DDD SHOUT

VENDOR & PROVIDER NEWSLETTER

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WellSky Issue with 837 Files

The Division has identified an issue within WellSky related to using 837 files to process “void” or “void and replace” claims. Remediating this issue is WellSky’s top priority to limit any adverse impact on Qualified Vendor claims submissions. Qualified Vendors should discontinue using 837 files to “void” or “void and replace” claims until a solution can be identified and implemented. Qualified Vendors can continue to “void” or “void and replace” claims using the WellSky user interface as that functionality is not impacted. Additional communication will be issued when a resolution is identified.

New Contract for Home and Community-Based Services (HCBS) Update

The Request for Qualified Vendor Application (RFQVA) is the Division’s contract for Home and Community-Based Services (HCBS). It is the Division’s goal to end the current Agreement, DDD-710000, and implement the new Agreement, DDD-2024, in March 2024.

As part of this process, the Division will stop accepting new applications from prospective Qualified Vendors and amendments to add a service to existing Qualified Vendor agreements for RFQVA DDD-710000 as of the close of business on March 31, 2023, as outlined on the timeline posted on the Division’s website.

Qualified Vendors must take action to correct or complete information in the Division’s Contract Administration System (CAS) or the Vendor’s FOCUS account as outlined below.

- Maintain insurance compliance prior to and throughout the DDD-2024 contract application review.
- Maintain current HCBS certification.
  - Ensure that all AHCCCS IDs are active and ensure timely revalidation of AHCCCS IDs associated with the agency/business’s Qualified Vendor Agreement.
- Ensure that each active service in CAS that requires an AHCCCS ID has one associated with that service.
- Ensure that at least one signatory or owner has a FOCUS account.
  - If at least one signatory or owner does not have a FOCUS account, they will need to set up a new account. Instructions are in section 2 of the DDD QVA User Guide and Manual.
  - It is recommended that the account use the first name, last name and email address of the owner or signatory already in use in CAS to avoid the submission of an amendment to the vendor’s QVA which requires review and approval.
- Have at least one signatory or owner with an exactly matching first name, last name, and email address in BOTH the Contract Administration System (CAS) and the vendor’s FOCUS account.

Failure to maintain compliance and take timely action on required activities will create barriers to a successful re-application and may result in the denial of a Qualified Vendor’s new application for RFQVA DDD-2024.

The Division has created a webpage specific to this project that includes a PDF copy of the final RFQVA DDD-2024 document, the projected timeline to help Qualified Vendors and applicants plan for the implementation of RFQVA DDD-2024 and a summary of changes between the current and future RFQVA for Qualified Vendor reference. Qualified Vendors with general questions about the new RFQVA should submit them using this Google Form. Qualified Vendors with specific questions about their contract should contact their Contracts Specialist.

AHCCCS Electronic Visit Verification (EVV)

Electronic Visit Verification (EVV) tracks and monitors timely service delivery and access to care for members. EVV applies to all providers of these services, including paid family direct care workers. EVV is a federal requirement and is a mandatory program. All individuals who receive services from AHCCCS must participate. The hard claims edit for Electronic Visit Verification went into effect on Sunday, January 1, 2023. This means that Qualified Vendors cannot be paid for claims for services with dates of service on or after January 1, 2023, if all EVV requirements are unmet. At a minimum, the EVV system must electronically verify the:

- Type of service performed
- The individual receiving the service
- Date of the service
- Location of service delivery
- The individual providing the service
- Time the service begins and ends

The DDD services impacted are:

- Attendant Care
- Homemaker/Housekeeping
- Habilitation Hourly
- Home Health (Nursing, Licensed Health Aid, Home Health Aid)
- Respite

Services including Speech Therapy, Occupational Therapy, and Physical Therapy provided by a Qualified Vendor that is enrolled as a “Provider Type 39-Habilitation Provider” or as a “Provider Type 01 Group Biller” are not required to use Electronic Visit Verification.

Place of Service (POS) Codes

Medical coding standards require Place of Service (POS) to be captured as part of the claims submission process. EVV does not limit where services are provided, however, the place where services are provided must be recorded. EVV captures location at the beginning and end of service delivery. EVV is only required for the following Place of Service (POS) codes:

- 12-Home
- 13-Assisted Living Facility
- 99-Other

Additional information about service codes, POS, and provider types required to use EVV can be found on the AHCCCS EVV webpage. The complete Place of Service (POS) code set can be found on the Centers for Medicaid and Medicare Services (CMS) website.

Available Resources

The Division has created a page on its website dedicated to Electronic Visit Verification. This page includes a

link to the AHCCCS website, an FAQ with questions specific to DDD and EVV, and a Google Form that members, families, stakeholders, and providers can use to submit EVV questions to the Division. Additional information about EVV can be found in the Division's Provider Manual Chapter 62 Electronic Visit Verification.

Common Errors

Qualified Vendor Agencies are now submitting claims for services provided after the Electronic Visit Verification claims "hard edit" was implemented on January 1, 2023. The Division has identified four common errors. Please consider the following before submitting claims:

1. Timing of claims: Please upload your visit data in Sandata **before submitting the claim to WellSky for that visit**. Otherwise, WellSky will deny claims submitted before the verified EVV data has been uploaded. For example, if you submit a claim on Tuesday and verified visit data on Thursday, the claim will be denied.
2. Incorrect payor: Visit data in Sandata must have "AZDDD" as the payor so the WellSky claims system validation process can "see" the visit. If the payor is another managed care organization (MCO) or AHCCCS, DDD's claims system cannot see the visit data. This is due to Sandata's data compliance protection that ensures HIPAA compliance.
3. Visit data does not match the claim: The visit data has to match the claim (aggregating is allowable). The number of verified visits must equal the total on the claim, or match it exactly.
4. Time zone: Be aware of the time zone used by Alt EVV systems and use the proper coding when uploading to Sandata. Using incorrect time zones may prevent the system from validating claims. Please refer to the AHCCCS Alternate EVV Vendor Specification guidelines for more information.

If you're a Qualified Vendor who made one of these errors and received a claim denial due to EVV compliance, please resubmit your claim only after correcting the EVV errors.

New Incident Report Form Effective May 1, 2023

The Division was engaged in a collaborative workgroup with AHCCCS and the DDD Independent Oversight Committees (IOC) to review and provide enhancements to the Incident Report form. These modifications were made to standardize and broaden the data collected through incident reporting, to reduce the initial follow-up with providers for additional needed information, to provide important information to the IOCs, and to capture required data elements defined in House Bill 2865; which was passed in June 2022. Examples of the HB 2865 reporting requirements include incidents involving medication errors, changes to the Behavior Plan and involved Law Enforcement.

The new Incident Report Form is divided into three (3) distinct Incident Types:

- Medication
- Death
- Other

Qualified Vendors will only need to complete the Incident Type section relevant to the nature of the incident being reported. For example, if the incident being reported is a member injury because of a fall, the Incident Type – Other Section would need to be completed. In this example, Incident Type- Medication and Incident Type – Death can be skipped.

Please note, all other sections of the form need to be completed as the new form collects more detailed information and data related to member demographics, required notifications and corrective actions the Qualified Vendor has already implemented.

The Division will implement the new form effective May 1, 2023. This will allow time for the Qualified Vendors to train staff and make necessary changes to their processes. Incidents being reported on or after May 1, 2023 must be submitted using the new Incident Report form.

Residential Billing Process

Some members receiving Home and Community Based Services (HCBS) from the Division may be required to make a financial contribution to the cost of their care based on their eligibility. A member who receives Residential Services has a cost of care based on the amount of income or benefits the member receives, including any Social Security, veteran's benefits, or railroad retirement benefits. The required financial contribution is a maximum of 70% of the member's income and monthly benefits received, but must not exceed the actual cost of Residential Services. Qualified Vendors with questions about the cost of care should refer to Division Operations Policy Manual Chapter 4002 Client Billing. In addition, the Division is reviewing opportunities to develop a streamlined monthly billing statement as the monthly billing amount is subject to change based on changes to the resident's income amount, occupancy of the home, and rate changes.

Residency Agreement for Community Residential Services

HCBS Setting Rule requirements ensure individuals receiving Home and Community Based Services are integrated into their community and have full access to the benefits of community living.

In order to ensure compliance with the HCBS Setting Rule, on March 1, 2023, the Division began using the Residency Agreement (DDD-2176A). The Residency Agreement must be completed and signed prior to a member:

- Moving into a Group Home, Nursing Supported Group Home, Enhanced Behavioral Group Home, or Developmental Home (both Child and Adult), or
- Moving between a Group Home, Nursing Supported Group Home, Enhanced Behavioral Group Home, or Developmental Home (both Child and Adult).

A Spanish version of the form is also available. Qualified Vendors with questions about the form should contact the Provider Network Support team via email at providernetworksupport@azdes.gov.

Additionally, DDD is developing an FAQ and will be sending it out to the Support Coordination team within the next week and have updated Medical Policy Manual 1620 D and provider Manual Chapter 2 which will be published for public comment in the next few weeks.

Federal COVID-19 Public Health Emergency

On January 30, 2023, the federal government announced the federal COVID-19 public health emergency would end on May 11, 2023. This means the remaining COVID-19 public health emergency flexibilities not ending on April 1, 2023, will end on June 30, 2023. The Division has updated its Actions Related to COVID-19 web page, so it's easier to understand changes to COVID-19 flexibilities. Flexibilities have been combined into a single table that lists their effective dates and end dates. Additionally, the Division has archived the "DDD Qualified Vendor and Provider Frequently Asked Questions" document. These questions and answers have been moved to a Google Document that is available for viewing from the updated Service Delivery Changes section. Qualified Vendors and Providers should reference the updated table in the Service Delivery Changes section in regard to the end of any flexibilities granted throughout the PHE rather than the frequently asked questions document.

Behavior Plans

The Division's Behavior Supports Policy Manual defines a "behavior plan" as "an integrated, individualized, written plan which may be based on a Behavioral Health Professional's provisional or principal diagnosis and assessment of behavior and the treatment needs, abilities, resources, and circumstances of a Member, that includes one or more treatment goals and one or more treatment methods".

Individuals with developmental disabilities may show an increased risk for behavior challenges, self-injury, repetitive behavior patterns, repetitive speech patterns, refusals, aggression, communication impairments, complex sensory needs, emotional dysregulation, and sleep disturbances. A Behavior Plan is required for members whose behavior intervention strategy includes a Restricted Technique.

The planning team MUST write a plan:

- For anyone prescribed psychotropic medication (except if they live in their own or family home)
- Upon the team's decision to use any technique that requires prior approval, which includes any of the following:
  - Techniques that require the use of force,
  - Programs involving the use of response cost
  - Programs that might infringe upon the rights of the individual
  - Protective devices used to prevent self-injury.

The team MAY CONSIDER developing a plan when the individual displays inappropriate behavior that interferes with the individual's learning or participation in their community or places the individual or others at risk of harm.

The team MUST MEET AND CONSIDER writing a behavior plan when an emergency measure is used two or more times in a 30-day period or when a behavior pattern is identified.

The Division offers several training courses for Qualified Vendors and their staff to assist them in executing requirements outlined in Division policies. One course, Behavior Plan Writing Workshops, teaches the requirements, components, and writing of behavior plans for submissionsubmittal to the Program Review Committee (PRC). This course is available to all Qualified Vendor agencies.

Program Review Committee Monthly Update

Positive Behavior Support offers strategies to modify the environment and interactions with Members in order to:

- Prevent the occurrence of challenging behaviors;
- Teach skills to replace challenging behaviors;
- Outline responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and
- Offer proactive and functional strategies to promote a positive lifestyle change.

Positive Behavior Support is based on four principles:

- An Understanding that people (even caregivers) do not control others but seek to support others in their own behavior change process.
- A Belief that there is a reason behind all challenging behavior, that people with challenging behavior should be treated with compassion and respect, and that they are entitled to lives of quality and effective services.

- The application of a large and growing body of knowledge about how to better understand people and make humane changes in their lives that can reduce the occurrence of challenging behavior.
- A Conviction to continually move away from the threat/and or use of unpleasant events to manage behavior.

Positive Behavior Support and Positive Teaching Techniques are considered GREEN LIGHT TECHNIQUES in Article 9. These techniques do not require prior approval to implement (not an exhaustive list)

- Active Listening
- Chaining
- Cues/Prompts
- Differential Reinforcement
- Discrimination Training
- Environmental Engineering
- Generalization Training
- Modeling
- Redirection
- Reinforcement
- Relaxation Training
- Shaping

Restricted Techniques in Article 9 are known as YELLOW LIGHT TECHNIQUES and require review and approval by the PRC/IOC prior to implementation.

Teams must develop and submit to the PRC/IOC any behavior plans that include:

- Techniques that require the use of force
  - Forced compliance
  - Forced exclusion time out
  - The use of contingent observation, if force is required
  - Logical consequences, if force is used.
- Techniques that infringe upon the rights of an individual
  - Exclusion from activities within the daily routine
  - Restitution
  - Response cost
  - Rights restrictions
    - Limitations
- The use of behavior modifying medications** (this does not apply when a member resides in a family home)
- Protective Devices used to reduce or limit the risk of injury from self-injurious behavior.

Prohibited Techniques in Article 9 are known as RED LIGHT TECHNIQUES. These behavioral intervention techniques may never be used and are prohibited.

- The use of seclusion, or locked time-out rooms
- The use of overcorrection
- The application of noxious stimuli
- Physical restraints, including mechanical restraints, when used as a negative consequence to behavior.
- Behavior Modifying Medications that are:
  - Administered “as needed” or on a PRN basis
  - In dosages that interfere with the individual’s daily living activities

    - Used in the absence of a behavior plan
- Techniques that are addressed in ARS Section 36-561.A
    - No psycho surgery, insulin shock treatment, electronshock, or experimental drugs shall be administered to any member

Town Hall Meetings

The Office of Individual and Family Affairs (OIFA) continues to host town hall meetings for members, families, and providers. The next town hall meeting will be held on Thursday, April 6, 2023, from 6:00 p.m. to 8:00 p.m. Please share this information with members and families and encourage them to participate at the next event. The town hall schedule and instructions to join via the Internet or phone can be found at bit.ly/dddtownhall.

Get Caught Up

Did you know the Division posts vendor announcements and editions of the Shout on the web? Get caught up and stay informed by visiting the Vendor Announcements page online.

Report Fraud, Waste, Abuse and Misconduct

Report to DDD:

- Call DDD at 1-877-822-5799
- Send an email to dddfwa@azdes.gov
- Send a letter to DES/DDD
- Attn: Corporate Compliance Unit
  1789 W Jefferson St.
  Mail Drop 2HA1
  Phoenix, AZ 85007
- Complete this online form.

Report to AHCCCS

- Provider Fraud
    - In Arizona: 602-417-4045
    - Outside Arizona: 1-888-ITS-NOT-OK (1-888-487-6686)
- Report Member Fraud:
    - In Arizona: 602-417-4193
    - Outside Arizona: 1-888-ITS-NOT-OK (1-888-487-6686)
- If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, email the AHCCCS Office of Inspector General (OIG) at AHCCCSFraud@azahcccs.gov.

If there are other individuals in your organization who would benefit from receiving DDD Vendor Announcements, please encourage them to sign up at https://azdes-community.secure.force.com/subscribe/.