submission of encounter data to the AHCCCS Administration by the Division.

B. All Providers must work directly with AHCCCS for enrollment.

AHCCCS Mandates

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. Meet AHCCCS requirements for professional licensure, certification, or registration.

C. Complete all applicable enrollment forms.

Questions regarding HCBS certification may be directed to hcbscertification@azdes.gov.

CHAPTER 62 ELECTRONIC VISIT VERIFICATION

EFFECTIVE DATE: September 22, 2021
REFERENCES: AMPM Policy 540, Electronic Visit Verification

PURPOSE

This Policy applies to DES DDD Qualified Vendors and establishes requirements regarding the mandated use of an Electronic Visit Verification (EVV) system for personal care and home health services pursuant to 42 U.S.C. 1396(b)(l).

DEFINITIONS

Aggregator - A function of the AHCCCS EVV Vendor System that allows the state to compile all data and present it in a standardized format for review and analysis.

Ahcccs Electronic Visit Verification (EVV) Vendor - The AHCCCS selected Statewide EVV vendor to comply with the 21st Century Cures Act (Cures Act).

Alternate Electronic Visit Verification (EVV) System - Any EVV system(s) chosen by a provider as an alternate to the AHCCCS selected Statewide EVV vendor.

Designee - For the purposes of this Policy, an individual who is 12 years of age or older and who is delegated by the member or Health Care Decision Maker the responsibility of verifying service delivery on behalf of the member.

Direct Care Worker (DCW) - For the purposes of this Policy, a DCW is an individual providing one or more of the services subject to EVV.

Electronic Visit Verification (EVV) - A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

Electronic Visit Verification (EVV) System Chapter 500 – Care Coordination Requirements - The AHCCCS procured system or an AHCCCS approved alternate EVV system.

Health Care Decision Maker - An individual who is authorized to make health care treatment decisions for the patient (member). As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231, or 36-3281.

Manual Edit - Any change to the original visit data. All edits shall include an appropriate audit trail.

Prior Authorization - For the purposes of this Policy, a process by which it is determined in advance whether a service that requires prior approval will be covered, based on the initial information received. Prior Authorization may be granted provisionally (as a

temporary authorization) pending receipt of required documentation to substantiate compliance with AHCCCS criteria. Prior Authorization is not a guarantee of payment.

Qualified Vendor: For the purposes of this policy, means the same as Provider in AHCCCS AMPM 540.

Service Plan - A complete written description of all covered health services and other informal supports that includes individualized goals, peer-and-recovery support and family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

POLICY

AHCCCS is required to comply with the EVV requirements in the 21st Century Cures Act, 42 U.S.C. 1396(b)(l). The Division and Qualified Vendors are required to utilize AHCCCS's single statewide EVV System for data collection. Qualified Vendors may use the EVV Vendor or choose an AHCCCS approved alternate EVV System capable of sharing data with the Aggregator. AHCCCS and the Division are using EVV to help ensure, track, and monitor timely service delivery and access to care for members.

The list of provider types and services that are mandated to use EVV can be found on the AHCCCS website and include but are not limited to Attendant Care, Habilitation Nursing, Homemaker, and Respite.

A. Service Verification

1. All Qualified Vendors who are subject to EVV must utilize the EVV Vendor or an AHCCCS approved alternate EVV System to electronically track the defined data specifications available on the AHCCCS website.

2. The member/Health Care Decision Maker, or Designee, shall verify hours worked by the DCW at the point of care or within 14 days of the visit. The member/Health Care Decision Maker, or Designee shall also verify Manual Edits to visits.

3. If a member/Health Care Decision Maker is unable or not in a position to verify service delivery on an ongoing basis, they shall arrange for a Designee to have the verification responsibility. In those instances, the member/Health Care Decision Maker is required to sign a standardized attestation specified in Electronic Visit Verification (EVV) – Designee Attestation form (DDD-2102A), at a minimum on an annual basis, attesting that they have communicated the requirements of the verification responsibility to the Designee to whom they are delegating the verification responsibility. The Qualified Vendor shall assist the member/Health Care Decision Maker to make an informed decision about verification delegation. The member/Health Care Decision Maker can change decisions about verification delegation at any time by completing a new attestation. The Qualified Vendor shall keep the attestation on file, following the Divisions record retention requirements outlined in the Qualified vendor Agreement.

4. Exceptions to the Designee age requirement shall be discussed with the treatment and/or planning team and documented on the DDD-2102A form prior to the delegation of service delivery verification responsibility.

5. Neither the Health Care Decision Maker nor a Designee is allowed to verify service delivery for the services that they have personally rendered. If this situation presents barriers to verification, the member or Health Care Decision Maker shall document on the DDD-2102A form.

B. Paper Timesheets

The use of paper timesheets is allowable when the actual date, start and end time of the service provision is independently verified, for example, a code that represents a time and date stamp through the EVV System and under the following circumstances:

1. The DCW and the member live in geographic areas with limited/intermittent or no access to landline, cell, or internet service.

2. Members for whom the use of electronic devices would cause adverse physical or behavioral health side effects/symptoms.

3. Members electing not to use other visit verification modalities on the basis of moral or religious grounds.

4. Members with a live-in caregiver or caregiver accessible on-site 24 hours and for whom the use of other visit verification modalities would be burdensome.

5. Members who need to have their address and location information protected for a documented safety concern (i.e., witness protection or domestic violence victim or members in the Address Confidentiality Program as outlined in DES Policy VR-2.2-v1).

The member/Health Care Decision Maker and Qualified Vendor are required to sign a standardized attestation as specified in the Electronic Visit Verification – Paper Timesheet Attestation form (DDD-2101A) and utilize the standardized paper timesheet specified in the DDD Electronic Visit Verification Paper Timesheet form (DDD-2100A). The DDD-2101A form is utilized to justify the allowance of the use of paper timesheets. The attestation is specific to the member and the services they receive from a single provider. The Division will review the records of the Qualified Vendor annually and monitor the use of these attestations to ensure they are utilized for allowable instances only. It is permissible for Qualified Vendors to utilize their own paper timesheet as long as AHCCCS minimum data elements are captured.

The Qualified Vendor shall enter the paper timesheet into their EVV System no more than 21 days past the date of service rendered as long as timeliness filing standards, as found in Division of Developmental Disabilities Provider Manual, Chapter 12-Billing and Claim Submission are also met. The signature does not have to be recorded in the EVV System, but Qualified Vendors shall have the original, wet copy of the signature on file for audit purposes. A faxed copy of the signature is permissible for billing purposes.

C. EVV Modalities

1. The member/Health Care Decision Maker is able to choose, at a minimum on an annual basis, the device that best fits their lifestyle and the way in which they manage their care. Qualified Vendors shall ensure that at least two different types of visit verification modalities are available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service. The Qualified Vendor shall assist the member/Health Care Decision Maker to make an informed decision about the choice of data collection modality. The member/Health Care Decision Maker shall be permitted to change the modality at any time.

2. It is allowable for Qualified Vendors to allow DCWs to utilize personal devices such as a smartphone. If the Qualified Vendor elects this option, the Qualified Vendor is responsible to have a back-up plan for EVV if the device becomes inoperable.

3. If the Qualified Vendor chooses to allow for GPS tracking while the DCW is on the clock, the Qualified Vendor shall disclose to members how and why the DCW is being tracked. The disclosure should be documented and on file.

4. Members shall be afforded the opportunity to change their preference for the visit verification device the DCW will use.

For members who receive service(s) on an intermittent basis, such as respite care or home health services, the choice of a modality may be limited.

D. Contingency/Back-Up Plan

Qualified Vendors are responsible for Contingency/Back-Up planning and shall use the standardized Contingency/Back-Up Plan as specified in Electric Visit Verification (EVV) Member Contingency/Back-Up Plan form (DDD-2099A) to plan for missed or late service visits and discuss the member's preference on what to do should a visit be late or missed. The preferences shall be noted for each service the Qualified Vendor is providing. It is allowable for members to choose different preference options based upon the service. The Contingency/Back-Up Plan shall be reviewed by the Qualified Vendor with the member at least annually, and a current copy provided to the assigned Support Coordinator. In the event a visit is late or missed, the Qualified Vendor is required to follow up with the member to discuss what action needs to or can be taken to meet the service need. The member/Health Care Decision Maker can change decisions about these preference levels and the Contingency/Back-Up Plan at any time. Should the member not choose a preference, a default preference shall be applied based upon the service.

E. Reporting

The Division will monitor and analyze the Qualified Vendor's EVV data including the following:

1. Member access to care, including:

a. Late and missed visits and adherence to contingency planning preferences, and

b. Timeliness of new services from the date it was determined medically necessary to the date the service was provided for newly enrolled and existing members. Additional information on this requirement is specified in AHCCCS AMPM Policy 1620-A (Initial Contact/Visit Standard), AMPM Policy 1620-D (Placement/Service Planning Standard), AMPM Policy 580 (Behavioral Health Referral and Intake Process), and AMPM Policy 310-B (Title XIX/XXI Behavioral Health Service Benefit).

2. Qualified Vendors Performance, including:

a. Unscheduled visits,

b. Manual Edits,

c. Device utilization,

d. EVV modality types in use,

e. Visits that follow the member's Contingency/Back-Up Plan, and

f. Monitoring of service hours authorized compared to service hours actually provided.

3. The Qualified Vendors shall self-monitor and analyze the following:

a. Performance, including:

i. Location discrepancies, and

ii. Visit exceptions.

b. Devices

i. Monitor and maintain the list of AHCCCS EVV Vendor devices assigned to the provider, as applicable.

c. Service Delivery

i. Monitor service hours authorized compared to service hours actually provided.

F. Qualified Vendor Requirements

1. Comply with annual EVV monitoring.

2. Collect and maintain records for the audit period of at least six years from the date of payment, applicable attestations regarding verification delegation,

paper timesheet allowances, and contingency/back-up plans as specified in this Policy.

3. Counsel the member/Health Care Decision Maker on the scheduling flexibility based on the member's Service Plan or provider plan of care and what tasks can be scheduled and modified depending on the DCWs scheduling availability at least every 90 days.

4. Develop a general weekly schedule for each service. The EVV System shall record the schedule for each service. The system is prohibited from canceling a scheduled visit; however, visits may be rescheduled. The EVV System shall denote what scheduled visits are rescheduled visits. Scheduling is not required for members that have live-in or onsite caregivers; however, the Qualified Vendor shall facilitate a conversation with the member, their family, case managers (if applicable) to make a determination whether or not the exemption from the scheduling requirement is the best decision to support the member.

5. Ensure that all associated EVV Systems users are trained on the EVV System.

6. For providers using an Alternate EVV System, submit data timely as a condition of reimbursement as specified in technical requirement documents available on the AHCCCS website.

7. Comply with member responsiveness including requirements that Qualified Vendors shall answer the phone 24/7 or return a phone call within 15 minutes to members or responsible persons who are reporting a missed or late visit.

8. For Qualified Vendors using the AHCCCS EVV Vendor, develop and implement policies to account for and ensure the return of devices issued by Qualified Vendors to DCWs.

9. Have at least two different types of visit verification devices available to accommodate member preferences and service delivery areas with limited/intermittent or no access to landline, cell, or internet service.

10. Ensure any device used to independently verify start and end times without the use of GPS is physically fixed to the member's home to ensure location verification.

11. Ensure that DCWs who utilize personal devices, such as a smartphone, have an alternate verification method or option if the device becomes inoperable.

12. Ensure that member devices are not used for data collection unless the member has chosen a verification modality that requires use of their device (e.g., landline telephone).

13. Contact the member to validate any visit exceptions including instances when the member indicates the service or duration does not accurately reflect the activity performed during the visit. The documentation of exceptions should be consistent with CMS's Medicare signature and documentation requirements

for addendums to records. Changes as a result of the exceptions process are considered an addendum to the record and do not change the original records.

14. Document Manual Edits to visits within the system and/or maintaining hard copy documentation.

G. Qualified Vendor Attestation

Qualified Vendors shall complete an attestation verifying agreement to comply with the requirements of Electronic Visit Verification. This attestation shall be incorporated as a requirement of the Division's credentialing and recredentialing process.

H. After-Hours Telephone Survey

The Division conducts a telephone survey of the after-hours response of Qualified Vendors (Vendors) contracted to provide services subject to Electronic Visit Verification (EVV) to ensure calls made to the Vendor after business hours are answered immediately or returned within 15 minutes. In addition to the After-Hours Survey, the Division also monitors member grievance information about Vendor's after-hour responsiveness.

In order to ensure access to care for Division members, the Vendor's telephone system shall have a recorded message providing information to callers including the Vendor name and how to reach staff after hours. The message shall indicate to the caller the timeframes the caller can expect to receive a return phone call, not to exceed 15 minutes. The current after-hour contact information shall be maintained in the Division's CAS system.

Survey Process

A. The Division randomly selects the Vendor to participate in the After-Hours Telephone Survey and calls the Vendor, using the Vendor's after-hours telephone number(s) identified in Focus.

B. If the Vendor answers the call immediately or returns the call within 15 minutes, the Division documents the Vendor response and requires no additional survey-related action from the Vendor.

C. If the Vendor does not answer the call and does not return the call within 15 minutes:

1. Corrective Action Plan (CAP)

a. The Division will send a CAP letter to the Vendor, requiring the Vendor to submit a CAP to the Division within 14 calendar days from the date of the CAP letter.

b. If the Vendor does not submit a CAP to the Division within 14 calendar days from the date of the CAP letter, the Division shall send a second CAP letter to the Vendor, requiring that the

Vendor respond to the Division within five calendar days from the date of the second CAP letter.

c. If the Vendor does not respond to the Division within five calendar days from the date of the second CAP letter, the Division may follow progressive contractual action.

2. CAP Review and Verification

a. After review, the Division sends a letter to the Vendor, accepting or rejecting the CAP.

b. If the CAP is not accepted, the Division shall schedule a meeting with the Vendor and offer technical assistance to support the vendor's resubmission.

c. After Acceptance:

i. Division Network staff shall conduct three follow-up calls to the Vendor on different dates/times over three consecutive months.

ii. If the Vendor answers each after-hours follow-up phone call within 15 minutes or returns the call within 15 minutes, the Division staff shall send a letter to the Vendor indicating:

- Vendor is in compliance
- CAP is closed

iii. If the Vendor is not successful in answering the follow-up after-hours calls, the Division may follow progressive contractual action.

CHAPTER 63 WORKFORCE DEVELOPMENT

REVISION DATE: 1/25/2023

EFFECTIVE DATE: May 8, 2019

REFERENCES: AHCCCS Contractor Operations Manual (ACOM) Policy 407; Division Operations Manual Policy 407

PURPOSE

The purpose of this policy is to establish the Qualified Vendors (QV) requirements to implement workforce development initiatives including:

1. Monitoring and collection of information about the workforce;
2. Collaborative planning of workforce development; and
3. Participation in Division directed initiatives, including surveys and technical assistance directed activities.

DEFINITIONS

1. "Competency" means a worker's demonstrated ability to perform the basic requirements of a job intentionally, successfully, and efficiently, multiple times, at or near the required standard of performance.

2. "Competency Development" means a systematic approach for ensuring that workers are adequately prepared to perform the basic requirements of their jobs.
3. "Workforce Capability" means the interpersonal, cultural, clinical/medical, and technical competency of the collective workforce or individual worker.
4. "Workforce Capacity" means the number of qualified, capable, and culturally representative personnel required to sufficiently deliver services to members.
5. "Workforce Connectivity" means the workplace's linkage to sources of potential workers, information required by workers to perform their jobs, and technologies for connecting to workers and/or connecting workers to information.
6. "Workforce Development Alliance (WFDA)" means a name given to the WFD Administrators from each contractor that jointly plan and conduct WFD activities for a particular line of business.
7. "Workforce Development Operation (WFDO)" means the organizational structure of personnel, processes, and resources that the Division implements including monitoring and

addressing current workforce capacity and capability, forecasting, and planning future workforce capacities and capabilities, and delivers technical assistance to provider organizations to strengthen their WFD programs.

8. "Workforce Development Plan (WFD-P)" means the Division's blueprint for ensuring the ongoing growth and development of the network's workforce.

A. GENERAL

1. Qualified Vendors shall work with the Division, AHCCCS, and Administrative Services Subcontractors (AdSS) to ensure members of the Division receive services from a workforce that is qualified, capable, and sufficiently staffed.
2. Qualified Vendors shall acquire, develop, and deploy a sufficiently staffed and qualified workforce that delivers services to members in an interpersonally, clinically, culturally, and technically effective manner.

B. WORKFORCE DEVELOPMENT PLAN

Qualified Vendors shall:

1. Develop and implement a Workforce Development (WFD) Plan that includes the following components:
    a. Workforce Profile;
    b. Workforce capacity assessment, development goals, and work plan; and
    c. Workforce capability/competency assessment, development goals, and work plan.
2. Annually review and update the plan, including an assessment of the progress toward the goals, maintain the plans on file, and submit to the Division upon request.

C. MONITOR WORKFORCE DEVELOPMENT ACTIVITIES

As part of the routine compliance monitoring process, the Qualified Vendor shall ensure:

1. The provider workforce has access to, and is in compliance with, all workforce training and competency requirements specified in federal and state law, Division policies, guidance documents, manuals, contracts and other Division generated plans;
2. There are processes for:
    a. Documenting training;

b. Verifying the qualifications, skills, and knowledge of personnel;

c. Retaining required training and competency transcripts and records; and

3. All initiatives specified in the WFD Plan are routinely monitored and evaluated.

D. WORKFORCE DATA

Qualified Vendors shall collect and analyze required and ad hoc workforce data that:

1. Proactively identifies potential challenges and threats to the viability of the workforce;
2. Conducts analysis of the potential impact of the challenges and threats to the access to care for members;
3. Develops and implements interventions to prevent or mitigate threats to workforce viability; and
4. Develops indicators to measure and monitor workforce sustainability that include metrics focused on recruitment, retention, turnover, and time to hire.

SUPPLEMENTAL INFORMATION

1. AHCCCS and the Division generate policies that shape the worker, workforce, and workforce development practices.
2. The Division:
    a. Monitors the performance of the network;
    b. Collects information about the workplace;
    c. Develops plans to strengthen the workforce; and
    d. When needed, directly assists qualified vendors to develop and maintain a qualified, capable, and sufficiently capacitated workforce.
3. The Division offers training and resources to qualified vendors to assist professionals and family caregivers with managing stress and burnout as required by the Report of the Abuse & Neglect Prevention Task Force.

64 PREVENTING MEMBER ABUSE, NEGLECT AND EXPLOITATION

REVISION DATE: 3/22/2023, 9/21/2022
EFFECTIVE DATE: July 14, 2021
REFERENCES: State of Arizona Executive Order 2019-03 relating to Enhanced Protections for Individuals with Disabilities; AHCCCS Minimum Subcontract Provisions Number 29; A.R.S. §46-451 and 41-1492.10; CFR §165.2 (p); Division Operations Policy 6002-G.

PURPOSE

To establish posting of signage requirements and training requirements for Qualified Vendor staff and Division Members on identifying, reporting, and preventing Member Abuse, Neglect, and Exploitation.

SCOPE

This policy applies to Qualified Vendors and their staff, whether employed or contracted, who provide day treatment and residential services to Members of the Division of Developmental Disabilities (Division). Residential services include all group homes (group home, nursing supported group home, and community protection group home) and all developmental homes.

DEFINITIONS

1. "Abuse" means the infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily

function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a client receiving behavioral health services or community services. Abuse shall also include sexual misconduct, assault, molestation, incest, or prostitution of, or with, a client under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

a. "Abuse (of a child)" means the infliction or allowing of physical injury, impairment of bodily function or disfigurement, or the infliction of or allowing another person to cause serious emotional damage as evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior and which emotional damage is diagnosed by a medical doctor or psychologist and is caused by the acts or omissions of an individual who has the care, custody, and control of a child. As specified in A.R.S. §8-201(2), Abuse includes:

i. Inflicting or allowing sexual Abuse, sexual conduct with a minor, sexual assault, molestation of a child, commercial sexual Exploitation of a minor, sexual Exploitation of a minor, incest, or child sex trafficking as those acts are described in the Arizona Revised Statutes, A.R.S. Title 13, Chapter 14.

ii. Physical injury that results from permitting a child to enter or remain in any structure or vehicle in which volatile, toxic, or flammable chemicals are found, or equipment is possessed by any person for the purpose of manufacturing a dangerous drug as defined in A.R.S. 13-3401.

iii. Unreasonable confinement of a child.

b. "Abuse (of a Vulnerable Adult)" means the intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual Abuse or sexual assault, and Emotional Abuse as specified in A.R.S.

§46-451(A)(1).

2. "Emotional Abuse" means a pattern of ridiculing or demeaning a Member; making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on a Member.

3. "Exploitation" means the illegal or improper use of a Member or the Member's resources for another's profit or advantage as specified in A.R.S. §46-451(A)(5).

4. "Member" means an individual who is receiving services from the Division of Developmental Disabilities (Division).

5. "Neglect" means a pattern of conduct without the individual's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health as specified in A.R.S. §46-451(A)(7), and includes:

    a. Intentional failure to report health problems or changes in health condition to immediate supervisor or nurse.

    b. Sleeping on duty or abandoning workstation.

c. Intentional failure to carry out a prescribed treatment plan for a Member.

6. "Retaliation" means an adverse action taken against an individual for raising a concern about a possible violation or allegation of a potential act of Abuse, Neglect, or Exploitation; or participating in the investigation or other matters related to said act. Staff are expected to report concerns about possible violations or allegations of a potential act of Abuse, Neglect, or Exploitation as soon as they become aware of possible violations. Discipline or termination for staff failure to report or intervene is not considered Retaliation under this policy.
7. "Vulnerable Adult" means an individual who is 18 years of age or older and who is unable to protect himself/herself from Abuse, Neglect, or Exploitation by others because of a physical or mental impairment as specified in A.R.S. § 46-451. Vulnerable Adult includes an incapacitated person as specified in A.R.S. §14-5101.
8. "Whistleblower" means an individual, or two or more individuals acting jointly, who reports Abuse, Neglect, or Exploitation of Members to someone in a position to rectify the wrongdoing. Whistleblowers are protected from Retaliation under federal Whistleblower laws.

POLICY

The Division is committed to providing a safe environment for its most vulnerable Members. As part of that commitment the Division requires Qualified Vendors (vendors) of day treatment and residential settings to post signage in areas accessible to all staff, Division Members, families, and visitors, illustrating how to identify and report Member Abuse, Neglect, and Exploitation, anonymously or otherwise. The Division also requires vendors to provide training to staff and to offer training to Members.

A. SIGNAGE

1. Vendors are required to post the DES/DDD approved sign, "Everyone Has the Right to be Safe," in the service setting's telephone location and/or near posted emergency numbers. The signage is provided by the Division and can be found on the DES Website, in the Document Center, available in English and Spanish. There are two versions: One for individuals under 18 years of age (child) and one for individuals 18 years of age or older (adult). The vendor must post child or adult signage appropriate for the age of the Members receiving service in the setting.

2. Vendors are responsible for providing interpretation or translation of the signs into other non-prevalent languages at the request of the Member or responsible person.
3. Signage should be maintained in good condition and be easily readable.

B. STAFF TRAINING

1. Vendors shall provide staff training on identifying and reporting Member Abuse, Neglect, and Exploitation as follows:

    a. Newly hired staff shall receive instructor-led training within 90 days of the hire date, and

    b. All staff shall receive annual training which may be delivered through computer-based training.

    NOTE: Staff hired on or after the effective date of this policy must be trained within 90 days of their hire date. Staff hired before the effective date of this policy must be trained within 180 days of the effective date of this policy using instructor-led training.

2. Vendors may use the DES/DDD published curriculum, "Recognizing and Reporting Abuse, Neglect and Exploitation of Vulnerable Populations," available on the Division's training webpage, or use alternative curriculum with minimum components below:

   a. Definitions of Abuse (physical, emotional, programmatic), Neglect and Exploitation (including social media and photography).

   b. Recognizing the physical, behavioral, and environmental signs of maltreatment.

   c. List the common characteristics of perpetrators.

   d. Identify the disability, environmental and cultural factors that increase vulnerability and how to decrease them.

   e. Identify the disability, environmental and cultural factors that increase vulnerability and how to decrease them.

   f. Defining and modeling boundaries with personal space.

   g. Maintaining professional relationships when providing

intimate care.

h. Modeling how to say "no" to unwanted touching.

i. Rules for necessary touch and understanding how individuals may give permission.

j. List the methods for reporting maltreatment to protective agencies.

k. Identify key differences between police, Adult Protective Services, and Department of Child Safety.

l. Whistleblower protections for reporting and protection against Retaliation.

3. Conduct annual testing for staff responses to potential acts of Exploitive, Abusive, and Neglectful behavior to verify their understanding of the reporting requirements. This requirement can be met by establishing and reviewing case studies or scenarios of potential Exploitive, Abusive, and Neglectful behavior with staff and documenting their responses.

4. Maintain records of all staff training offered and delivered under

this policy. Using the following roster format:

a. Last Name

b. First name

c. DOB

d. Staff Fingerprint clearance number or Fingerprint application number

e. Vendor name

f. Vendor Assists ID

g. Trainer name

h. Date training completed

5. Issue a training certificate to each staff trained, signed, and dated by the trainer, and maintain a copy in vendor files.

C. MEMBER TRAINING

1. Vendors must offer Division Members training within six months of a new Member beginning day treatment or residential services, and annually thereafter, on the topic of identifying and reporting Member Abuse, Neglect, and Exploitation.

2. Vendors must use the "Awareness and Action" training materials provided by the Division on the Division's training website.

Members are not required to take training offered but should be encouraged to do so.

3. Vendors must maintain records of all Member training offered and delivered under this policy and include the following:

   a. Member Name,
   b. Date training offered, and
   c. A roster of Members that received training, including:
      i. Last Name
      ii. First name
      iii. DOB
      iv. Member Assist ID
      v. Vendor Name
      vi. Vendor Assists ID
      vii. Trainer name
      viii. Date training completed
      ix. Time training completed
   d. Issue a training certificate to each Member trained, signed by

the trainer, and dated. Provide a copy to the Member and maintain a copy in vendor files.

4. Member training shall be instructor led.

5. Training shall be incorporated within routine service delivery.

   a. When Members are dually served in day treatment and residential services, the day treatment service vendor shall be responsible to offer and provide Member's training.

   b. Residential vendors shall offer and provide training to Members who do not participate in day treatment services.

Signature of Chief Medical Officer: Anthony Dekker (Mar 14, 2023 10:05 PDT)
Anthony Dekker, D.O.

CHAPTER 65 PROVIDING OUT OF STATE SERVICES

REVISION DATE: 2/7/2024, 6/24/2022
REVIEW DATE: 1/27/2023
EFFECTIVE DATE: March 3, 2021
REFERENCES: Division Operations Policy 4004-H, Division Medical Policy 1620-D, AdSS Medical Policy 450

PURPOSE

This policy provides guidance to Qualified Vendors and Providers for providing Medicaid services to Members who are eligible for Arizona Long Term Care System (ALTCS) and are Temporarily Out of State and need Medicaid services to support them out of state.

DEFINITIONS

1. "Home and Community-Based Services (HCBS)" means the same as in R6-6-1501.

2. "Medically Necessary Services" means those covered services provided by qualified service providers within the scope of their practice to prevent disease, disability, and other adverse health conditions or their progression or to prolong life.

3. "Member" means the same as "Client" as defined in A.R.S. §

36-551.

4. "Out-of-Country" means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

5. "Out-of-State Services" means services provided to Members outside of Arizona that are covered as provided for under Code of Federal Regulations (CFR) 42 CFR, Part 431, Subpart B. This includes services that, as determined on the basis of medical advice, are more readily available in other states and services needed due to a medical emergency.

6. "Planning Team" means a defined group of individuals comprised of the Member, the Responsible Person if other than the Member, and, with the Responsible Person's consent, any individuals important in the member's life, including extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems.

7. "Provider" means any individual or entity that is engaged in the

delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

8. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability or an adult with a developmental disability who is a member or an applicant for whom no guardian has been appointed.

9. "Qualified Vendor" means a provider of community developmental disability services that has applied for Qualified Vendor status, meets the criteria for Qualified Vendor status, and has entered into a Qualified Vendor Agreement with the Department.

10. "Temporarily Out-of-State" means a Member is absent from Arizona and the member:

    a. Intends to return to Arizona when the reason for the absence is completed.

    b. Has not become a resident of another state.

i. For Members under the age of 18, residency is based on the custodial parent.

ii. Residency of another state includes, but is not limited to, applying for medical assistance, renting or buying a home, getting a job, and/or applying for a driver's license or identification in another state.

POLICY

A. DELIVERING OUT OF STATE SERVICES

1. All Qualified Vendors and Providers, prior to delivering Out of State Services, shall be:

   a. Enrolled with the Arizona Health Care Cost Containment System (AHCCCS), and

   b. Prior authorized by:

      i. The Division for HCBS, or

      ii. The Member's DDD Health Plan for physical and behavioral health services.

2. Qualified Vendors and Providers, shall ensure all service and

reporting requirements are met during the provision of Out of State Services.

3. The Qualified Vendor shall ensure nursing providers traveling Out of State are licensed in the state(s) they are traveling to with the Member.

4. The Qualified Vendor with the planning team, shall develop a plan for the Member's emergency medical care while delivering Out of State Services.

B. REQUESTING SERVICES OUT OF STATE

1. The Qualified Vendor, within one business day of a request for Out of State Services by a responsible person, shall:

   a. Notify the Member's Support Coordinator, and

   b. Inform the Responsible Person to notify the Member's Support Coordinator of the request for Out of State Services.

2. The Qualified Vendor shall receive approval from the Division prior to providing Out of State Services to the Member.

C. REQUIREMENTS FOR BEHAVIORAL-SUPPORTED GROUP HOME, GROUP HOME, AND DAILY SUPPORTED LIVING SERVICES

1. The Qualified Vendor shall submit a revised staffing schedule when additional staff are needed to support a Member traveling out of state.

2. The Qualified Vendor shall receive Division approval for the revised staffing schedule prior to the Member receiving Out of State Services.

D. OUT OF STATE SERVICES THAT ARE NOT COVERED

A Qualified Vendor or Provider shall not bill or be paid for Medicaid covered services when the Member is Out of Country.

E. SUPPLEMENTAL INFORMATION

The Division does not cover Medicaid services including emergency medical care and HCBS for a Member traveling Out of Country.

66 BEHAVIORAL HEALTH

EFFECTIVE DATE: June 24, 2022

REFERENCES: 42 C.F.R. § 438.102; A.R.S § 8-512.01; A.R.S. § 36-550; A.R.S.§ 36-551; A.R.S. Title 36, Chapter 5, Article 4 and 5; A.A.C. R6-6-807; AMPM 100; AMPM Chapter 200 Behavioral Health Practice Tools; AMPM 650; Behavior Supports Manual; AMPM 960; AdSS Medical Policies 310-B, 320-O, 320-P, 320-R, 320-S, 320-U, 320-V, 320-W, 320-X, 450, 541, 580, 960, 963, 964, 1020, 1040; AdSS Operations Policies 110, 415, 417, 446, 449

PURPOSE

The purpose of this policy is to clarify expected roles and responsibilities of Qualified Vendors (QVs) related to coordinating and supporting the implementation of behavioral health services, as well as to provide additional information regarding the System of Care.

DEFINITIONS

1. "Adult Recovery Team" (ART) means a group of individuals that, following the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a member's assessment, service

planning, and service delivery. At a minimum, the team consists of the member/responsible person, advocates (if assigned), and a qualified behavioral health representative. The team may also include the member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other individuals identified by the member.

2. "Child and Family Team" (CFT) means a group of individuals that includes, at a minimum, the child and their family/) Responsible Person., a behavioral health representative, and any individuals important in the child's life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, temples, synagogues, mosques, or other places of worship/faith, agents from other service systems like the Arizona Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD). The

size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore, expand and contract as necessary to be successful on behalf of the child.

3. "Serious Mental Illness" (SMI) means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.
4. "Support Coordinator" means a "case manager" as defined in A.R.S. § 36-551.

POLICY

A. QV ROLES AND RESPONSIBILITIES RELATED TO BEHAVIORAL HEALTH SERVICES

While the Division delegates the delivery of behavioral health services to the Administrative Services Subcontracted health plans (AdSS), the Division's QVs play an integral role in supporting the delivery and coordination of behavioral health services. QV shall complete the

following activities to ensure members have access to coordinated and integrated services.

1. All QVs shall:
    a. Be knowledgeable of and support the System of Care and Guiding Principles outlined in AMPM 100.
    b. Play an integral role by providing input to the Planning Team and behavioral health providers regarding a member's behavioral health needs.
    c. Implement strategies to address behavioral concerns about the member, assist in developing behavior intervention programs, and coordinate with behavioral health programs to ensure proper review of medication treatment plans.
    d. Communicate with behavioral health providers and the Planning Team as needed to ensure coordination of care. Responsibilities include but are not limited to:
        i. Identify and communicate barriers to accessing behavioral health services.

ii. Communicate the progress, or lack of progress with achieving goals outlined in a member's Behavioral Plan or Functional Behavioral Assessment.

iii. Provide the Planning Team updates regarding changes with behavioral health needs and services.

iv. Share any concerns about behavioral health symptoms or changes with behavioral health needs.

v. Complete Incident Reporting as required. Refer to Division Operations Policy Chapter 6000 for details regarding Incident Reporting requirements.

vi. Respond via email or phone communications with behavioral health providers within 2 business days.

vii. Advise or advocate on behalf of a member. The QV shall comply with the requirements under 42 C.F.R. § 438.102 and the intergovernmental Agreement between the Division and AHCCCS. 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 member who is authorized

to receive services from the provider for the following:

1) The member's health status, medical care, or treatment option including any alternative treatment that may be self-administered.
2) Any information the member needs in order to decide among all relevant treatment options.
3) The risks, benefits, and consequences of treatment of no treatment.
4) 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.

e. Ensure staff participation in trainings and implement recommended behavioral strategies from behavioral health professionals, as outlined in a member's planning document.

f. Attend Child and Family Team (CFT) meetings or Adult Recovery Team (ART) meetings.

g. Implement Behavior Plans (BP)/Functional Behavioral Assessments (FBAs) as described in Behavior Supports Manual.

h. Ensure timely and complete behavioral data collection and submission. Refer to Provider Manual Chapter 35 for further details regarding progress reporting requirements.

2. In addition to the above, the following applies to residential QVs:

a. Notify the Division of all hospitalizations within twenty-four hours of admission, including admission to a behavioral health facility.

b. Participate in proactive discharge planning for any hospital or emergency department admissions.

c. Ensure members attend scheduled services, as outlined in a member's Planning Document.

d. Provide environmental and programmatic safeguards and structures that protect the community and treatment for member care as well as other members, neighbors, and the community from those behaviors that endanger the community and treatment of the member, other people, or

property, and/or interfere with the rights of others. The QV shall be responsible for assuring supervision of the member as defined in the Planning Document.

B. ADULT SYSTEM OF CARE - NINE GUIDING PRINCIPLES

The Adult System of Care (ASOC) is a continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health or substance use challenges. The ASOC is organized into a comprehensive network to create opportunities that foster rehabilitation addressing impairment, managing related symptoms, and improving health outcomes by:

1. Building meaningful partnerships with members served.
2. Addressing the member's cultural and linguistic needs, and
3. Assisting the member in identifying and achieving personal and recovery goals.

The following principles were developed to promote recovery in the adult behavioral health system. System development efforts, programs,

service provision, and stakeholder collaboration shall be guided by these Nine Guiding Principles:

1. RESPECT

   Respect is the cornerstone. Meet the individual where they are without judgment, with great patience and compassion.

2. INDIVIDUALS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS

   An individual in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Individuals in recovery should be involved at every level of the system, from administration to service delivery.

3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS

An individual in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.

4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE

An individual in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE

   An individual in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST

   An individual in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. INDIVIDUALS IN RECOVERY DEFINE THEIR OWN SUCCESS

An individual in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Individuals in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES

An individual in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. An individual in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY

An individual in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience.

C. CHILD SYSTEM OF CARE - 12 GUIDING PRINCIPLES

Arizona's Child and Family Team (CFT) practice model blends shared concepts of the 12 Arizona Principles with the 10 Principles of Wraparound: Family voice and choice, teambased, natural supports, collaboration, community based, culturally competent,

individualized, strengths based, unconditional, and outcome based. In CFT Practice, it is the child's and family's complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually for each child and family based on their needs and strengths.

One variable that is considered when determining complexity of needs for children is the involvement of other child-serving agencies, such as Juvenile Justice (Probation or Parole), Division of Developmental Disabilities (DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family, contributes to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved.

Service delivery shall incorporate the Arizona Model in all aspects of service delivery to children and families at all levels of need/acuity as well as children with complex needs or who are determined to have a Serious Emotional Disturbance (SED).

ARIZONA VISION

In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to

the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

12 GUIDING PRINCIPLES

1. COLLABORATION WITH THE CHILD AND FAMILY

Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.

2. FUNCTIONAL OUTCOMES

Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.

3. COLLABORATION WITH OTHERS

When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other individuals needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team: a. Develops a common assessment of the child's and family's strengths and needs, b. Develops an individualized service plan, c. Monitors implementation of the plan, and d. Makes adjustments in the plan if it is not succeeding.

4. ACCESSIBLE SERVICES

Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.

5. BEST PRACTICES

Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by Arizona Department of Health Services (ADHS) that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive

sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. MOST APPROPRIATE SETTING

Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.

7. TIMELINESS

Children identified as needing behavioral health services are assessed and served promptly.

8. SERVICES TAILORED TO THE CHILD AND FAMILY

The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.

9. STABILITY

Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan

for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.

10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE

Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.

11. INDEPENDENCE

Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including

transportation assistance, advance discussions, and help with understanding written materials, will be made available.

12. CONNECTION TO NATURAL SUPPORTS

The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

D. COVERED BEHAVIORAL HEALTH SERVICES

The Division covers Title XIX/XXI behavioral health services for members eligible for ALTCS regardless of the health plan they choose. The responsibilities of the Division for providing Title XIX/XXI behavioral health services to members are outlined in the Division Medical Policy Manual (DMPM) 310-B, including additional requirements for members that have chosen the DDD Tribal Health Program (THP) as their health plan. The Division is responsible for collaborating with Tribal entities and behavioral health providers to ensure access to

services for THP members. See AdSS Medical Policy 310-B for responsibilities of the Division's Subcontracted Health Plans providing Title XIX/XXI behavioral health services.

Title XIX/XXI Behavioral Health Services Categories/Subcategories:

1. Treatment Services: Assessment, Evaluation (non-court ordered), Screening, Counseling, Therapy, Psychophysiological Therapy and Biofeedback.
2. Rehabilitation Services: Skills Training and Development, Psychosocial Rehabilitation Living Skills Training, Cognitive Rehabilitation, Health Promotion, Psychoeducational Services, Ongoing support to maintain employment services/Job Coaching, Pre-vocational services.
3. Medical Services: Medication, Laboratory, Radiology, Medical Imaging, Medical Management.
4. Support Services: Case Management, Respite, Home Care Training/Family Support, Self-Help/Peer Services (Peer and Recovery Support), Therapeutic Foster Care for Children, Adult Behavioral Health Therapeutic Home, Unskilled Respite Care,

Behavioral Health Day Programs, Community Psychiatric Supportive Treatment Programs.

5. Behavioral Health Residential Facility Services.
6. Behavior Analysis.
7. Crisis Intervention Services (delivered through the RBHA's): Telephonic Crisis Intervention, Mobile Crisis Team Intervention, Facility Based Crisis Interventions, Emergency and Non-Emergency Medical Transportation.
8. Inpatient Services: Hospital and Behavioral Health Inpatient Facility (BHIF).

E. BEHAVIORAL HEALTH ASSESSMENT AND REFERRAL

DDD ALTCS eligible members have access to covered behavioral health services for mental, emotional, and substance use disorders without the requirement of a referral. A member, responsible person, family member or care provider may make oral, written or electronic requests for behavioral health services at any time. To avoid duplication of referrals, the QV shall communicate with the Support Coordinator prior to making direct referrals. Refer to Division Medical Policy 1620-G for details Division Behavioral Health Referrals.

A referral may be made directly by the member, prospective member, responsible person, Primary Care Physician (PCP), the health plan, or another care provider, hospital, treat and refer provider, jail, court, probation, or parole office, school or other government or community agency as specified in A.R.S. § 8-512.01. Refer to AdSS Medical Policy 580, and AdSS Operations Policy 417, and 449 for information regarding timeline requirements in place to ensure members have timely access to behavioral health services.

F. BEHAVIOR PLANS AND PROGRAM REVIEW COMMITTEE

Refer to the Behavior Supports Manual for details related to the implementation of Behavior Plans and requirements related to Article 9.

THE FOLLOWING INFORMATION APPLIES TO THE AdSS AND THEIR NETWORK OF BEHAVIORAL HEALTH PROVIDERS. THIS DOES NOT APPLY DIRECTLY TO QVS, HOWEVER, INCLUDES INFORMATION THAT MAY BE HELPFUL TO ENSURE COORDINATION OF CARE.

G. DUTY TO WARN

Behavioral health providers have a duty to protect others against a member's potential danger to self and/or danger to others. When a

behavioral health provider determines, or under applicable professional standards, reasonably should have determined that a member poses a serious danger to self or others, the provider has a duty to take reasonable precautions to prevent harm and protect others against imminent danger of a member harming him/herself or others. Reasonable precautions include:

1. Communicating, when possible, the threat to all identifiable victims.

2. Notifying a law enforcement agency in the vicinity where the member or any potential victim resides.

3. Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate and in accordance with AdSS Medical Policy 320-U.

4. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

Behavioral health providers have immunity from liability when they perform duty to warn under A.R.S. § 36-517.02. Refer to AMPM 960, AdSS 960 or A.R.S. § 36-517.02 for further details.

H. HOUSING CRITERIA FOR INDIVIDUALS DETERMINED TO HAVE AN SMI

The AHCCCS Housing Programs (AHP) consists of the permanent supportive housing and supportive health programs. The majority of AHCCCS available housing funding is reserved for members with a designation of Serious Mental Illness (SMI), although limited housing is provided for some individuals without an SMI designation who are considered to have a General Mental Health and/or Substance Use Disorder (GMHSUD) need. For persons with GMHSUD needs, housing priority is focused on persons identified with increased service utilization including crisis or emergency services and/or services addressing complex chronic physical, developmental, or behavioral conditions. For a limited number of units within the program, eligibility is further based upon receipt of specific behavioral health services such as an Assertive Community Treatment (ACT) Team.

AHP is community-based permanent supportive housing where a member should have a renewable lease, the right of entry and exit (not restricted by program), and can voluntarily select services. Housing subsidies are provided for permanent supportive housing in both scattered site units (Scattered Site Program) as well as for dedicated site-based units (Community Living Program). All subsidized rental units must meet minimum standards of health and safety, as determined by Federal Housing Quality Standards (FQS), and have a reasonable rent based on market standards. Housing subsidies are currently paid to the landlord directly on behalf of the member/household. Members are expected to pay up to 30% of their income toward their rent with the balance subsidized by the program. In addition to housing subsidies, AHP funding also provides for housing related supports and payment such as deposits, move-in assistance, eviction prevention, and damages related to member occupancy. AHP does not include any Behavioral Health Residential Facilities, Group Homes, or other licensed clinical residential settings.

Funds for these purposes are limited based on budget availability. Supportive services are critical to housing stability and the related

benefits of permanent supportive housing. AHCCCS and AHP promote a Housing First model based upon principles of permanent supportive housing provided by the Substance Abuse and Mental Health Service Administration (SAMHSA). Supportive services for members in AHCCCS subsidized housing are determined by their provider and generally provided through Medicaid and other reimbursable services supplied by the managed care health plans and their provider networks. The State allocation for AHP is for approximately 3,000 members throughout Arizona. Arizona's State Legislature allocates Non-Title XIX/XXI General Fund money to AHCCCS annually to provide permanent supportive housing.

I. OUTREACH, ENGAGEMENT AND RE-ENGAGEMENT FOR BEHAVIORAL HEALTH

Outreach includes activities designed to inform members of behavioral health services availability and to engage or refer those members who may need services. Outreach and engagement activities are essential elements of clinical practice. Behavioral health providers must reach out to vulnerable populations, establish an inviting and non-threatening environment, and reestablish contact with members who have become

temporarily disconnected from services. Refer to AdSS Medical Policy 1040 for more details.

J. PARTNERSHIP REQUIREMENTS WITH FAMILIES AND FAMILY-RUN ORGANIZATIONS IN THE CHILDREN AND CHILDREN AND ADULT BEHAVIORAL HEALTH SYSTEM

The Division recognizes the importance of the Parent/Family Support role as a viable component in the delivery of integrated services. Parent/Family Support Services may involve support activities including, but not limited to:

1. Assisting the family to adjust to the individual's needs.
2. Developing skills to effectively interact, and/or
3. Guide the individual's:
    a. Understanding of the causes and treatment of behavioral health issues.
    b. Understanding and effective utilization of the system, or planning long term care for the individual and the family.

Refer to AdSS Medical Policy 963

K. PEER SUPPORT/RECOVERY TRAINING, CERTIFICATION, AND CLINICAL SUPERVISION

Individuals with lived experiences of recovery are an integral part of the behavioral health workforce. Peer support services include the provision of assistance to more effectively utilize the service delivery system (e.g. assistance in developing plans of care, identifying needs, accessing supports, partnering with other practitioners, overcoming service barriers); or understanding and coping with the stressors of the member's disability (e.g. support groups, coaching, role modeling, and mentoring). These services shall only be provided by Peer and Recover Support Specialists who have completed training and certification and receive clinical supervision. Refer to ADSS Medical Policy 963 for details.

L. PRE-PETITION SCREENING, COURT ORDERED EVALUATIONS AND TREATMENT

Court-ordered treatment (COT) is the civil commitment process laid out in A.R.S. Title 36, Chapter 5, Article 4 and 5. It states that when there is a belief that, due to a person's mental disorder and their unwillingness to engage with treatment, they are:

1. Danger to self
2. Danger to others

3. Persistently or acutely disabled

4. Gravely disabled

More information about these screenings and court-ordered treatment can be found in the AdSS Medical Policy Manual 320-U.

Members may seek a voluntary evaluation at any screening agency available statewide. During the COE and COT process, members may agree to a voluntary evaluation. A voluntary evaluation occurs after a pre-petition screening is filed but before a COE is filed. It requires the person's informed consent.

Emergency Situations: When a member is a danger to themselves or others due to their inability or unwillingness to seek voluntary mental health treatment, they may apply for emergency evaluation and admission in person. If the screening agency approves the application, it issues a pick-up order to law enforcement in the region where the member is located, requesting the member be delivered to the screening agency for evaluation.

Non-Emergency Situation: When members are not a danger to themselves or others but could be if their behavioral health issues

remain untreated, a non-emergent application can be filed through any of the following agencies.

M. REQUIREMENTS FOR BEHAVIORAL HEALTH PROVIDERS TO ASSIST INDIVIDUALS

Behavioral health providers are required to assist individuals with applying for Arizona Public Programs (Title XIX/XXI, Medicare Savings Programs, Nutrition Assistance, and Cash Assistance), and Medicare Prescription Drug Program (Medicare Part D), including the Medicare Part D "Extra Help with Medicare Prescription Drug Plan Costs" low income subsidy program, as well as verification of U.S. citizenship/lawful presence prior to receiving Non-Title XIX/XXI covered behavioral health services, at the time of intake for behavioral health services. Refer to AMPM 650 for further details.

N. SECLUSION, RESTRAINT, AND EMERGENCY RESPONSE REPORTING REQUIREMENTS

All facilities are required to report seclusions, restraints and emergency responses. This applies to all state licensed behavioral health inpatient facilities, mental health agencies, out-of-state facilities and ADHS

treating members with ACC, DD and ALTCS EPD coverage. Types of restraint and seclusion include:

1. Chemical restraint: Pharmacological restraint that is not standard treatment. It helps manage the member's behavior or restrict their movement to lower the safety risk to themselves or others.
2. Mechanical restraint: Any device, article, or garment attached or next to a member's body that restricts the member's movement and is not easily removed. This lowers the safety risk to themselves or others.
3. Seclusion: Involuntary confinement in a room or an area from which the member cannot leave.

Refer to AdSS Medical Manual Policy 962 for details.

O. SERIOUS MENTAL ILLNESS (SMI) ELIGIBILITY DETERMINATION

Determination of SMI requires both the qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis. The licensed psychiatrist, psychologist, or NP of the determining entity (either the authorized AHCCCS designee or a TRBHA authorized to make the final determination) designates must make a final

determination about whether the person meets the SMI status eligibility requirements based on:

1. A face-to-face assessment or a qualified clinician's review of a face-to-face assessment (AMPM Policy 950), and

2. A review of current and historical information, if any, obtained orally or in writing by the assessor from collateral sources, and/or present or previous treating clinicians.

3. A member must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the following four areas for most of the past 12 months. Or it must last for most of the past six months with an expected duration of at least six months:

    a. Inability to live in an independent or family setting without supervision.

    b. A risk of serious harm to self or others.

    c. Dysfunction in role performance.

    d. Risk of deterioration.

AHCCCS contracts with a specific determining entity to complete the SMI determinations. The determining entity will send the member a Notice of Decision letter by mail informing them of the final decision regarding their SMI determination. This letter will include information about their rights and how to appeal the decision. For more information, please refer to AdSS 320-P.

P. SMI GRIEVANCE AND APPEAL PROCESS

The SMI grievance process applies only to adults who have been determined to have a serious mental illness (SMI) and to all behavioral health services received by the member.

A grievance may be submitted if:

1. Rights have been violated.
2. Suspected abuse or mistreatment by staff of a provider.
3. Subjected to a dangerous, illegal, or inhuman treatment environment.

SMI grievances must be filed within 12 months of the rights violation occurring. The grievance must be filed with the agency responsible for

delivering the behavioral health services. Grievances concerning physical abuse, sexual abuse or a person's death are investigated by AHCCCS.

Q. SMI Determination Appeal Process

AHCCCS contracts with a Determining Entity to make a determination of SMI upon referral or request. Members seeking a determination of SMI and members who have been determined to have an SMI can appeal the result of the determination.

The determining entity will send a letter by mail to let the member know the final decision on their SMI determination. This letter is called a Notice of Decision. The letter will include information about your rights and how to appeal the decision. If the determining entity finds the member is not eligible for SMI services, the letter will tell why. To file an appeal, members can call the determining entity or submit a written request to appeal the decision within 60 calendar days from the date on the Notice of Decision letter.

Refer to AdSS Operations Policy Manual 446 for additional details regarding the SMI grievance process.

R. SMI Treatment Appeal Process

Persons who have been determined to have a serious mental illness can also appeal parts of their treatment plan, including:

1. A decision regarding fees or waivers.
2. The assessment report, and recommended services in the service plan or individual treatment or discharge plan.
3. The denial, reduction, suspension or termination of any service that is a covered service funded through Non-Title 19/21 funds.
4. Capacity to make decisions, need for guardianship or other protective services, or need for special assistance.
5. A decision is made that the member is no longer eligible for SMI services.

6. A PASRR determination in the context of either a preadmission screening or an annual resident review, which adversely affects the member.

To file an appeal related to any SMI treatment plan/behavioral health services, the member/responsible person must call or send a letter to the agency/health plan that made the denial, discontinuance, suspension, or reduction in services.

The member/responsible person will receive written notice from the responsible agency that your appeal was received within 5 business days of the agency's receipt. An informal conference will be held with the responsible agency within 7 business days of filing the appeal.

The informal conference must happen at a time and place that is convenient for the member/responsible person. The member/responsible person has the right to have a designated representative of their choice assist them at the conference. The member/responsible person and any other participants will be informed of the time and location of the conference in writing at least two

working days before the conference. Individuals may participate in the conference over the telephone.

For an appeal that needs to be expedited, a written notice that the appeal was received will be sent to the member/responsible person within 1 business day of the responsible agency's receipt, and the informal conference must occur within 2 business days of filing the appeal.

If the appeal is resolved to satisfaction at the informal conference, the member/responsible person will receive a written notice that describes the reason for the appeal, the issues involved, the resolution achieved and the date that the resolution will be implemented.

If there is no resolution of the appeal during this informal conference, the next step is a second informal conference with AHCCCS. The member/responsible person may waive the second level informal conference and proceed to a State Fair Hearing, however. If the second level informal conference with AHCCCS is waived, the responsible agency will assist the member/responsible person in filing a request for

State Fair Hearing at the conclusion of the health plan informal conference.

If there is no resolution of the appeal during the second informal conference with AHCCCS, the member/responsible person will be given information that will tell them how to get a State Fair Hearing. The Office of Grievance and Appeals at AHCCCS handles requests for State Fair Hearings upon the conclusion of second level informal conferences.

If an appeal is filed, any services already in place will continue, unless:

1. A qualified clinician decides that reducing or terminating services is best for you, or
2. You agree in writing to reducing or terminating services.

If the appeal is not decided in the member's favor, the responsible agency may require the member/responsible person to pay for the services received during the appeal process. If the member/responsible person still does not understand the Notice of Adverse Benefit Determination letter, they have the right to contact AHCCCS Medical Management at MedicalManagement@azahcccs.gov.

Persons determined to have a serious mental illness cannot appeal a decision to deny, suspend or terminate services that are no longer available due to a reduction in State funding.

Refer to AdSS Operations Manual Policy 944 for additional details regarding SMI appeals processes.

S. OTHER BEHAVIORAL HEALTH GRIEVANCE AND APPEAL PROCESSES

Members or their responsible person may refer to the DDD website or their DDD Health Plan websites for information about how to file grievances or appeals regarding behavioral health services that are not related to SMI determinations or SMI treatment.

T. AHCCCS DUGless PORTAL GUIDE

AHCCCS has developed a plan to help health care providers collect and report demographic and social determinants of health data. This plan reduces the number of data points care providers must report. It involves using: 1. Alternative data sources. AHCCCS has identified

current demographic elements in other AHCCCS data systems and other source agreements. 2. Social Determinants of Health ICD-10 Diagnosis codes. These diagnosis codes reported on claim submissions began April 1, 2018. 3. Demographic Portal. For those social determinant/demographic/outcome elements with no identified alternative data source or Social Determinate diagnosis identifier, AHCCCS created an online portal (DUGless) accessed directly by care providers to collect applicable identified data elements for members. Both the provider organizations that historically provided data for the DUG as well as all care providers who typically provide these types of data will provide the required information through DUGless. For more information refer to the Demographics, Social Determinants and Outcomes page on the azahcccs.gov website.

U. BEHAVIORAL HEALTH BEST PRACTICE TOOLS

AHCCCS developed a set of Behavioral Health Best Practice Tools which have been converted to formal policies in the AMPM Chapter 200. The policies/tools set the expectations for the behavioral health providers. Many of the policies include information relevant to partner agencies,

such as QVs, who participate on the Child and Family Teams (CFTs) or Adult Recovery Teams (ARTs):

1. AMPM 210 Working with the Birth through Five Population.
2. AMPM 211 Psychiatric and Psychotherapeutic Best Practices for Children Birth through Five Years of Age.
3. AMPM 220 Child and Family Team.
4. AMPM 230 Support and Rehabilitation Services for Children, Adolescents, and Young Adults.
5. AMPM 240 Family Involvement in the Children's Behavioral Health System.
6. AMPM 250 Youth Involvement in the Children's Behavioral Health System.
7. AMPM 260 The Unique Behavioral HEalth Services - Needs of Children, Youth, and Families involved with DCS.
8. AMPM 270 Children's Out of Home Services.
9. AMPM 280 Transition to Adulthood.

Chapter 67 GENERAL AND INFORMED CONSENT

EFFECTIVE DATE: May 18, 2022
REFERENCES: A.R.S. § 8-514.05(C), A.R.S. § 15-104, A.R.S. § 36-501 et seq, A.R.S. § 36-2272, A.A.C. R9-21-206.01, AHCCCS Medical Policy Manual (AMPM) Policy 310-V, and AMPM Policy 320-Q.

PURPOSE

The purpose of this policy is to outline the requirements for reviewing and obtaining General and Informed Consent for members receiving physical and/or behavioral health services, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

DEFINITIONS

1. "General Consent" means a one-time agreement that shall be obtained from a member or the member's responsible person to receive certain services, including but not limited to behavioral health services, that is usually obtained during the intake process at the initial appointment and is always obtained prior to the provision of any behavioral health services.
2. "Informed Consent" means an agreement to receive physical or behavioral health services following the presentation of facts necessary to form the basis of an intelligent consent by a member or the member's responsible person with no minimization of known

dangers of any procedures.

POLICY

A. MEMBER RIGHTS

1. Each member has the right to participate in decisions regarding his or her physical and/or behavioral health care, including the right to refuse treatment.
2. Members seeking physical or behavioral health services shall be made aware of the service options and alternatives available to them, as well as specific risks and benefits associated with these services in order to be able to agree to these services.

B. GENERAL CONSENT

1. Unless otherwise provided by law, General Consent shall be obtained before any services and/or treatment are provided. Verification of a member's enrollment does not require consent.
2. Providers treating members in an emergency are not required to obtain General Consent prior to the provision of emergency services. Providers treating members pursuant to court order shall obtain consent, as specified in A.R.S. Title 36, Chapter 5.

C. INFORMED CONSENT

1. A higher level of consent may be required for provision of specific behavioral or physical health services or for services provided to

vulnerable members. These requirements can be found in AMPM Policy 320-Q.

2. Providers of behavioral health services shall gain Informed Consent in a variety of specific circumstances for members with a Seriously Mentally Ill (SMI) designation. These requirements can be found in A.A.C. R9-21-206.01.

CHAPTER 68 ADVANCE DIRECTIVES

EFFECTIVE DATE: June 15, 2022
REFERENCES: 42 CFR 489.102; 42 U.S.C. § 1396(a)(57); A.R.S. § 36-3231; AHCCCS Medical Policy Manual (AMPM) policy 640

PURPOSE

The purpose of the policy is to ensure processes are in place for hospitals, nursing facilities, hospice providers, residential service providers, and home health care or personal care services to comply with Federal and State laws regarding Advance Directives for Adult Members. [42 U.S.C. §1396(a)(57)].

DEFINITIONS

1. "Adult Member" means a member aged 18 and over.
2. "Advance Directive" means a document by which an individual makes provision for health care decisions in the event that, in the future, the individual becomes unable to make those decisions.
3. "Conscientious Objections" means refusal to perform a legal role or responsibility because of moral or other personal beliefs, including practitioners providing or not providing certain care or

treatment to their patients based on reasons of morality or conscience.

POLICY

A. Members have the right to have information provided to them about the importance of Advance Directives including their rights to establish and rescind Directives at any time. At a minimum, providers shall comply with the following:

1. Maintain written policies for Adult Members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an Advance Directive;
2. Provide written information to Adult Members regarding the provider's policies concerning Advance Directives, including any Conscientious Objections;
3. Document in the member's record whether or not the Adult Member has been provided the information, and whether an Advance Directive has been executed;
4. Prevent discrimination against a member because of the

member's decision to execute or not execute an Advance Directive, and not place conditions on the provision of care to the member, because of the member's decision to execute or not execute an Advance Directive;

5. Provide education to staff on issues concerning Advance Directives including notification to staff who provide home health care or personal care services such as attendant care, respite, and nursing if any Advance Directives are executed by members to whom they are assigned to provide services; and
6. Ensure alternative Home and Community Based Services (HCBS) setting staff have immediate access to Advance Directive documents to provide to first responder requests.

B. Adult Member, and when the member is incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. § 36-3231, shall be provided written information regarding Advance Directives as delineated in 42 CFR 489.102(e) concerning:

1. The member's rights, regarding Advance Directives under Arizona state law.
2. The organization's policies respecting the implementation of

those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

3. A description of the applicable state law and information regarding the implementation of these rights.
4. The member's right to file complaints with Arizona Department of Health Services, Division of Licensing Services, and
5. Written policies including a clear and precise statement of limitations if the provider cannot implement an Advance Directive as a matter of conscience. This statement, at a minimum, shall:
    a. Clarify institution-wide Conscientious Objections and those of individual physicians,
    b. Identify state legal authority permitting such objections, and
    c. Describe the range of medical conditions or procedures affected by the conscience objection.

C. The provider is not relieved of its obligation to provide the above information to the member once the member is no longer

incapacitated or unable to receive such information. The provider shall have follow-up procedures in place to provide the information to the member directly at the appropriate time.

D. The above information shall also be provided to a member upon each admission to a hospital or nursing facility and each time the member comes under the care of a home health agency, hospice, or personal care provider. [42 U.S.C. § 1396a(w)(2)]

E. Providers shall provide a copy of a member's executed Advance Directive or documentation of refusal to the member's Primary Care Provider (PCP) for inclusion in the member's medical record, and provide education to staff on issues concerning Advance Directives.

69 CARE COORDINATION

EFFECTIVE DATE: June 15, 2022
REFERENCES: 20 U.S.C.§ 1400; A.R.S. § 13-3620; A.R.S. § 46-454; A.R.S. §15-765; AHCCCS Contract; AMPM 541; AMPM 1021; AMPM 1022; AMPM 1610; AMPM 710; AMPM 580; ACOM 416; ACOM 417; ACOM 449

PURPOSE

The purpose of this document is to provide a high-level overview of care coordination for Division of Developmental Disabilities (Division) members. It applies to all DDD providers.

DEFINITIONS

1. "Care Management" is a group of activities performed to identify and manage clinical intervention or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include the day-to-day duties of service delivery.
2. "Planning Document" means a plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP) or a Person-Centered Service Plan (PCSP).

3. "Support Coordinator" means a "case manager" as defined in A.R.S. § 36-551.

A. OVERVIEW

The Division uses an integrated model and person-centered approach to meet the service and support needs for ALTCS eligible members. The Support Coordinator shall coordinate the physical and behavioral health services and Home and Community Based Services (HCBS) for Arizona Long term Care (ALTCS) eligible members enrolled with the Division as well as coordinate with other entities providing services and supports as outlined in this policy.

The Division has mechanisms and processes to identify barriers to timely services for members served by an AHCCCS health plan and/or other providers or entities and works collaboratively to remove barriers to care and to resolve concerns. The Division's Support Coordinator shall ensure that appropriate authorizations to release information are obtained prior to releasing information to other entities or providers. As mandatory reporters, Division staff shall make reports to DCS and APS as required per A.R.S. § 13-3620 and A.R.S. § 46-454.

B. CARE MANAGEMENT

For DDD members who have chosen a subcontracted health plan, the Division collaborates with the DDD Health Plan Care Managers to ensure member's biopsychosocial needs are met by early identification of health risk factors and special health care needs. DDD members who have chosen the Tribal Health Program (THP) receive Care Management from Division staff. Care Management is a team-based, outcome-driven program that identifies members with high and/or complex needs and ensures there is no duplication and over/under utilization of services. Members are assigned to the Care Management program to learn how to better manage their illnesses and meet their health care needs. For additional information regarding the Care Management program, refer to AMPM 1021.

C. DEPARTMENT OF CHILD SAFETY (DCS)

The Division collaborates with DCS to coordinate services for children in the care and custody of DCS or with family involvement with DCS. Children who are eligible for ALTCS shall receive physical and behavioral health services from a DDD subcontracted health plan. DDD members who

are in the care and custody of DCS but not eligible for ALTCS will receive these services from the Comprehensive Health Plan (CHP).

The Support Coordinator shall coordinate with the DCS caseworker to:

1. Ensure a behavioral health assessment is performed and identify behavioral health needs of the child, the child's parents and family, and provide necessary behavioral health services, including support services to caregivers;
2. As appropriate, engage the child's parents, family, caregivers, and DCS Specialist in the behavioral health assessment and service planning process as members of the Child and Family Team (CFT).
3. Coordinate behavioral health services to support family reunification and/or other permanency plans identified by DCS;
4. Coordinate activities and services that support the child and family case plans and monitor adherence to established timeframes in Division Operations Manual Policy 417, AdSS

Operations Manual Policy 449, and Division Medical Manual Policy 580.

5. Coordinate with providers rendering services to the member's family.

6. Coordinate with the Tribal Regional Behavioral Health Authority (TRBHA) for members receiving behavioral health services through a TRBHA.

D. COORDINATION OF CARE BETWEEN THE DIVISION AND SCHOOL SYSTEM

Although the Division is not financially responsible for educational services as specified in AMPM 710, coordination of care related to educational services is required to ensure members' needs are being met. For children over the age of 3 who receive special education services, the Support Coordinator shall include information and recommendations contained in the Individualized Education Plan (IEP) during the ongoing assessment and service planning process. The Support Coordinator shall:

1. Develop and maintain effective working relationships with the various school districts within the proximity of the Support Coordinator's assigned Division office. This includes identifying the appropriate teachers and the school hierarchy for addressing any issues that may arise for members they support.

2. Ensure that the member's Planning Document complements the education plan and reflects coordinated care for the member.

3. Coordinate with the Local Educational Agency (LEA) and the IEP team per A.R.S. §15-765 when a residential placement is needed for educational purposes to accomplish specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive environment.

E. ARIZONA DEPARTMENT OF ECONOMIC SECURITY

1. Arizona Early Intervention Program (AZEIP)

AZEIP is Arizona's statewide interagency system of services and supports for families of infants and toddlers, birth to three years of age, with disabilities or delays. AzEIP is established by Part C

of the Individuals with Disabilities Education Act (IDEA), which provides eligible children and their families access to services to enhance the capacity of families and caregivers to support the child's development.

For children who are eligible for AZEIP and enrolled with the Division, the Support Coordinator shall:

a. Work collaboratively with Team Based Early Intervention Services (TBEIS) providers and the member's AHCCCS/ALTCS health plan to coordinate services and supports for these children and their families.
b. Ensure ALTCS/TSC requirements are met for Division members who are eligible for ALTCS or Targeted Support Coordination.
c. Coordinate with the LEA when the child reaches ages two years six months to plan for preschool transition.

2. Rehabilitation Services Administration/Vocational Rehabilitation (RSA/VR)

a. The Division and RSA/VR support Employment First policy, and practice, which means that employment should be the preferred day time activity for members of working age. For further details regarding Employment First Principles, Policy and Practice along with a description of models to support members in a variety of job-related settings, see Division Medical Policy 1240-E.

b. An Interagency Service Agreement (ISA) is in place between AHCCCS and RSA to provide specialty employment supports for members determined to have a Serious Mental Illness (SMI). Through this ISA, behavioral health agencies and RSA's Vocational Rehabilitation program (RSA/VR) work collaboratively with the ultimate goal of increasing the number of employed members who are successful and satisfied with their vocational roles.

3. Adult Protective Services (APS)

The Division collaborates and coordinates care for members involved with Adult Protective Services (APS)including, but not limited to, when APS is investigating a member incident involving abuse, neglect, or exploitation.

F. COURTS AND DEPARTMENT OF CORRECTIONS

1. The Division collaborates and coordinates care for members with physical or behavioral health needs and for members involved with:
    a. Arizona Department of Corrections (ADOC),
    b. Arizona Department of Juvenile Corrections (ADJC),
    c. Administrative Offices of the Court (AOC), and/or
    d. County Jails System.
2. The Division collaborates with courts or correctional agencies to coordinate member care as outlined in AMPM Policy 1022.

CHAPTER 70 QUALIFIED VENDOR INCIDENT REPORTING

EFFECTIVE DATE: May 10, 2023
REFERENCES: Division Medical Policies 960, 961; Division Operations Policy 416

PURPOSE

The purpose of this policy is to establish the requirements for qualified vendors and individual Providers to report Member Incidents, Accidents, Deaths, and Sentinel Events to the Division of Developmental Disabilities (Division) and Quality Management Unit. It also provides information on mandatory reporting requirements.

DEFINITIONS

1. "Abuse" means the infliction of, or allowing another individual to inflict, or cause, physical pain or injury, impairment of bodily function, disfigurement or serious emotional damage which may be evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior. Such Abuse may be caused by acts or omissions of an individual having responsibility for the care, custody or control of a Member receiving behavioral health services or community services. Abuse also includes sexual misconduct, assault, molestation, incest, or

prostitution of, or with, a Member under the care of personnel of a mental health agency. A.A.C. R9-21-101(B).

2. "Community Complaint" means a complaint from the community that puts a Member or the community at risk of harm.
3. "Death" means expected (natural), unexpected (unnatural), or no Provider present.
4. "Death Expected" means Death from long-standing, progressive medical conditions, or age-related conditions, such as end-stage cancers, end-stage kidney or liver disease, end-stage Human Immunodeficiency Virus or Acquired Immunodeficiency Syndrome, end-stage Alzheimer or Parkinson diseases, severe congenital malformations.
5. "Death Unexpected" means Death from motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma Abuse, sudden Deaths from undiagnosed conditions or generic medical conditions that progress to rapid deterioration.
6. "Death No Provider Present" means Death of a Member living independently or with family and no Provider is being paid for service provision at the time of Death.

7. "Exploitation (Of a Vulnerable Adult)" means, as specified in A.R.S. §46-451(A)(5), the illegal or improper use of a Vulnerable Adult or their resources for another's profit or advantage.
8. "High Profile Case" means a case that attracts or is likely to attract attention from the public or media.
9. "Human Rights Violation" means a violation of a Member's rights, benefits, respect, and privileges guaranteed in the laws of the United States and the State of Arizona.
10. "Incident" means an unexpected event or occurrence that causes harm or has the potential to cause harm to a Member, or an indicator of risk to the health or welfare of the Member.
11. "Medication Error" means that one or more of the following has occurred:
    a. Member given the wrong medication,
    b. Member given the wrong medication dosage,
    c. Member given medication at the wrong time,
    d. Member not given medication at all,
    e. Member given medication wrong route, or
    f. Medication given to the wrong person.
12. "Member" means the same as "Client" as defined in A.R.S. § 36-551.

13. "Neglect (Of a Child)" means, as specified in A.R.S. §8-201, the inability or unwillingness of a parent, guardian, or custodian of a child to provide that child with supervision, food, clothing, shelter, or medical care.
14. "Neglect (Of a Vulnerable Adult)" means, as specified in A.R.S. §46-451(A)(7), a pattern of conduct without the Member's informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health.
15. "Planning Document" means a plan which is developed by the planning team, such as an Individualized Family Service Plan (IFSP) or Person-Centered Service Plan (PCSP).
16. "Provider" means an individual or entity that contracts with the Division or Arizona Health Care Cost Containment System for the provision of covered services to Members according to the provisions prescribed in A.R.S. §36-2901 or any subcontractor of a Provider delivering services pursuant to A.R.S. §36-2901.
17. "Responsible Person" means the parent or guardian of a minor with a developmental disability, the guardian of an adult with a developmental disability

who is a member or an applicant for whom no guardian has been appointed as defined in A.R.S. §36-551.

18. "Sentinel Event" means an unexpected Incident involving Death, serious physical or psychological injury, or risk thereof.
19. "Serious Injury" means any type of injury requiring medical care or treatment beyond first aid, including assessment or treatment in an emergency room, treatment center, physician's office, urgent care, or admission to a hospital.
20. "Vulnerable Adult" means, as specified in A.R.S. §46-451(A)(10), an individual who is eighteen years of age or older and who is unable to protect themselves from Abuse, Neglect, or Exploitation by others because of a physical or mental impairment.

POLICY

A. REPORTABLE INCIDENTS

Qualified Vendors and Providers shall report any of the following reportable Incidents:

1. Allegations of Abuse, Neglect, or Exploitation of a Member;
2. Death of a Member;
3. Delays or difficulty accessing care or services;
4. Healthcare acquired conditions and other Provider preventable

conditions;

5. Serious Injury;
6. Injury resulting from the use of a personal, physical, chemical or mechanical restraint, or seclusion;
7. Injury requiring medical care or treatment beyond first aid;
8. Medication error;
9. Missing Member;
10. Member suicide attempt;
11. Suspected or alleged criminal activity;
12. Emergency measures used by staff;
13. Environmental circumstances, such as inclement weather, loss of air conditioning, loss of water, loss of electricity, which pose a threat or may cause harm to a Member or requires a change in operations;
14. Health Insurance Portability and Accountability Act violation;
15. Allegations of Medicaid fraud, waste or abuse;
16. Missing or loss of Member funds or property less than $1,000;
17. Property damage less than $10,000;
18. Illicit drug use by staff or Member;
19. Allegations of Human Rights Violations;

20. High Profile Case or police involvement;
21. Community Complaint; or
22. Any other Incident that causes harm or has the potential to cause harm to a Member.

B. REPORTABLE SENTINEL EVENTS

Qualified Vendors and Providers shall report any of the following reportable Sentinel Events:

1. Death or Serious Injury associated with a missing Member;
2. Suicide, attempted suicide, or self-harm that results in Serious Injury;
3. Death or Serious Injury of a Member associated with a Medication Error;
4. Death or Serious Injury of a Member associated with a fall;
5. Stage 3, Stage 4, and any unstageable pressure ulcers acquired after admission or presentation to a healthcare setting;
6. Death or Serious Injury of a Member associated with the use of a personal, physical, chemical or mechanical restraint, or seclusion;
7. Sexual Abuse or sexual assault of a Member during the provision of services;

8. Death or Serious Injury of a Member resulting from a physical assault that occurs during the provision of services;
9. Homicide committed or allegedly committed by a Member;
10. Missing or loss of Member funds or property over $1,000; or
11. Property damage over $10,000.

C. INCIDENT AND SENTINEL EVENT REPORTING

1. Qualified Vendors and Providers shall report Incidents to the Division no later than the next business day after the occurrence or notification of the occurrence, including submission of a detailed incident report to the Division's Quality Management Unit.
2. Qualified Vendors and Providers shall report Sentinel Events to the Division immediately at 602-375-1403 or 1-855-375-1403 and submit a detailed incident report to the Division's Quality Management Unit no later than the next business day after the occurrence. Phone lines are available 24 hours a day, weekdays, weekends, and holidays.
3. Qualified Vendors shall notify the following individuals or agencies as applicable:
   a. Member's Responsible Person unless otherwise specified in

the Member's Planning Document;

b. Assigned support coordinator; and

c. Law enforcement or other protective service agencies, as applicable, and document:

i. Name and title of the person submitting the report,

ii. Name of regulatory agency report was made,

iii. Name and title of regulatory agency taking the report,

iv. Date and time of the report, and

v. Tracking and report number from the regulatory agency, as applicable.

D. MANDATORY REPORTING

Qualified Vendors and independent Providers who have a reasonable basis to suspect that Abuse, Neglect, or Exploitation of a Member has occurred must report such information immediately to a peace officer or protective services agency.

Signature of Chief Medical Officer: Anthony Dekker (May 3, 2023 13:59 PDT)
Anthony Dekker, D.O.

Qualified Vendor Application and Directory System (QVADS)

Provider Instructions – Agency with Choice Option

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Document ID: DDD-QVADS-2885-001

Version 1.0

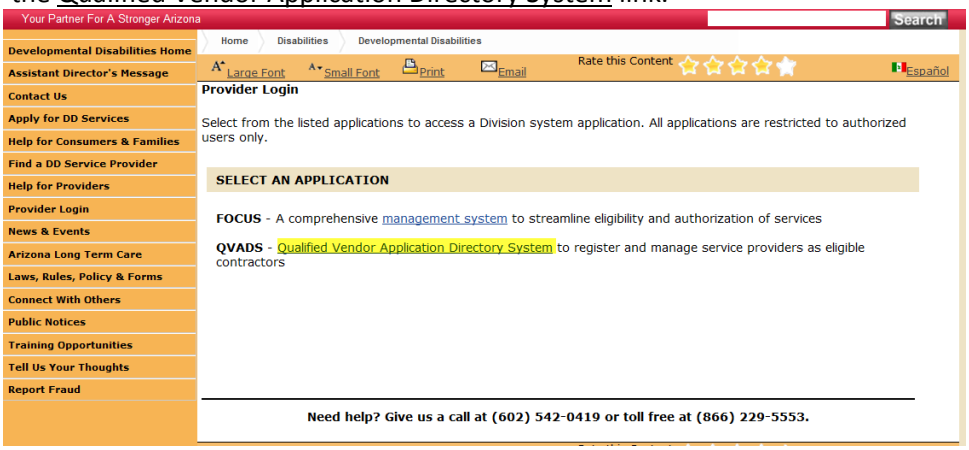
August 05, 2014

Division of Developmental Disabilities

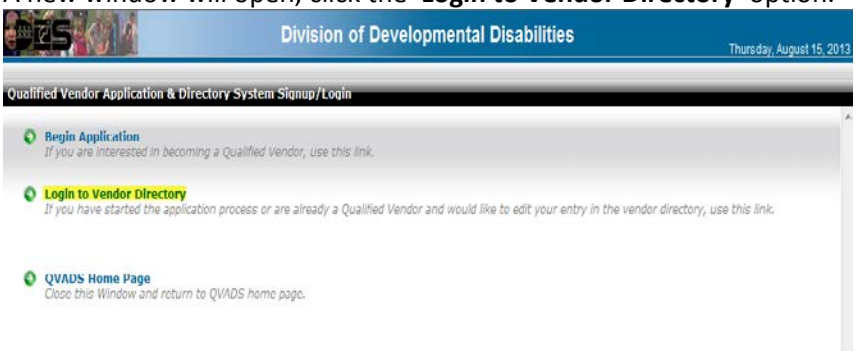
Table of Contents

1 How to Login to QVADS

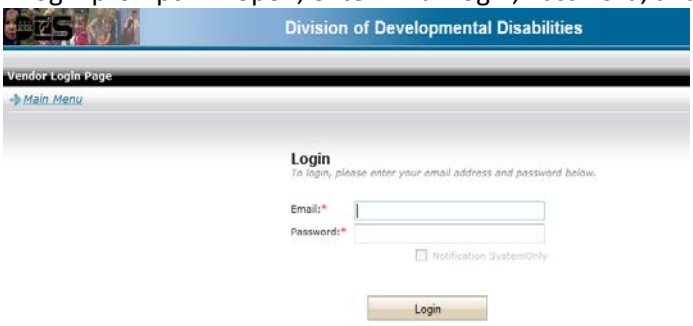
1. Login to QVADS by going to url https://www.azdes.gov/main.aspx?menu=96&id=2476 and click the Qualified Vendor Application Directory System link.



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

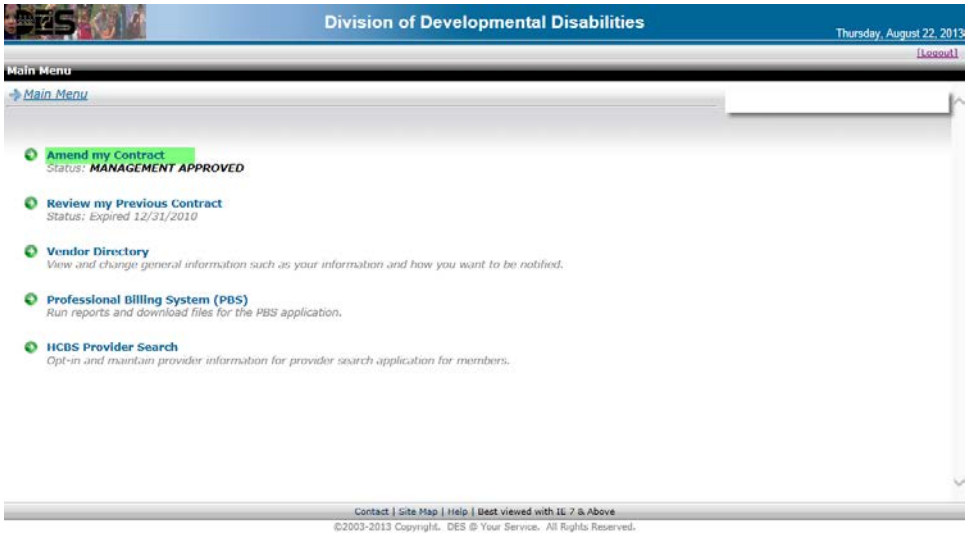


3. A login prompt will open; enter Email login, Password, and click [Login]

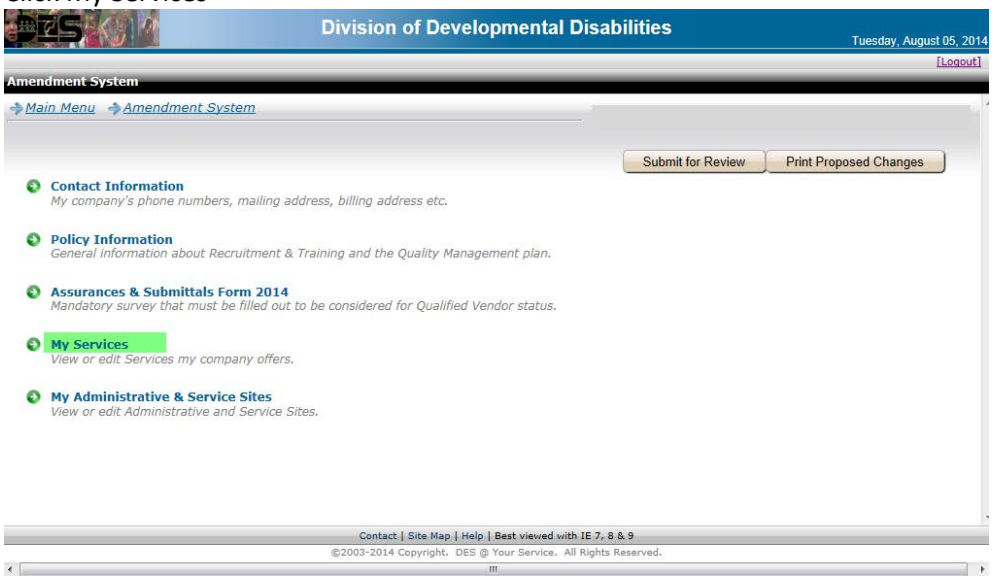


2 Updating the Agency with Choice Selection

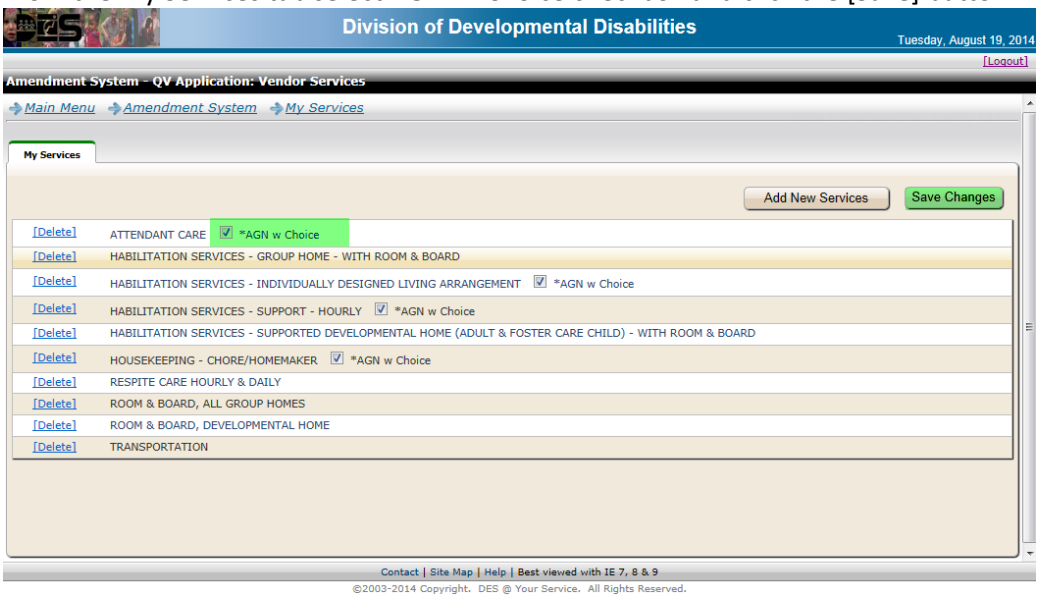
1. Click Amend my Contract



2. Click My Services



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



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

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Division of Developmental Disabilities

Table of Contents

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.

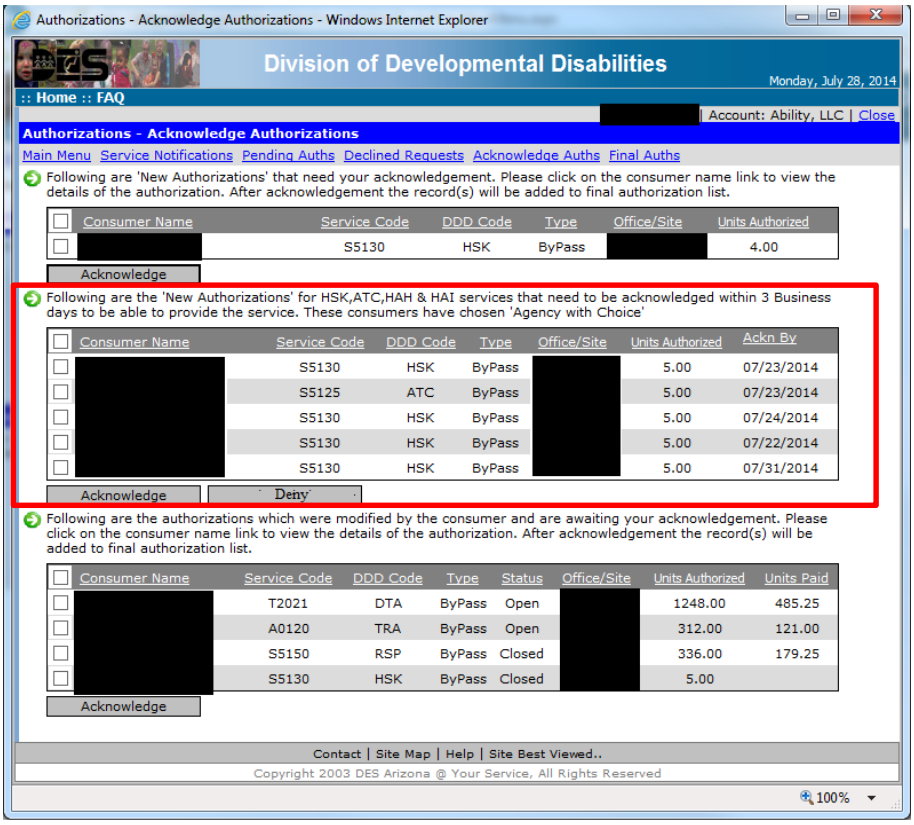
2.1 Acknowledge within 3 business days

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



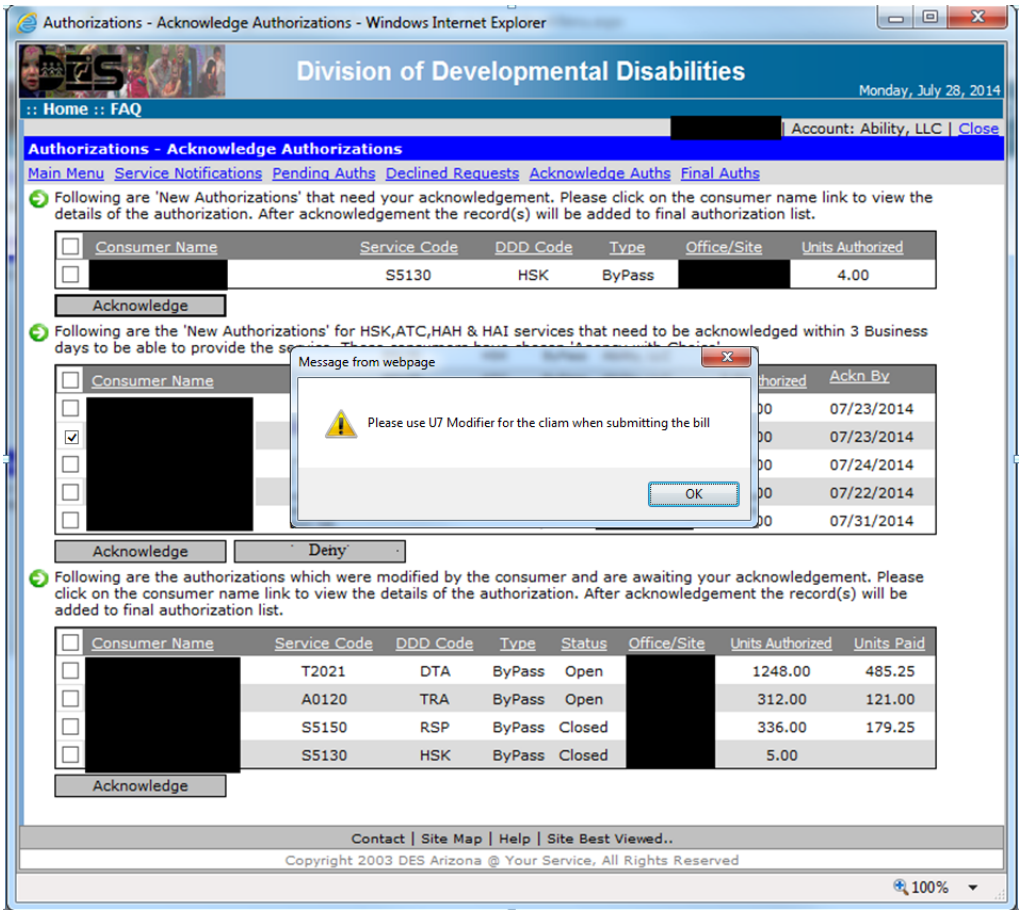
User will be able select members and Acknowledge/Deny the authorization.

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 modifer for submitting claims for services provided under Agency with choice option.

Example:



Medicaid Encounter

Data Validation

1/10/2022

Introduction

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System Administration (AHCCCSA) to oversee and report on the utilization of medical services of AHCCCS's prepaid capitated Contractors. DDD is an AHCCCS prepaid capitated Contractor. DDD reports service utilization on an encounter. An encounter is a record of a service rendered by a provider who is registered with AHCCCS to a recipient who is enrolled with DDD. DDD is required to submit encounters to AHCCCS for all services.

CMS requires AHCCCS to submit progress reports on the encounter data collection process. AHCCCS must take appropriate action to correct deficiencies identified in the collection of encounter data and enforce financial penalties on Contractors that are not in compliance with data collection requirements.

AHCCCS's encounter collection actions are based on the results of encounter data validation studies. Collecting accurate, timely and complete encounters is a high priority for AHCCCS. Encounter data is used to support programmatic budget assumptions and in actuarial analyses to set capitation

rate ranges. In addition, this data is used for AHCCCS Contractor Performance Measures and Performance Improvement Projects.

This document provides DDD and its Providers with the methodology and statistical formulae used in Encounter Data Validation. These processes may change year to year and this document will be updated accordingly.

Annual Encounter Data Validation Study

On an annual basis, the AHCCCS Division of Health Care Management (DHCM) conducts an Encounter Data Validation Study. The purpose of this study is to compare recorded utilization information from claim or other source with DDD's submitted encounter data. Any and all covered services may be validated as part of this study.

Errors resulting from this study may fall into several categories defined as:

- Omission Error - an encounter for a medically related service for which a Contractor incurred a financial liability not submitted to AHCCCS. Or, an encounter inappropriately voided from AHCCCS historical files and not resubmitted, but still appearing as a paid claim for the Contractor is an omission.
- Accuracy Error - an inconsistency between the claim documentation and an encounter submitted in respect to member ID, Provider ID/NPI, procedure, modifiers, diagnosis, date of service, billed charged, paid amount, units, coordination of benefits.

- Timeliness Error - an encounter received at AHCCCS beyond the allowable time period as defined in the contract.

Encounter Data Validation Study Steps

Approximately 9 months after the end of a contract year, encounter extract files are generated from AHCCCS Data Warehouse based on adjudicated encounter data for each Contractor.

AHCCCS will request an extract from the Contractor's claims system. Upon receipt of the requested claims file extract, AHCCCS will sort and prepare the file for matching through the data validation process. Random sample files will be created for each of the study measures. The review scope will include two sections: Acute study "A" for all professional services and the Acute study "B" for all facility services. The studies will measure:

- Claims included in the Contractor's claim submission and encountered in AHCCCS' Prepaid Medical Management Information System (PMMIS) (Match) – to be reviewed for accuracy and timeliness.

- Claims included in the Contractor's claim submission but not encountered in PMMIS (NotEnc InClm) – to be reviewed for omission.
- Encounters reported in PMMIS but not included in the Contractor's claim submission (InEnc NotClm) – to be reviewed for omission from claim submission file.

Once the samples have been determined, the Contractor will be notified. For each record identified on the samples, the Contractor will be required to submit a copy the claim (or EDI) submitted by the provider, along with any other pertinent information such as, primary insurance EOB, AHCCCS CRN, proof of timely encounter submission, explanation for omission from claim file extract, etc. The Contractor will return all documentation to the SFTP server.

Once the Contractor's response is received, AHCCCS will review the documentation against the encounter data in PMMIS. Preliminary findings will be reported back to the Contractor. The Contractor will have 30 days to challenge the preliminary findings. Once all challenges have been considered, a final report will be generated and sent to the Contractor. Sanctions are applied based on the final report.

Random Sample Calculation

The health plans should send DAR the Plan Data, datasets required in a fixed width text format according to the attachments to the preliminary letters, which contain Np records. DAR analysts pull the Agency Data from AHCCCS Data Warehouse following exactly the same formats and time period as the Plan Data. Then following the below process the random samples are selected.

1. Assuming the health plans send the complete datasets to AHCCCS using SPSS or other software to do the data manipulation, match the plan data to the agency data and find the number of omission claims. This data matching includes three steps:

    a. Step 1. Match the Plan Data to the Agency Data by 4 columns, Member ID Number, Date of Service, Service Provider Number, Procedure Code (Study A) or First Revenue Code (Study B). Most of plan data records can be found in agency data and some of the plan data are omissions. Part of the result of this step is also for internal use.

b. Step 2. Match the omission data from Step 1 to the Agency Data by 3 columns, Member ID Number, Date of Service, Service Provider Number. Some of omission records can be found in the agency data and some of them are still omissions. Part of the result of this step is also for internal use.

c. Step 3. Match the omission data from Step 2 to the Agency Data by 3 columns, Member ID Number, Month of Service, Service Provider Number. Some of omission records can be found in the agency data and some of them are still omissions, which result in the overall omission number N_o

2. The overall omission rate is calculated as $i_o = N_o / N_p$, where N_o is from Step 3 and N_p is from the plan data.

3. Using statistical method by SPSS or Excel to select a random omission sample datasetof 500 records from the overall omissions. If the omissions are less than 500, select them all.

4. DAR analysts manually check each of these 500 records in AHCCCS Prepaid Medical Management Information System (PMMIS) to see whether those omissions are truly omissions and

come up with a number N_r,(i.e. how many records are not found in PMMIS by any chance.) A random sample rate i_r is calculated as $i_r = N_r /500$, where thenumber of 500 can be substituted by the actual number if $N_o<500$.

5. The final omission rate $\boldsymbol{i_f}$ is calculated as $\boldsymbol{i_f = i_r * i_o = (N_o / N_p) /(N_r /500)}$, where thenumber of 500 can be substituted by the actual number if $N_o<500$.

Example of Random Sample Calculation

In this example, assume that Nearly Perfect Health Plan sends a complete Study A dataset to AHCCCS in a fixed width text format which contain Np =3,283,651 records. DAR analysts pull the agency data from AHCCCS Data Warehouse following exactly the same formats and time period as the Nearly Perfect Data. Then following the below process the random samples are selected.

1. Using SPSS or other software to do the data manipulation, match the Nearly Perfect Data to the Agency Data and find the number of omission claims. This data matchingincludes three steps:

a. Step 1. Match the Nearly Perfect Data to the Agency Data by 4 columns, Member ID Number, Date of Service, Service Provider Number, and Procedure Code. Most of the3,283,651 records can be found in agency data and 705,382 records are omissions. This number is also for internal use.

b. Step 2. Match the 705,382 records from Step 1 to the Agency Data by 3 columns, Member ID Number, Date of Service, and Service Provider Number. Some of omission records can be found in the agency data and 683,176 are still omissions. This number isalso for internal use.

c. Step 3. Match the 683,176 records from Step 2 to the Agency Data by 3 columns, Member ID Number, Month of Service, and Service Provider Number. Some of omission records can be found in agency data and 652,928 records are still omissions, i.e. the overall omission number N_o=652,928.

2. The overall omission rate is calculated as i_o =19.9 %(

652,928/3,283,651).

3. Using the statistical methods by SPSS or Excel to select a random omission sampledataset of 500 records from the overall omissions since N_o>500.

4. DAR analysts manually check each of these 500 records in the AHCCCS Prepaid Medical Management Information System (PMMIS) to see whether those omissions aretruly omissions and come up with 16 records that are not found in PMMIS by any chance. The random sample rate i_r is calculated as i_r = 3.2 %(16/500).

5. The final omission rate $\boldsymbol{i_f}$ is calculated as $\boldsymbol{i_f}$ **=** 0.6 %(19.9%*****3.2%).

Sanctions

Sanction Calculation

The sanction amount by Contractor is calculated by applying the sanction formula:

S = P x ((L - A) x NAdj), where:

S = sanction amount,

P = per-error sanction amount,

L = lower limit of the confidence interval,

A = allowable error rate of 5%, and

NAdj = total number of encounters by form type adjusted for omissions by Contractor.

NAdj = Ntot / (1-LOm), where:

NTot = total number of encounters submitted by form type by Contractor, and

LOm = the lower limit of the omission error by Contractor.

The per-error base sanction amounts are:

ERROR TYPE	**SANCTION AMOUNT**
Omission	$5.00
Accuracy	$5.00
Untimely	$2.00

Guidelines

Response Documentation Guidelines

In order to properly submit the claims file extract to AHCCCS, these guidelines must be followed:

Acceptable form submission files examples:

1. Number each file submission to match the Row on the excel spreadsheet.
2. One file numbered to match spreadsheet which holds all the documentation for that row.

   Example (Use for all audit file submissions)

   AHCCCS ID # (Folder name)

   a. Add all documentation needed to support claim/encounter into one folder with the row number

   b. Make sure if using your own ID for members to add AHCCCS ID to your documentation.

3. Do this for each row on spreadsheet

4. Do not put all documentation all in one word document, pdf document, or insert into spreadsheet.

5. Zip all the individual files into one zip file and upload to AHCCCS server under "Other" and the particular health plan.

Focused Audits Override/Void Logs

At its discretion AHCCCS may conduct focus audits.

The Contractor is required to maintain logs for all overridden or voided encounters. Those logs are submitted quarterly pursuant to the Encounter Manual. AHCCCS will conduct periodic focused audit of the logs. The purpose of the audit is to ensure the override/void was an appropriate action.

From the information provided on the logs, AHCCCS will select a file sample. The file sample will be forwarded to the Contractor with a request for the documentation used to override or void the encounter. The Contractor will follow the guidelines below to support each override or void. AHCCCS will review the documentation for appropriateness and return the findings to the Contractor.

Override Log Audit Guidelines

Provide all documentation that supports the reason for the override of the encounter – including any guidelines, Medical Director approval, policy, etc.

If replaced with another CRN, please include CRN information

Return spreadsheet in same format as sent to you – you may add an additional column at the end to provide additional comments.

See Response Documentation Guidelines above.

Upload all documentation and spreadsheet on SFTP server, placed in "Other" folder.

Void Log Audit Guidelines

Provide all documentation that supports the reason the encounter was voided.

Return spreadsheet in same format as sent to you – you may add an additional column at the end to provide additional comments.

See Response Documentation Guidelines above.

Upload all documentation and spreadsheet on SFTP server, placed in "Other" folder.