Division Policy Manuals

Medical Policy Manual
Eligibility Policy Manual
Behavior Supports Policy Manual
Provider Policy Manual
AdSS Medical Policy Manual
Chapter 100  Administration

101  Marketing
103  Fraud, Waste and Abuse
104  Continuity of Operations/Emergency Preparedness
110  Mental Health Parity

Chapter 200  Claims

203  Claims Processing
205  Ground Ambulance Transportation Reimbursement Requirements for Non-contracted Providers

Chapter 300  Financial

302  Prior Period Coverage Reconciliation: Administrative Services Subcontractors
305  Performance Bond and Equity Per Member Requirements
314  Auto-Assignment Algorithm
317  Change in Organizational Structure
321  Payment Reform – E-Prescribing
325  Access to Professional Services Initiative and Reconciliation

Chapter 400  Operations

404  Contractor Website and Member Information
406  Member Handbook and Provider Directory
407  Workforce Development
412  Claims Recoupment
414  Requirements for Service Authorization Decisions and Notices of Adverse Benefit
415  Provider Network Development and Management Plan: Periodic Network Reporting Requirements
416  Provider Network Information
417  Appointment Availability, Monitoring and Reporting
424  Verification of Receipt of Paid Services
## Table of Contents

<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>426</td>
<td>Children’s Rehabilitation Services Application, Designation and Coverage</td>
</tr>
<tr>
<td>435</td>
<td>Telephone Performance Standards and Reporting</td>
</tr>
<tr>
<td>436</td>
<td>Network Standards</td>
</tr>
<tr>
<td>438</td>
<td>Administrative Services Subcontracts</td>
</tr>
<tr>
<td>439</td>
<td>Materials Changes: Provider Network and Business Operations</td>
</tr>
<tr>
<td>446</td>
<td>Grievances and Investigations Concerning Persons with Serious Mental Illness</td>
</tr>
<tr>
<td>449</td>
<td>Behavioral Health Services for Children in Department of Child Safety and Adopted Children</td>
</tr>
</tbody>
</table>

### Chapter 1000  
**Members and Families**

1001-A  
Basic Human and Disability Related Rights

1001-B  
Responsibilities of Individuals Applying for and/or Receiving Supports and Services

1001-C  
Rights of Persons with Developmental Disabilities Living in residential Settings

1001-D  
Program Values and Guiding Principles

1002  
Voter Registration

1003  
District Independent Oversight Committees

1004-A  
Informed Consent

1004-B  
Consent to Medical Treatment of Minors, Incapacitated Minors, and Incapacitated Adults

1005-A  
Guardianship and Conservatorship or Surrogate Parent

1005-C  
Authorized Representative for ALTCS Benefits

1005-D  
Representative Payee

1006  
Healthcare Directives/Advance Directives (AHCD)

### Chapter 2000  
**Support Coordination**

2001  
Planning Team Members Roles and Responsibilities

2002  
Planning Meetings

2003  
Planning Documents

2004  
Service Authorizations
2005  Referral and Placement in Services
2006  Arizona Long Term Care Non-Users
2007  Case Closure

**Chapter 3000  Network**

3001  Family Members as Paid Providers
3002  Home and Community Based Service Delivery
3003  Selection of Providers
3004  Reserved
3005  Notification of Network Changes
3006  Short term Emergency Situations (residential and Day Programs)
3007  Service Provider Information, Authority, and Notification

**Chapter 4000  Business Operations Third Party Liability**

4001  Third Party Liability
4002  Client Billing
4003  Administrative Review/Appeal and Hearing Rights

**4004  Management of Member Funds**

4004  Overview
4004-A  Definitions
4004-B  Member Funds System
4004-C  Policy
4004-D  Responsibilities
4004-E  Safeguarding Member Funds
4004-F  Member Funds Security
4004-G  Disbursing Member Funds
4004-H  Member Funds – Provider Responsibilities
4004-I  Ledgers Maintained by Providers
4004-J  Bank of Reconciliation
4004-K  Use of Member Funds
4004-L  Reviewing Member’s Accounts
4004-M  Changes in a Member’s Status
4004-N  Investing Member Funds
4004-O  Termination of a Member’s Account or Change in Representative Payee

Chapter 5000  Reserved

Chapter 6000  Administrative Operations Records Retention

6001-A  Confidentiality
6001-B  Release of Information
6001-C  Access to Personally Identifiable Information
6001-D  Lawful Disclosure of Confidential Information
6001-E  Violations and Penalties
6001-F  Case Records
6001-G  Documentation Requirements
6001-H  Records Storage and Security
6001-I  Management and Maintenance of Records Related to the Medical Line of Business

6002  Incident Management

6002-A  Definitions of Incidents and Serious Incidents
6002-B  Incident Management Systems Definitions
6002-C  Reporting Requirements
6002-D  Members At-Risk if Missing
6002-E  Incident Reports
6002-F  Fact Finding
6002-G  Abuse and Neglect
6002-H  Referral to other Investigative Agencies
6002-I  Incident Closure and Corrective Actions
6002-J  Trending for Quality Improvement
6002-K  Information Sharing
6002-L  Mortality Review Audits
6002-M Mortality Review Process
6002-N Fraud and False Claims
6002-O Health Care Acquired Conditions

**6003 Grievance and Appeals**

6003-A Definitions
6003-B Informal Resolution/Grievance Process Non-Arizona long term Care System
6003-C Appeal Process for Members Who Receive State Funded Services
6003-D Notice of Intended Action (State Only)
6003-E Administrative Review Process (State Only)
6003-F Fair Hearings and Appeals
6003-G Arizona Long term Care System Grievance process
6003-H Arizona Long Term Care System Notice of Adverse Benefit Determination
6003-I Arizona Long Term Care Services Appeal Process
6003-J Arizona Long Term Care System Fair Hearing Process
6003-K Claim Disputes
6003-L Attorneys at Planning Meetings
6003-M Conducting All Meetings

**6004 Program Oversight**

6004-A Quality Management
6004-B Internal Oversight
6004-C External Oversight
6004-D Division Oversight Findings
6004-E Operational Reviews
6004-F Compliance Program
101 MARKETING

EFFECTIVE DATE: October 1, 2019

ACOM 101 - Marketing defines Marketing as any communication from Contractors to a member not enrolled with the Contractor that can reasonably be interpreted as intended to influence the member to enroll with the Contractor, or to not enroll or disenroll with another Contractor’s Medicaid product as described in 42 CFR 438.104. Marketing does not include communication to any Medicaid member about a Qualified Health Plan, as defined in 45 CFR 155.20. For the purposes of this Policy, Marketing contrasts with Member Information found in DDD Policy 404, which addresses requirements and restrictions for Contractors related to member and potential member information and activities.

The Division is the sole contractor with AHCCCS for providing Medicaid services to individuals with Developmental Disabilities. As the sole contractor, the Division does not engage in Marketing as defined by AHCCCS. See Division Operations Policy 404 – Member Information Material and AdSS Operations Policy 101 – Marketing for more information.
103 FRAUD, WASTE, AND ABUSE

EFFECTIVE DATE: October 1, 2019


Purpose

This Policy applies to the Division of Developmental Disabilities (DDD, the Division). The purpose of this Policy is to outline the corporate compliance requirements including the reporting responsibilities for alleged fraud, waste, and abuse involving Division program funds regardless of the source. This Policy also addresses additional responsibilities regarding compliance with broader program integrity, regulatory and programmatic requirements.

Definitions

A. Administrative Services Subcontract - An agreement that delegates any of the requirements of the Contract with AHCCCS, including, but not limited to the following:
   1. Claims processing, including pharmacy claims
   2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization)
   3. Management Service Agreements
   4. Service Level Agreements with the Division
   5. DDD acute care subcontractors

Providers are not Administrative Services Subcontractors.

B. Abuse of the Program - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Division 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 Division Program. 42 CFR 455.2.

C. Agent - Any person who has been delegated the authority to obligate or act on behalf of a Provider. [42 CFR 455.101]

D. Corporate Compliance Officer - The on-site management official designated by the Division to implement, oversee and administer the Division’s compliance program.
The Corporate Compliance Officer must be available to all of the Division’s employees, and possess the authority to access and provide records, and make independent referrals to the AHCCCS Office of Inspector General (AHCCCS-OIG). 42 CFR 438.608.

E. **Credible Allegation of Fraud** - A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

1. Fraud hotline complaints
2. Claims data mining
3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations

Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis. 42 CFR 455.2.

F. **Fraud** - An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable State or Federal law, as defined in 42 CFR 455.2.

G. **Managing Employee** - A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. [42 CFR 455.101]

H. **Provider** - Any person or entity that contracts with the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

I. **Waste** - Over-utilization or inappropriate utilization of services, misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

**Policy**

A. **Authority**

The AHCCCS Office of Inspector General (AHCCCS-OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations relating to fraud, waste, and abuse involving the programs administered by AHCCCS. Pursuant to 42 CFR 455, Subpart A, and an Intergovernmental Agreement with the Arizona Attorney General’s Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action. AHCCCS-OIG also has the authority to make independent referrals to other law enforcement entities.

1. Pursuant to A.R.S. §36-2918, AHCCCS-OIG has the authority to issue subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony as the
Inspector General deems relevant or material to an investigation, examination, or review undertaken by the Office.

2. Pursuant to A.R.S. §§36-2918 and 2957, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to $2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.

3. AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG to access the National Crime Information Center (NCIC) data base as well as the Arizona Criminal Justice Information System. Additionally, OIG is authorized to receive and share restricted criminal justice information with other federal, state and local agencies.

4. If AHCCCS-OIG determines that a credible allegation of fraud exists, AHCCCS-OIG may suspend payments to Providers pursuant to 42 CFR 455.23.

B. Division Responsibilities

The Division must:

1. Have in place internal controls, policies and procedures to prevent, detect, and report fraud, waste, and abuse activities to AHCCCS-OIG.

2. Have a Corporate Compliance Program that complies with the Division’s contract with AHCCCS, and all state and federal laws., including 42 CFR Part 438, Subpart H. The Corporate Compliance Program must include but not be limited to:
   a. Program integrity goals and objectives,
   b. Descriptions of internal and external controls employed by the Division to ensure compliance with State and Federal law,
   c. The Division’s corporate compliance activities, and,
   d. The roles and responsibilities of the Division staff as they relate to the Corporate Compliance Program.

The Division may use the sample Corporate Compliance Plan provided as ACOM 103, Attachment B, for guidance on how to present such compliance activities. The Division’s written Corporate Compliance Plan must be submitted to AHCCCS-OIG annually as specified in Contract.

3. The Corporate Compliance Plan must include a program integrity audit/review program designed to identify fraud, waste and/or abuse. The program will ensure that the Division tracks inadequate billing practices and identifies emerging trends in an effort to provide technical assistance to contracted Providers and avoid future occurrences of problematic billing.

4. The Division must provide the external auditing schedule and executive
summary of all individual Provider audits to AHCCCS-OIG as specified in Contract.

5. Obtain and disclose the information regarding Ownership and Control, and Disclosure of Information on Persons Convicted of Crimes in accordance with 42 CFR Part 455, Subpart B, 42 CFR 455.436, State Medicaid Director Letters 08-003 and 09-001, and the contractual provisions contained in the contract. The Division must also obtain and disclose the same information regarding its Administrative Services Subcontractors. The results of the Disclosure of Ownership and Control and the Disclosure of Information on Persons Convicted of Crimes shall be held by the Division. The Division and its Administrative Services Subcontractors shall disclose to AHCCCS-OIG the identity of any person excluded from participation in federal healthcare programs.

6. Submit annually, Attachment A, Attestation of: Disclosure of Ownership and Control and Disclosure of Information of Persons Convicted of a Crime, as specified in Contract, attesting that the information has been obtained and verified by the Division, or upon request, provide this information to AHCCCS-OIG.


8. Ensure all employees, subcontracted Providers and members receive adequate training and ongoing education on the following aspects of the Federal False Claims Act provisions:
   a. The administrative remedies for false claims and statements
   b. Any State laws relating to civil or criminal penalties for false claims and statements
   c. The whistleblower protections under such laws

9. Ensure adequate training addressing fraud, waste, and abuse prevention, recognition and reporting, and encourage employees, contracted Providers, and members to report fraud, waste, and abuse without fear of retaliation.

10. Ensure an internal reporting process that is well defined and made known to all employees.

11. Conduct research and proactively identify changes for program integrity that are relevant to their program, and periodically review and revise the fraud, waste, and abuse policies or guidance from the Division to reflect such changes due to rules, regulations or new initiatives.

12. Regularly attend and participate in AHCCCS-OIG work group meetings.

13. Respond promptly and no later than 30 days to requests for information from OIG.

14. Cooperate with AHCCCS-OIG regarding any allegation of member billing in
violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702.

15. The Division must have a method of verifying with Division members that they received the services billed by Providers to identify potential service/claim fraud. The Division must perform periodic audits through member contact and to report the results of these audits as described in ACOM Policy 424.

16. In addition to the specific requirements stated above, it is required that the Division be in compliance with all State and Federal laws and regulations related to fraud, waste, and abuse even if not directly detailed in this Policy.

C. Reporting Responsibilities

1. Fraud, Waste and Abuse
   a. If the Division discovers, or is made aware, that an incident of alleged fraud, waste, or abuse has occurred, the Division shall immediately report the incident to AHCCCS-OIG within ten business days, by completing and submitting the Report Suspected Fraud or Abuse of the Program form available on the AHCCCS-OIG webpage. All pertinent documentation that would assist AHCCCS in its investigation shall be attached to the form,
   b. If the Division, Administrative Service Subcontractor, or Provider identifies an incident which warrants self-disclosure, the incident must be reported within ten business days to AHCCCS-OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS-OIG webpage. All pertinent documentation that would assist AHCCCS in its investigation shall be attached to the form,
   c. Once the Division has referred a case of alleged fraud, waste, or abuse to AHCCCS-OIG, the Division must take no action to recoup or otherwise offset any suspected overpayments,
   d. In the event AHCCCS-OIG feels it would be beneficial to seek additional and/or clarifying details regarding a referral from the Division, AHCCCS-OIG may first choose to request preliminary review work from the Division in order to expand the allegation and to obtain further documentation that will support an investigation by AHCCCS-OIG,
   e. If AHCCCS-OIG chooses to seek additional and/or clarifying details regarding a referral from the Division, the Division will have 30 business days or more to provide the requested documentation, or provide an update as to the status of completing such request,
   f. Once AHCCCS-OIG receives a referral, it will conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation,
AHCCCS-OIG will notify the Division when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation,

If it is determined by AHCCCS-OIG not to be a fraud, waste, or abuse case, AHCCCS-OIG will return the matter to the Division for disposition in accordance with any applicable laws and/or contracts,

The Division agrees that AHCCCS has the sole authority to handle and dispose of any matter involving fraud, waste or abuse. The Division assigns to AHCCCS the right to recoup any amounts overpaid to a Provider as a result of fraud, waste or abuse. If the Division receives anything of value that could be construed to represent the repayment of any amount expended due to fraud, waste or abuse, the Division must forward that recovery to AHCCCS-OIG within 30 days of its receipt. The Division relinquishes any and all claims to any monies received by AHCCCS as a result of any program integrity efforts which include, but are not limited to:

- Civil monetary penalties and/or assessments
- Civil settlements and/or judgments
- Criminal restitution

The Division must also report to AHCCCS, as specified in Contract, and DDD Medical Policy 950, any credentialing denials including, but not limited to:

- Those which are the result of licensure issues
- Quality of care concerns
- Excluded Providers
- Alleged fraud, waste, or abuse

D. The Division’s Responsibilities related to Fraud, Waste and Abuse

1. Process all referrals of allegations of suspected member and provider fraud.

2. Oversee, monitor and be the focal point for the Division’s compliance program, with the authority to review all documents and functions as they relate to fraud, waste and abuse prevention, detection and reporting.

3. Maintain and monitor a tracking system of fraud, waste and abuse referrals.

4. Ensure all employees, Subcontractors, Providers, agents and members receive adequate training and information regarding fraud, waste and abuse prevention, identification and reporting. Assure employees, Subcontractors, Providers, agents and members that they can report fraud, waste and abuse without fear of retaliation.
5. Develop and maintain open channels of communication with AHCCCS OIG, Subcontractors, Providers, agents and members to combat fraud, waste, and abuse at all levels in the System.

6. Develop and maintain open channels of communication with DES OIG in the prevention and detection of fraud, waste, and abuse.

7. Make referrals to AHCCCS OIG to investigate cases of potential member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702.

8. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of Providers to ensure their compliance.

9. Ensure that the Division is in compliance with its federal obligations with regard to Disclosure of Ownership and Control, Managing Employees Database Exclusion, and Checks, and Criminal Convictions Checks, and all other federal requirements related to Provider Screening and Enrollment.
110 MENTAL HEALTH PARITY

EFFECTIVE DATE: October 1, 2019

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual 110, Mental Health Parity for the Division policy governing AdSS responsibilities regarding this topic.
This Policy outlines the requirements for the adjudication and payment of claims for the Division of Developmental Disabilities (the Division).

**Definitions**

A. **Receipt Date** - The receipt date of the claim is the date stamp on the claim, or the date electronically received. The receipt date is the day the claim is received at the Division’s specified claim mailing address, received through direct electronic submission to the Division, or received by the Division’s designated Clearinghouse.

B. **Clean Claim** - A clean claim is a claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

C. **Claim Submission Timeliness** - Unless a contract specifies otherwise, the Division ensures that, for each form type (Dental/Professional/Institutional), 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim.

**General Claims Processing Information**

The Division develops and maintains claims processes and systems that ensure the accurate collection and processing of claims, analysis, integration, and reporting of data. These processes and systems result in the provision of information on areas including, but not limited to, service utilization, claim disputes, member grievances and appeals, and disenrollment for reasons other than loss of Medicaid eligibility.

The Division ensures there is a mechanism, such as the Division website or other provider platforms, to inform providers of the appropriate place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

The Division follows all general claims processing requirements as described below.

A. The Division uses nationally recognized methodologies to correctly pay claims; these methodologies include but not limited to:
   1. Medicaid National Correct Coding Initiative (NCCI) for Professional, Ambulatory Surgery Centers and Outpatient services
   2. Multiple Procedure/Surgical Reductions
   3. Global Day E & M Bundling standards

B. The Division’s claims payment system assesses and/or applies data-related edits, including but not limited to:
   1. Benefit Package Variations
2. Timeliness Standards

3. Data Accuracy

4. Adherence to Arizona Health Care Cost Containment System (AHCCCS) Policy

5. Provider Qualifications

6. Member Eligibility and Enrollment

7. Over-Utilization Standards

C. If a claim dispute is overturned, in full or in part, the Division reprocesses and pays the claim(s) in a manner consistent with the decision within 15 business days of the decision.

D. The Division’s claims payment system does not require a recoupment of a previously paid amount when the provider’s claim is adjusted for data correction (excluding payment to a wrong provider) or an additional payment is made. The Division ensures encounters are submitted in accordance with AHCCCS’ standards and thresholds.

E. The Division adheres to the following:

1. Coordination of Benefits and Third Party Liability requirements per the AHCCCS Contract, ACOM Policies 201 and 434,

2. Claims Reprocessing requirements per the AHCCCS Contract, ACOM Policy 412, and the AHCCCS Claims Dashboard Reporting Guide,

3. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 CFR Parts 160, 162, and 164.

F. When the Division cost avoids a claim, the following payment provisions apply:

1. Claims from Providers contracted with the Division: The Division pays the difference between the Contracted Rate and the Primary Insurance Paid amount, not to exceed the Division’s Contracted rate.

2. Claims from Providers not contracted with the Division: The Division will pay the difference between the AHCCCS Capped-Fee-For-Service rate and the Primary Insurance Paid amount, not to exceed the AHCCCS Capped-Fee-For Claims Processing by Administrative Services Subcontractors (AdSS) Contractors.

The Division Responsibilities

A. Discounts

The Division applies a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the clean claim was received (A.R.S. §36-2903.01.G). Quick pay discounts are applied to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a UB-04 claim form.
B. Interest Payments

The Division pays interest on late payments and reports the interest as required.

1. For hospital clean claims, the Division pays slow payment penalties (interest) on payments made after 60 days of receipt of the clean claim. Interest is paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment. Slow pay penalties (interest) are applied to any acute hospital inpatient, outpatient, and freestanding emergency department claims billed on a UB-04 claim form.

2. A claim for authorized services submitted by a licensed skilled nursing facility, an assisted living ALTCS provider, or a home and community based ALTCS provider shall be adjudicated within 30 calendar days after receipt by the Division. The Division pays interest on payments made after 30 days of receipt of the clean claim. Interest is paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment.

3. For non-hospital clean claims, the Division pays interest on payments made after 45 days of receipt of the clean claim. Interest is paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.

4. The Division pays interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).

C. Electronic Processing and Remittance Advices

The Division accepts and generates required HIPAA-compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission.

1. Accepted electronic submissions include eligibility verifications, claims, claims status verifications, and prior authorization requests.

2. The Division makes claim payments via electronic funds transfer and accepts electronic claim attachments.

3. The Division generates an electronic remittance that includes:
   a. The reason(s) for denials and adjustments
   b. A detailed explanation/description of all denials, payments and adjustments
   c. The amount billed
   d. The amount paid
   e. Application of Coordination of Benefits (COB) and copays
   f. Providers rights for claim disputes

*Note: The Division includes instructions and timeframes for the submission of claim disputes and corrected claims on its remittance advice.*
4. The Division sends the remittance advice with the payment, unless the payment is made by Electronic Funds Transfer (EFT). Any remittance advice related to an EFT is sent no later than the date of the EFT.

**Claim Timely Filing**

Per *ARS 36-2904, Section G*, the Division will not pay:

A. Claims initially submitted more than six months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

B. Claims submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

**AdSS Claims Processing**

The Division contracts with health plans and delegates the processing of medical claims. Refer to the *AdSS Operations Manual, 203 Claims Processing policy* for further details.
Purpose
To provide ground ambulance transportation reimbursement requirements. It is limited to the Division of Developmental Disabilities (the Division) and ambulance or emergent care transportation providers when a contract does not exist between these entities.

Definitions
A. Advanced Life Support (ALS) - 42 CFR 414.605, describes ALS, level 1 (ALS1) as transportation by ground ambulance vehicle, medically necessary supplies and services, either an ALS assessment by ALS personnel or provision of at least one ALS intervention. Advanced life support, level 2 (ALS2) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures:
   • Manual defibrillation/cardioversion,
   • Endotracheal intubation,
   • Central venous line,
   • Cardiac pacing,
   • Chest decompression,
   • Surgical airway, or
   • Intraosseous line.
B. Ambulance - Ambulance as defined in A.R.S. §36-2201.
C. Basic Life Support (BLS) - 42 CFR 414.605, describes BLS as transportation by ground ambulance vehicle that has medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished. Also, at least one of the staff members must be certified, at a minimum, as an emergency medical technician-basic (EMT-Basic) by the State of local authority where the services are furnished and be legally authorized to operation all lifesaving and life-sustaining equipment on board the vehicle.
D. **Emergency Ambulance Services** - Emergency ambulance services are as described in 9 A.A.C. 22, Article 211.

E. **Emergency Ambulance Transportation** - Ground or air ambulance services that are medically necessary to manage an emergency physical or behavioral health condition and which provide transport to the nearest appropriate facility capable of treating the DDD member’s condition.

F. **Emergency Medical Care Technician (EMCT)** - As defined in A.A.C. R9-25-101(18).

G. **Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

H. **Emergency Medical Services** - Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

**Policy**

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS) are reimbursed by the Division at a percentage, prescribed by law, of the Ambulance provider’s ADHS-approved fees for covered services. These rates are contained in the AHCCCS Capped Fee for Service (FFS) Fee Schedule for Certificate of Necessity Providers and will be used by the Division for reimbursement when no contract exists with the provider.

For Ambulance providers, whose fees are not established by ADHS, and no contract exists with the provider, the AHCCCS Capped FFS Fee Schedule is for Ground Transportation will be used by the Division.

**Emergency Ground Ambulance Claims are Subject to Medical Review**

Claims are submitted with documentation of medical necessity and a copy of the trip report, with the following information:

A. Medical condition, signs, symptoms, procedures, and treatment.

B. Transportation origin, destination, and mileage (statute miles).

C. Supplies.

D. Necessity of attendant, if applicable.

E. Name and DHS numbers of the attendants providing care along with the signature of the trip report author.
Claims submitted without such documentation are subject to denial. The Division will process the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

**Criteria and Reimbursement Processes for Advanced Life Support (ALS) and Basic Life Support**

A. Advanced Life Support (ALS) level

1. In order for Ambulance services to be reimbursable at the ALS level, all of the following criteria shall be satisfied:
   a. The Ambulance shall be ALS licensed and certified in accordance with A.R.S. §36-2202, A.R.S. §36-2204, and A.R.S. §36-2212,
   b. Emergency Medical Care Technician (EMCT) are present and EMCT services/procedures are medically necessary, based upon the member’s symptoms and medical condition at the time of the transport, and
   c. EMCT services/procedures and authorized treatment activities were provided.

B. Basic Life Support (BLS) level

1. In order for Ambulance services to be reimbursable at the BLS level, the following requirements will be met:
   a. The Ambulance must be BLS licensed and certified in accordance with A.R.S. §36-2212 and A.A.C. R9-25-201.
   b. EMCT are present
   c. EMCT services/procedures, are medically necessary, based upon the member’s symptoms and medical condition at the time of the transport.
   d. EMCT services/procedures and authorized treatment activities were provided.

Claims submitted without such documentation are subject to denial. The Division processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

**Non-Emergent Ground Ambulance Transportation Payment Provisions**

A. Non-emergent Ambulance transportation is subject to review for medical necessity by the Division. Medical necessity criteria is based upon the medical condition of the member. Non-emergent transportation by Ambulance is appropriate if:

1. Documentation supports that other methods of transportation are
2. The member’s medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an Ambulance.

Non-emergent transportation ordered by the Division cannot be denied upon receipt. This claim is not subject to further medical review.

B. At the Division’s discretion, non-emergent Ambulance transport may not require prior authorization or notification. This may include after-hours calls. An example is an Ambulance company which receives a call from the emergency room to transport a nursing facility member back to the facility and the Division cannot be reached.

All hospital-to-hospital transfers are paid at the BLS level unless the transfer meets ALS criteria. This includes transportation between general and specialty hospitals.

C. Transportation reimbursement is adjusted to the level of the appropriate alternative transportation when circumstances do not necessitate an Ambulance transport, or the services rendered at the time of transport are deemed not medically necessary. Ambulance providers that have fees established by ADHS are reimbursed in accordance with A.R.S. § 36-2239(H).

Refer to AMPM Policy 310-BB for additional requirements for coverage of transportation.
302 PRIOR PERIOD COVERAGE RECONCILIATION: ADMINISTRATIVE SERVICES SUBCONTRACTORS

EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. § 36-2905 and § 36-2944.01; A.A.C. R9-22-101; Patient Protection and Affordable Care Act, Section 9010; ACOM 412

Due to the uncertainty regarding actual utilization and medical cost experience during the Prior Period Coverage (PPC) period, the Division intends to limit the financial risk to its Administrative Services Subcontractors (ADSS). The PPC Reconciliation applies to dates of service effective in Contract Year Ending (CYE) 19 and Forward, and is based upon prior period expenses and prior period net capitation as described in this policy. The Division will recoup/reimburse a percentage of the AdSS’s profit or loss for all risk groups as described below. All profit/loss sharing is based on adjudicated encounter data and subcapitated/block purchase expense reports. This reconciliation is performed annually on a contract year basis, which is October 1 to September 30.

Definitions

A. Access to Professional Service Initiative (APSI) - Effective October 1, 2018, the Division seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to members and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the AdSS’s rates for professional services provided by qualified physicians and non-physician professionals affiliated with designated hospitals who meet the definition outlined in ACOM Policy 325.

B. Administrative Component - The administrative component is equal to the administrative Per Member Per Month (PMPM) built into the rates multiplied by the actual PPC member months for the contract year being reconciled.

C. Health Insurer Fee Capitation Adjustment - An amount equal to the capitation adjustment for the year being reconciled that accounts for the Contractor’s liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

D. Prior Period Coverage (PPC) - The period of time prior to the member’s enrollment, during which a member is eligible for covered services. The timeframe is from the effective date of eligibility until the date the member is enrolled with an AdSS. Refer to A.A.C. R9-22-101. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for the Division via the full application process, prior period coverage for the member will be covered by AHCCCS Fee-For-Service (FFS) and the member will be enrolled with the Contractor only on a prospective basis. The time period for prior period coverage does not include the time period for prior quarter coverage.

E. PPC Capitation - Capitation payment for the period of time from the first day of the
month of application or the first eligible month, whichever is later, to the day a member is enrolled with the Contractor.

F. **PPC Medical Expense** - Total expenses covered under the contract for services provided during the PPC time period, which are reported through **fully adjudicated encounters**. This will exclude APSI expenses.

G. **PPC Net Capitation** - PPC capitation less the administrative component, the health insurer fee capitation adjustment, APSI capitation and the premium tax component.

H. **PPC Reconciliation Risk Groups** - Populations subject to this reconciliation include all PPC risk groups except State Only Transplants and Adult Group above 106% FPL (Adults > 106%) (formerly known as Newly Eligible Adults or NEAD) (Acute Care Contractors Only).

I. **Premium Tax** - The premium tax is equal to the tax imposed pursuant to A.R.S. § 36-2905 and §36-2944.01 for all payments made to AdSSs for the Contract Year.

**Policy**

A. **General**

1. The reconciliation must relate solely to fully adjudicated PPC medical expense for all PPC reconciliation risk groups. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to AHCCCS cost settlement will not be included in the reconciliation, the non-enhanced portion of the payment will be included in the reconciliation. The enhanced portion of a payment for APSI that is subject to a unique reconciliation as outlined in ACOM Policy 325 will also be excluded from this reconciliation.

2. The reconciliation will limit the AdSS’s profits and losses to 2% of the AdSS’s PPC net capitation for all PPC reconciliation risk groups combined (See Attachment A for calculation). Any losses in excess of 2% will be reimbursed to the AdSS, and likewise, profits in excess of 4% will be recouped. The full PPC period is eligible for this reconciliation.

B. **Division Responsibilities**

1. No less than six months after the contract year to be reconciled, the Division will perform an initial reconciliation. The reconciliation will be calculated as follows:

   **PPC Net Capitation**
   
   **Less:** PPC Medical Expense
   
   **Equals:** Profit/Loss to be reconciled adjusted for PCP Parity

   The Division may incorporate completion factors in the initial reconciliation based on internal data available at the time of the reconciliation.
PPC capitation and medical expense to be included in the reconciliation are based on the **date of service** for the contract year being reconciled.

2. The Division will compare fully adjudicated encounter information to financial statements and other AdSS submitted files for reasonableness.

3. The Division will provide the AdSS with the data used for the initial reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through a future monthly capitation payment.

4. A second and final reconciliation will be performed no less than 12 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. The Division will provide the AdSS with the data used for the final reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

5. Any amount due to or due from the AdSS as a result of the final reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

C. **AdSS Responsibilities**

1. The AdSS must submit encounters for PPC medical expense and those encounters must reach a fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the medical expenses used in the reconciliation.

2. The AdSS must maintain financial statements that separately identify all PPC transactions, and must submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide.

3. The AdSS must monitor the estimated PPC reconciliation receivable/payable and record appropriate accruals on financial statements submitted to the Division on a quarterly basis.

4. It is the AdSS’s responsibility to identify to the Division any encounter data issues or necessary adjustments by the initial reconciliation due date. It is also the responsibility of the AdSS to correct (including adjudication of corrected encounters) any identified encounter data issues no later than 12 months after the end of the contract year being reconciled. Reconciliation data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

5. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file).
6. If the AdSS performs recoupments/refunds/recoveries on PPC claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due to the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.
305 PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 35-155

The Division contracts with Administrative Services Subcontractors (AdSS) and delegate’s responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual (same policy number and name as stated above) for the Division policy governing AdSS responsibilities regarding this topic.
314 AUTO-ASSIGNMENT ALGORITHM

EFFECTIVE DATE: October 1, 2019

This policy describes the method used to auto-assign members to an Administrative Services Subcontractor (AdSS) and the assignment of available models.

A. Prior to auto-assignment to an AdSS, assignment to a model must be completed.
   1. Regarding Annual Enrollment Choice, members who are newly eligible for the Division and ALTCS, and members already enrolled in a plan, may select an available model prior to the start of a new contract.
   2. If the member does not select an available model, the Division will assign to Model A.

B. Upon award of a new contract, the Division will auto-assign members as follows:
   1. Prior to the start of the contract (choice period), the Division gives current members a choice to select from the newly awarded AdSS contractors.
   2. If a member does not select an AdSS during the choice period and the member’s current AdSS is awarded a contract, the Division assigns the member to the same AdSS.
   3. If a member does not select an AdSS during the choice period and the member’s current AdSS is NOT awarded a contract, the Division reassigns the member to one of the newly contracted AdSS.
   4. Auto-assignment to a newly contracted AdSS will continue until the number of members assigned to the newly contracted AdSS reaches 50% of the number of members assigned to the AdSS that continued to contract.
   5. If all AdSS are new, the Division gives the members a choice to select an AdSS prior to the start of the contract.

C. Ongoing, the Division will auto assign to the available AdSS in a revolving sequence. The Division may change the auto assignment process at any time during the term of the contract in response to AdSS-specific issues (e.g., imposition of an enrollment cap), when in the best interest of the ALTCS Program and/or the state, or to recognize and reward AdSS performance across a variety of factors of importance to the Division.
317 CHANGE IN ORGANIZATIONAL STRUCTURE

REVISION DATE: 10/1/2018
EFFECTIVE DATE: May 13, 2016

Purpose

This policy identifies the requirements for submitting changes in the Division’s organizational structure resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature or resulting from a planned change in a Management Service Agreement (MSA) Subcontractor. This policy also identifies the Division’s role in monitoring and evaluating changes in organizational structure, as defined below, for a Management Service Agreement subcontractor.

Definitions

A. Acquisition – an acquiring, by one company, of all of a target company’s assets, capital, or stock.

B. Administrative Services Subcontract - agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:
   1. Claims processing, including pharmacy claims
   2. Credentialing, including those requirements for only primary source verification
   3. Management Service Agreements (MSAs)
   4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSS.

C. Articles of Incorporation - basic legal instrument required to be filed with the state upon incorporation of a business (sometimes also referred to as the Certificate of Incorporation or the Corporate Charter).

D. Change In Organizational Structure - any of the following:
   1. Acquisition
   2. Change in Articles of Incorporation
   3. Change in ownership
   4. Change of MSA subcontractor (to the extent management of all or substantially all plan functions has been delegated to meet Division contractual requirements)
5. Joint venture

6. Merger

7. Reorganization

8. State agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature

9. Other applicable changes that may cause a change in any of the following:
   a. Employer Identification Number/Tax Identification Number (EIN/TIN)
   b. Critical member information, including the website, member or provider handbook and member ID card
   c. Legal entity name.

E. **Change in Ownership** - any change in the possession of equity in the capital, stock, profits, or voting rights, with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non-stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.

F. **Joint Venture** - business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture, each of the participants is responsible for profits, losses and costs associated with it. However, the venture is its own entity, separate and apart from the participants’ other business.

G. **Management Service Agreement (MSA)** - type of subcontract with an entity in which the entity’s management delegates all or substantially all management and administrative services necessary.

H. **Merger** - Two companies join together to form a single entity, using both companies’ assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors or their voting rights. Both companies cease to exist separately and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined or their voting rights are transferred to the new corporation.

I. **Performance Bond** - A cash deposit with the State Treasurer or a financial instrument secured by the AdSS in an amount designated by the Division to guarantee payment of AdSS claims.

J. **Reorganization** - An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work with its creditors to restate its assets and liabilities which may be an attempt to avoid a bankruptcy.
Change in Organizational Structure

A change in organizational structure includes any of the following:

A. Acquisition
B. Change in Articles of Incorporation
C. Change in Ownership
D. Change of MSA Subcontractor
E. Joint Venture
F. Merger
G. Reorganization
H. Other applicable changes that may cause:
   1. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)
   2. Changes in critical member information, including the website, member or provider handbook, and member ID card, or
   3. A change in legal entity name.

In addition, a change in organizational structure may require a contract amendment to the Division’s contract with AHCCCS. If the Division does not obtain prior approval, or AHCCCS determines that a change in the Division’s organizational structure is not in the best interest of the state, AHCCCS may terminate the contract. Similarly, a change in organizational structure may require a contract amendment to the AdSS contract with the Division. If the AdSS does not obtain prior approval, or the Division determines that a change in the AdSS organizational structure is not in the best interest of the state, the Division may terminate the contract. The Division may offer open enrollment to the members assigned to the AdSS should a change in organizational structure occur. The Division will not permit one organization to own or manage more than one contract within the same line of business in the same Geographic Service Area (GSA).

Transition Plan

The Division submits a summary of all changes in organizational structure and a transition plan to AHCCCS 180 days prior to the effective date of the change.

Items in the transition plan, for which information is not yet available for submission, or is still considered draft, must be noted and submitted, or resubmitted, to AHCCCS no later than 90 days prior to the effective date.

As part of the transition plan, the Division will complete an assessment of the following:

A. Any potential interruption of services to members including steps to ensure there are no interruptions
B. The ability to maintain and support the contract requirements

C. Major functions of the Division, as well as Medicaid programs, are not adversely affected

D. The integrity of a fair, competitive procurement process for MSA Subcontractors.

**Notification to AHCCCS**

When notifying AHCCCS, the considerations listed above, and the following information is included in the summary:

A. Any material change to operations as specified in ACOM Policy 439 and AHCCCS Contract, Section D

B. The state or federal legislation, rule, or action that necessitates a change in Organizational Structure

C. A description of the following:
   1. Any changes to the management and staffing of the organization currently overseeing services provided under the contract
   2. Any changes to existing Management Services Subcontracts
   3. Any changes to the administration of critical components of the organizations, information systems, prior authorization, claims processing, or grievances
   4. The plan for communicating the change to members, including a draft notification to be distributed to affected members and providers
   5. The planned changes to critical member information, including the website, member and provider handbook, and member ID card
   6. Any anticipated changes to the network
   7. Any changes in federal or state funding that directly impact the Medicaid line of business.

D. Upon AHCCCS approval of the transition plan, any additional information requested by AHCCCS will be submitted within 120 days of the change, as specified in Contract, Attachment F3, Contractor Chart of Deliverables.

The Division submits the following no later than 45 days prior to the effective date of the change in organizational structure and commencement of operations under the new structure, as specified in Contract, Attachment F3, Contractor Chart of Deliverables:

A. Information regarding the Disclosure of Ownership and Control


C. AHCCCS Contract Section D, Corporate Compliance, and AHCCCS ACOM Policy 103
For a change of MSA Subcontractor, the Division follows the process for the review and approval of the new MSA Subcontractor as outlined in AHCCCS ACOM Policy 438.

**Changes in Organizational Structure for an MSA Subcontractor**

MSA Subcontractors that also have a contract with AHCCCS must notify the Division at the same time notification is given to AHCCCS. As appropriate, the Division must collaborate with AHCCCS in monitoring and evaluating the transition plan.

The Division evaluates and monitors the transition plan for MSA Subcontractors that do not have a contract with AHCCCS.
321  PAYMENT REFORM - E-PRESCRIBING

EFFECTIVE DATE: 10/01/2019

REFERENCES: AHCCCS Contract #YH6-0014 Section D, Program Requirements, E-Prescribing. ACOM 321 Payment Reform- E-Prescribing.

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility excluding Indian Health Services, for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Policy 321 Payment Reform – E-Prescribing for the Division policy governing AdSS responsibilities regarding this topic.
325 ACCESS TO PROFESSIONAL SERVICES INITIATIVE AND RECONCILIATION

EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. § 48-5501 et seq., ACOM Policy 412

This Policy establishes guidelines for AdSSs regarding the Access to Professional Services Initiative (APSI) and related reconciliation. The Division seeks to provide enhanced support to certain professionals in order to:

A. Preserve and enhance access to these professionals who deliver essential services to members, and

B. Support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the AdSS’s rates for professional services provided by Qualified Practitioners affiliated with designated hospitals.

Due to uncertainty regarding actual use of Qualified Practitioners, and because the state share of the capitation paid to the AdSSs will be funded using Inter-Governmental Transfer (IGT) funds for this specific purpose, the Division intends to eliminate the financial risk to its AdSSs. The Division will isolate the APSI revenue and expenses and reconcile AdSSs’ prospective and Prior Period Coverage (PPC) profits and losses to 0%. A risk pool will be used to capture unexpended funds.

Definitions

A. APSI Expense - PPC and Prospective Expenses incurred by the AdSS for the 40% rate increase to providers. APSI Expenses excludes Subcapitated/Block Purchase Expenses.

B. APSI Revenue - Amount of additional PPC and Prospective capitation provided for the 40% rate increase to providers.

C. Designated Hospitals - For purposes of this Policy, designated hospitals include:
   • A hospital facility with an Accreditation Council for Graduate Medical Education (ACGME)-accredited teaching program and which is operated pursuant to the authority in A.R.S. Title 48, Chapter 31 (A.R.S. § 48-5501 et seq.); or,
   • A hospital facility with:
     o An ACGME-accredited teaching program with a state university, and
     o AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2018; or,
     o A freestanding children’s hospital or a pediatric unit of a general acute care hospital with greater than 100 licensed pediatric beds, excluding nursery beds.

D. Qualified Practitioner - For purposes of this Policy, qualified practitioners are
providers who bill for services under one of the Group NPI numbers that are affiliated with one of the Designated Hospitals identified in Section III of this Policy, and include the following practitioners:

- Physicians, including doctors of medicine and doctors of osteopathic medicine
- Certified Registered Nurse Anesthetists
- Certified Registered Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dentists
- Optometrists.

**Policy**

A. General

1. Designated Hospitals participating in APSI effective October 1, 2018, include the following:
   a. Banner University Medical Center Phoenix
   b. Banner University Medical Center Tucson
   c. Banner University Medical Center South
   d. Cardon Children’s Medical Center at Banner Desert Medical Center
   e. Maricopa Medical Center
   f. Phoenix Children’s Hospital
   g. St. Joseph’s Hospital and Medical Center
   h. Tucson Medical Center.

2. The reconciliation must relate solely to the APSI portion of encounters for fully adjudicated prospective and PPC medical expenses, excluding services provided under subcapitated/block purchase arrangements, for Qualified Practitioners. The amount due from or due to the AdSS as a result of this reconciliation will be based on aggregated profits and losses from APSI Revenue and Expenses across both prospective and PPC risk groups.

3. The reconciliation will limit the AdSS’s profits and losses from APSI Revenue
and APSI Expenses to 0% (See Attachment A for calculation). Any losses in excess of 0% will be reimbursed to the AdSS, and likewise, profits in excess of 0% will be recouped.

B. AdSS Responsibilities

1. Effective with dates of service on and after October 1, 2018, the AdSS will provide a 40% increase to the otherwise contracted rates to Qualified Practitioners for all claims for which the Division is the primary payer.

2. The AdSS must submit encounters for APSI medical expenses and those encounters must reach fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the APSI medical expenses used in the reconciliation.

3. The AdSS must maintain financial records that separately identify all APSI-related prospective and PPC transactions, and must submit such information through a footnote in the financial statements as required by Contract and as specified in the AHCCCS Financial Reporting Guide.

4. The AdSS must monitor the estimated APSI reconciliation receivable/payable and record appropriate accruals on financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide.

5. It is the AdSS’s responsibility to identify to the Division any encounter data issues or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data for reconciliations submitted by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

6. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file).

7. If the AdSS performs recoupments/refunds/recoveries on any APSI claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued APSI reconciliation results for the impact of the revised encounters and recoup any amounts due the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.

C. Division Responsibilities

1. No less than six months after the Contract Year to be reconciled, the Division will perform an initial reconciliation. The reconciliation will be calculated as follows:
Profit/Loss to be reconciled = APSI Capitation – APSI Medical Expense
Attachment A provides an example of the APSI reconciliation calculation.

2. The Division will use only expenses supported by fully adjudicated encounters reported by the AdSS to determine the expenses subject to reconciliation.

3. The Division will compare fully adjudicated encounters to AdSS financial statements and other AdSS submitted files for reasonableness.

4. The Division will provide to the AdSS the data used for the initial APSI reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through a future monthly capitation payment.

5. A final APSI reconciliation will be performed no sooner than 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. The Division will provide to the AdSS the data used for the final reconciliation and provide a set time period for review and comment by the AdSS.

6. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

7. Any amount due to or due from the AdSS as a result of the final APSI reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

8. The Division may include adjustments to the initial APSI reconciliation to account for completion factors.

9. The Division will create and use an APSI risk pool to capture recouped funds. The monies included in the risk pool will be used to reimburse AdSS with losses in excess of 0%.
404 CONTRACTOR WEBSITE AND MEMBER INFORMATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C R9-22-504; 42 CFR 438.10; 42 CFR 438.310(d)(3); ACOM Chapter 404; ACOM 404, Attachment A – Organizations Recognized by AHCCCS, ACOM 404, Attachment B - Contractor Website Certification Checklist, and ACOM 404, Attachment C - Member Information Attestation Statement; ACOM 406, Attachment B – CMS Required Definitions, Section F3, Contractor Chart of Deliverables

DELIVERABLES: Member Information Attestation Statement; Member Newsletter

PURPOSE:

This policy applies to the Division of Developmental Disabilities (DDD, the Division). This policy establishes requirements for the Division regarding member information and the approval process for member information materials developed by or used by the Division. This policy pertains to oral and written communication disseminated to the Division’s enrolled members and to the content of the Division’s website.

Definitions

A. **File and Use** - A process whereby the Division submits qualifying member information materials to AHCSSS prior to use and can proceed with distributing the materials without any expressed approval from AHCCCS.

B. **Member Information Materials** - Any materials given to DDD membership. This includes, but is not limited to; member handbooks, member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, mobile applications and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member’s phone.

C. **Vital Materials** - Written materials that are critical to obtaining services which include, at a minimum, the following:
   1. Member Handbooks
   2. Provider Directories
   3. Consent Forms
   4. Appeal and Grievance Notices
   5. Denial and Termination Notices

Policy

A. **Member Information Materials**

   1. The Division must comply with the requirements in this Policy for all member information materials. In addition, refer to the requirements outlined in:
a. AHCCCS ACOM Policy 405 for requirements regarding Cultural Competency, Language Access Plan and Family/Patient Centered Care,
b. AHCCCS ACOM Policy 406 for requirements regarding the Member Handbook and Provider Directory,
c. AHCCCS ACOM Policy 425 for requirements regarding Social Networking activities,
d. AHCCCS ACOM Policy 433 for requirements regarding Member ID Cards,
e. AHCCCS ACOM Policy 414 for sample Notice of Adverse Benefit Determination and Notice of Extension
f. The Division Contract, Grievance and Appeal System Standards section for the requirements of the Notice of Appeal Resolution letters and written grievance determination letters, when indicated, and
g. AHCCCS ACOM Policy 406, Attachment B:

2. DDD must attest it is in compliance with member information requirements by signing and submitting ACOM 404, Attachment C, as specified in the Contract.

3. DDD must provide all member information materials to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members.

4. DDD must inform members that member information is available in paper form, without charge and upon request, and must provide it upon request within five business days.

5. DDD must use state developed member notices as indicated in Contract and Policy [42 CFR 438.10(c)(4)(ii)].

B. Language, Readability, and Oral Interpretation Requirements

All member information materials must include taglines in the prevalent non-English languages in Arizona and include large print (font size of at least 18 point) explaining the availability of written translation or oral interpretation services with the Division’s toll free and TTY/TTY telephone numbers for customer service, which shall be available during normal business hours. In addition, DDD shall provide members DDD’s toll free and TTY/TTY nurse triage line telephone number which shall be available 24hr/7days a week.

1. Vital materials must be made available in the prevalent non-English language spoken for each LEP population [42 CFR 438.310(d)(3)]. Oral interpretation services must not substitute for written translation of vital materials. The Division is not required to submit translated member materials to AHCCCS. It is the Division’s obligation to ensure that the translation is accurate and culturally appropriate.
2. All written materials for members must be translated into Spanish regardless of whether or not the materials are vital.

3. Readability - The Division must make every effort to ensure that all information prepared for distribution is written in an easily understood language and format. The Division should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale. The Division must use a font size no smaller than 12 point. Member information materials must also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, have other disabilities, or who have limited reading proficiency. Large print materials must be made available using a font size no smaller than 18 point.

4. Oral Interpretation - The Division makes oral interpretation services available to its members at no cost. Services for all non-English languages and the use of auxiliary aids such as TTY/TDY and American Sign Language are available [42 CFR 438.10(d)(4)].

C. Materials not Requiring Submission to the Division

1. Customized letters for individual Members need not be submitted to AHCCCS as described in this Policy. Information sent by the Division to Members enrolled in a Medicare Dual Special Needs Plan (D-SNP) that clearly and exclusively relate to their Medicare benefits and services do not require submission to AHCCCS.

2. Health related brochures developed by a nationally recognized organization included in ACOM Policy 404 Attachment A, do not require submission to the AHCCCS. However, in the event the informational material provided by an approved organization references services that are not medically necessary, or are not AHCCCS covered benefits, or do not align with Division policy, the Division may not distribute the organization’s informational materials to members. In these instances, the Division may use the organization’s material only as a reference to develop its own member information materials specific to Division recipients.

3. Attachment A is not an all-inclusive list. The Division must refer to this policy for updates when considering using information from organizations listed in Attachment A. The Division will be held accountable for the content of materials developed by the organizations listed in Attachment A. The Division must review the materials to ensure that:

   a. The services are covered by the Division.
   b. The information is accurate.
   c. The information is culturally sensitive.
It is important to note that in all instances where the Division is required by its Contract with AHCCCS to educate its members, brochures developed by outside entities must be supplemented or replaced with informational materials developed by the Division which are customized for the Medicaid population.

D. Member Newsletter Content and Requirements

1. The Division must develop and distribute, at a minimum, two member newsletters during each contract year. Newsletters must be submitted in the form of an initial mock-up version of what the Member will be receiving in addition to the individual articles referencing readability levels and must be submitted as specified in the Contract. Member newsletters will be reviewed in accordance with this Policy. The Member Newsletter does not fall under the 15-day File and Use review process.

2. At a minimum, the Member newsletter must include the following at least annually (except as otherwise indicated):
   a. Educational information on chronic illnesses and ways to self-manage care,
   b. Reminders of flu shots and other preventative measures at appropriate times,
   c. Medicare Part D issues,
   d. Cultural Competency, other than translation services,
   e. Contractor specific issues (in each newsletter),
   f. Tobacco cessation information,
   g. HIV/AIDS testing for pregnant women,
   h. Suicide Prevention information,
   i. Opioid/Substance Use information,
   j. Contractor contact information and Crisis Hotline information (in each newsletter),
   k. Resources to assist with Social Determinants of Health,
   l. Information on the Division’s integration efforts to improve overall member outcomes, as applicable (e.g. behavioral health and physical health services), and,
   m. Other information required by the Division or AHCCCS.
E. **Website**

The Division’s website must contain all the information required in 404 - Attachment B. The Division must submit Attachment B as specified in Contract. All of the information must be located on the Division’s website in a manner that members can easily find and navigate (e.g. “Consumer, Enrollee, Member or Recipient Page”) from the Division’s home page. Information should be in a format that can be retained and printed by the member.

Websites must be specific to the Division’s Medicaid program and must not include links or references to private insurance. For the approval process for additional information added to the Division’s website that is directly related to members or potential members, refer to requirements outlined in this Policy.

F. **Submission, Requirements and Restrictions for All Other Materials**

1. The Division must inform all members of any changes considered to be significant by the Division, 30 calendar days prior to the implementation date of the change. These changes include, but are not limited to:
   a. Cost Sharing
   b. Prior Authorization
   c. Service Delivery
   d. Covered Services.

   In addition, the Division must make a good faith effort to give written notice to members within 15 calendar days after receipt or issuance of a provider termination notice to each member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(1)].

   AHCCCS has adopted a File and Use review process for all other member information materials developed by the Division. All other member information materials disseminated by the Division to its members must be submitted, as specified in Contract, 15 calendar days before it is to be released. If a 15-day notice is not possible, the Division may request an expedited review, but the request must be clearly marked as expedited and also indicate the reason for the shortened timeframe. AHCCCS reserves the right to determine if the request for an expedited review is warranted.

2. The Division must submit the following information to AHCCCS prior to releasing member information materials:
   a. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its members or potential members. Translations of the material into other languages as required by this policy are not required to be submitted,
b. A description of the process it will use to disseminate the material, and,

c. The reading level of the material as measured on the Flesch-Kincaid scale.

The Division may disseminate the member information as indicated in their request upon the expiration of the 15 day time period, unless AHCCCS notifies the Division otherwise. Member materials submitted outside of standard business hours will be considered received the following business day. State Holidays that fall on business days are not counted as part of the 15 day review period.

Member information materials that are a component of new initiatives, or special projects, (e.g. new member portal, health education initiatives), or are comprised of a bulk submission (e.g. booklet, magazine), may require additional review time.

AHCCCS reserves the right to require any necessary changes to the material. AHCCCS may also conduct audits and/or operational reviews to ensure compliance.

Member information materials can also be used for marketing purposes as defined in Division Operations Manual, Policy 101. In these cases, the materials must receive prior approval from AHCCCS as outlined in Policy 101. In addition, for social networking applications and content requirement, refer to Division Operations Manual, Policy 425.

3. The Division must ensure:

a. All materials are labeled with the Division’s name and/or logo; this includes member material that is located on the Division’s website, e-mail messages, and voice or text -recorded phone messages delivered to the member’s phone.

b. Information contained within the material is accurate, updated regularly, and appropriately based on changes in benefits, Contract, policy, or other relevant updates.

c. Updated member information is re-submitted for approval, including the date the material was previously approved, the reason for the update and clearly identify all content revisions.

d. A log is kept for all member material distributed each year; the log must identify the date the material was originally submitted to AHCCCS as described in this policy, as well as re-submission dates.

e. The log is made available to AHCCCS upon request.

f. Member information materials do not directly or indirectly refer to the offering of private insurance, do not include inaccurate, misleading, confusing or negative information about AHCCCS or the Division, or any information that might defraud members.
Division of Developmental Disabilities
Operations Manual
Chapter 400
Operations

404 Contractor Website and Member Information
Page 7 of 7

Division of Developmental Disabilities
Operations Manual
Chapter 400
Operations

Member information materials developed for services under contract with AHCCCS are not considered proprietary to the Division.

Member information materials:

g. Member information materials do not use the word “free” in reference to covered services.

h. Member information materials directly relate to the administration of the Medicaid program, or relate to health and welfare of the member.

i. Member information materials do not have political implications, and,

j. Retention materials do not refer to competing plans.
406 MEMBER HANDBOOK AND PROVIDER DIRECTORY

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 457.1207; 42 CFR 438.10, 42 CFR 438.102(a)(2); ACOM Policy 404, Attachment C, ACOM 406 Attachment A; ACOM 406 Attachment B; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Member Handbook; Member Handbook Request for Approval to Forgo Issuing Hard Copy; Website Certification

This policy applies to the Division of Developmental Disabilities (DDD, the Division). This policy establishes guidelines regarding Member Handbooks and Provider Directories.

Definitions

A. **Business Day** - A Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

B. **Multi-Specialty Interdisciplinary Clinic (MSIC)** - A facility where specialists from more than one specialty meet with members and their families in order to provide interdisciplinary services to treat members.

General Requirements

A. The Division must provide annually a Member Handbook to members.

B. The Division must provide annually a Provider Directory to members.

C. The Member Handbook must contain all information required, as identified in AHCCCS ACOM 406 Attachment A, Model Member Handbook Checklist, including definitions as required by Centers for Medicare and Medicaid Services specified in AHCCCS ACOM 406 Attachment B, Definitions for AHCCCS Members. The required information must be incorporated into the Division’s Member Handbook in the order identified on the Checklist.

D. The Member Handbook must be submitted as described in the section “Member Handbook Review Process” below.

E. The Division may publish information modifying or expanding the contents of the DDD Member Handbook. The Division may distribute this information in the form of inserts and supply these inserts with subsequently distributed Member Handbooks.

F. The Division must update the hard copy provider directories at least monthly, and the electronic provider directories no later than 15 days after the Division receives updated provider information [42 CFR 457.1207, 42 CFR 438.10].

G. The Division must ensure that the electronic versions of the Member Handbook and the Provider Directory meet the following requirements [42 CFR 457.1207, 42 CFR 438.10]:

1. The format is readily accessible.
2. The information is located in a place on the DDD website that is prominent and readily accessible.

3. The information is provided in an electronic form which can be electronically retained (saved) and printed.

4. The information is consistent with federal content and language requirements.

5. The information is available in hard copy format upon request, at no cost, and will be provided within five business days of the request.


H. The language and format requirements are standardized as outlined in Policy 404 of the DDD Operations Policy Manual, [42 CFR 457.1207, 42 CFR 438.10].

**Member Handbooks**

A. Member Handbook Review Process

The DDD Member Handbook, must be submitted for review annually to AHCCCS, as specified in Section F3, Chart of Deliverables, or as directed by AHCCCS. A copy of the DDD Member Handbook must be submitted to AHCCCS after the Division has given final approval, as specified in Section F3, Contractor Chart of Deliverables. The Division is responsible for the DDD Member Handbook and Provider Directory.

B. Distribution Requirements

1. Electronic-Only Member Handbooks

   If a hard copy member handbook will not be provided:

   a. Submit a request for approval to forego providing the hard copy of the handbook and include a statement of intent to notify members as specified in Section F3, Contractor Chart of Deliverables.

      Ensure the written notification gives the member the option to obtain a printed version of the member handbook.

   b. Acquire approval of the member notification in accordance with DDD Operations Manual, Policy 404.

   c. Send the written notification to members within the member handbook timeframes as outlined above [42 CFR 438.102(a)(2)].

2. Providing Member Handbooks to Members

   a. Provide to the member either a hard copy of the member handbook or an electronic version of the member handbook (or both versions) as follows:
i. Hard Copy

Provide the member handbook in hard copy format with the new member packet or inform the member that the information is available in paper form upon request at no cost and provide it within five business days.

ii. Electronic

Via electronic mail or postal mailing, provide notification of how to access the information in the member handbook on the AdSS website, to each member/representative or household within 10 business days of receipt of:

- Notification of the enrollment date [42 CFR 457.1207, 42 CFR 438.102(a)(2)]
- When member is determined medically eligible for CRS covered services [42 CFR 438.102(a)(2)]

b. Annually, provide the member handbook, or notification of how to access the information in the member handbook, to each member/representative or household.

C. Other Requirements

1. The Division must make available copies of the member handbook to known consumer and family advocacy organizations and other human service organizations.

2. Member Handbook Inserts – the Division may require updates to its Member Handbooks throughout the contract year to address program changes for inclusion in the member handbook.

   a. These changes must be incorporated in subsequently distributed handbooks through inserts until the handbooks are updated with the new information.

   b. The DDD must also post the content of the insert on its website.

3. DDD shall ensure Member Handbook and Provider Directory requirements are delegated to its Subcontracted Health Plans. DDD shall review its Subcontracted Health Plan Member Handbook and Provider Directories for approval in accordance with this Policy.

Provider Directory Content

A. Creating, Revising, and Maintaining Provider Directories

The Division must:

1. Update a hard copy (paper) format of the Provider Directory at least monthly
Division of Developmental Disabilities  
Chapter 400  
Operations

B. Provider Directories are Made Available to Members

The DDD must:

[42 CFR 438.10(h)(3)].

2. Ensure the electronic version of the Provider Directory is searchable (including specialists for referrals) and meets the following requirements [42 CFR 457.1207, 42 CFR 438.10] (see ACOM Policy 404, Attachment B).
   a. Format is readily accessible and user friendly.
   b. The information is placed in a location on the DDD website that is prominent and readily accessible.
   c. The information is provided in an electronic form which can be electronically retained (saved) and printed.
   d. The information is consistent with federal content and language requirements.
   e. Language and formatting comply with Division Operations Manual Policy 404. [42 CFR 438.10]


4. Ensures the provider directory (hard copy and electronic) includes:
   Note: See [42 CFR 457.1207, 42 CFR 438.10.]
   a. Provider name
   b. Provider address
   c. Provider telephone number
   d. Web site URL, as appropriate
   e. Specialty, as appropriate
   f. Non-English languages spoken
   g. Provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
   h. A designation for identifying provider locations that meet the criteria for accommodating members with physical or cognitive disabilities and a description of how the members can obtain details of the accessibility features for specific providers with this designation.
1. Ensure that a hard copy format of the Provider Directory is available to members upon request and that one will be provided at no cost within five business days of their request.

2. Provide the member either a hard copy of the Provider Directory or an explanation of how to use the electronic version (or both versions) as follows:
   
   a. Hard Copy
      
      Provide the provider directory in hard copy format with the new member packet.
   
   b. Electronic
      
      Within 10 business days of receipt of notification of the enrollment date [42 CFR 438.102(a)(2)], inform each member/representative or household how to access the Provider Directory online.

      Via electronic mail, postal mailing, or inclusion in the member handbook, provide written notification of how to access the provider directory information located on the DDD website. This member notification must:

      i. Be approved in accordance with this policy and with Division Operations Manual Policy 404

      ii. Give the member the option to obtain a hard copy version of the provider directory upon request.
407 WORKFORCE DEVELOPMENT

EFFECTIVE DATE: October 1, 2018

Purpose

Overseeing the development of the provider workforce is a function of the Division’s network management responsibilities. This policy describes the Division’s requirements regarding:

- Monitoring and collection of information about the workforce
- Collaborative planning of workforce development initiatives (including the recruitment and employment of members of the Division into healthcare roles)
- When needed, the provision of direct assistance to providers in order to develop the workforce.

Definitions

A. Competency Requirement - A requirement mandating personnel to behaviorally demonstrate to a qualified staff member that they have acquired specific information or skill and or that they are capable of routinely using the information or skill in the performance of their duties.

B. Training Requirement - A requirement mandating personnel to participate in a specific training course or program.

General

The Division, AHCCCS, providers, and Administrative Services Subcontractors (AdSS) work together to ensure members of the Division receive services from a workforce that is qualified, capable and sufficiently staffed.

A. Providers are responsible for acquiring, developing and deploying a sufficiently staffed and qualified workforce that capably delivers services to members.

B. AHCCCS and the Division generate policies that shape worker, workplace and workforce development practices. AHCCCS’s Office of Workforce Policy analyzes current and future healthcare trends; forecasts the workforce capacities and capabilities needed to address these trends, and assists the Division and providers by mobilizing governmental and community resources as needed to strengthen Arizona’s healthcare workforce.

C. The Division ensures that provider workforce management and development processes align with AHCCCS workplace and workforce development policies. The Division monitors the performance of the network, collects information about the workforce, develops plans to strengthen the workforce, and when needed, directly assists providers to develop and maintain a qualified, capable and sufficiently capacitated workforce.
The Division ensures that subcontracted provider organizations are deploying a qualified, sufficiently staffed workforce that capably provides services to members of the Division in an interpersonally, clinically, culturally and technically effective manner.

**Maintain a Workforce Policy Management Function**

The Division performs specific workforce monitoring, data collection, planning and technical assistance as follows:

A. Maintain a workforce policy management function to implement the requirements of this policy.

B. Designate a staff member with experience and expertise in workforce development to oversee the Division’s and providers’ workforce development responsibilities.

C. Ensure that resources are available to monitor provider workforce development activities, collect workforce data, produce a workforce development plan, ensure subcontracted personnel are receiving the training required by Division policy, and provide technical assistance to provider organizations to improve their workforce development programs if determined necessary.

**Workforce Development Plan and Progress Report**

The Division produces a Workforce Development Plan (WFD) in collaboration with providers, members of the Division and their families, and other stakeholders, including but limited to, other Division contracted providers and AdSS, and industry, education and community groups. The WFD Plan describes the goals, objectives, tasks and timelines to develop the workforce. The Division submits the WFD Plan to AHCCCS as specified in Contract.

The Division includes the following in the WFD Plan:

A. Short and long term strategic WFD capacity and capability requirements (e.g. addressing health professional shortage areas, and integrated care)

1. Forecast of anticipated workforce capacity (e.g., size, job types) and capability (skills and workplace support) needs

2. Specific WFD goals

3. Description of the actions to be taken to implement WFD initiatives, such as programs to recruit members of the Division to seek employment in various roles within the AHCCCS healthcare system

4. How stakeholders, members, families and the general public will be involved in the development and implementation of the WFD Plan.
B. The Division maintains a general assessment of the progress of the WFD Plan and formally assesses and submits a written WFD Progress Report of overall progress as specified in Contract. The WFD Progress Report(s) includes:

1. Progress being made toward the achievement of statewide WFD goals as well as Division specific – provider network WFD goals

2. A summary of technical assistance activities provided to provider organizations.

**Monitor Provider Workforce Development Activities**

Division and AHCCCS policies, guidance documents, manuals and plans may include training and or competency requirements. As part of the routine audit and compliance monitoring process, the Division ensures:

A. All required training content or competency descriptions are incorporated into the appropriate orientation, education or training program and evaluation processes and are being made available to provider personnel.

B. Providers have processes for documenting training, verifying the qualifications, skills and knowledge of personnel, and retaining required training and competency transcripts and records

C. All initiatives specified in the WFD Plan are routinely monitored and evaluated.

**Workforce Data**

The Division collects and analyzes required and ad hoc workforce data; the Division:

A. Proactively identifies potential challenges and threats to the viability of the workforce

B. Conducts analysis of the potential impact of the challenges and threats to access to care for members

C. Develops and implements interventions to prevent or mitigate threats to workforce viability

D. Develops indicators to measure and monitor workforce sustainability.

The Division also assists AHCCCS to develop forecasts and plans concerning the WFD needs of Arizona’s healthcare system.
Provider Technical Assistance

As needed, the Division provides technical assistance to providers to develop, implement and improve programs for workforce recruitment, selection, evaluation, education, training, and retention. The Division determines the need, scope (all, segments or individual providers), and the most effective and efficient methods for providing technical assistance to providers. Potential examples of technical assistance include, but are not limited to:

A. Workforce development planning
B. Talent identification and acquisition
C. Competency based training and development programs and systems
D. Workforce retention and promotion strategies
E. Workplace culture development.

The Division’s technical assistance activities are reported on the WFD Progress Report(s).
412 CLAIMS RECOUPEMENT

REVISION DATE: 7/10/2019
EFFECTIVE DATE: May 20, 2016
INTENDED USER(S): Division Claim staff


This policy identifies the AHCCCS requirements for the Division’s claims recoupment and refund activities.

Definitions

A. **Day** - Calendar day unless otherwise specified.

B. **Provider** - Any individual or entity that contracts with AHCCCS or the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a Provider delivering services. For the purposes of this policy, a Provider delivering services pursuant to A.R.S. §36-2901.

C. **Recoupment** - The process the Division takes to recover all or part of a previously paid claim(s). Recoupments include Division initiated/requested repayments, as well as overpayments identified by the Provider where the Division seeks to actively withhold or withdraw funds to correct the overpayment from the Provider.

D. **Refunds** - An action initiated by a Provider to return an overpayment to the Division. In these instances, the Provider writes a check or transfers money to the Division directly.

Policy

The Division is responsible for reimbursing Providers and coordinating care for services provided to a member pursuant to state and federal regulations, including, but not limited to A.A.C. R9-22-701 et seq., A.A.C. R9-28-701 et seq.

The Division is required to follow AHCCCS Recoupment provisions as outlined in Contract and Policy. For requirements for adjudication and payment of claims and encounters, refer to ACOM Policy 203. The Division’s claims processes, as well as its prior authorization, and concurrent and retrospective review processes, minimize the likelihood of the need to recoup paid claims.

An adjustment that is completed within 30 days from the date of the original payment does not require AHCCCS prior approval, but will be tracked and made available to AHCCCS upon request. The information tracked should include, at a minimum, the AHCCCS Member ID number, date(s) of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

Adjustments completed more than 30 days from the date of the original payment may require AHCCCS prior approval, as outlined below.
**Individual Recoupments in Excess of $50,000**

Prior to initiating any individual Recoupment in excess of $50,000 per Provider Tax Identification Number (TIN), the Division submits a written request for approval as specified in Contract (30-days) or earlier if the information is available, in the format detailed below:

A. A detailed letter of explanation will be submitted with the following:
   1. How the need for recoupment was identified.
   2. The systemic causes resulting in the need for a recoupment.
   3. The process that will be utilized to recover the funds.
   4. Methods to notify the affected Provider(s) prior to recoupment.
   5. The anticipated timeline for the project.
   6. The corrective actions that will be implemented to avoid future occurrences.
   7. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted.
   8. Other recoupment action(s) specific to this Provider within the contract year.

B. An electronic file containing the following:
   - AHCCCS member ID
   - Date of service
   - AHCCCS claim number
   - Date of payment
   - Amount paid
   - Amount to be recouped.

C. A copy of the written communication that will serve as prior notification to the affected Provider(s) shall include a minimum of the following:
   1. How the need for the recoupment was identified.
   2. The process that will be utilized to recover the funds.
   3. The anticipated timeline for the recoupment.
   4. The Provider’s right to file a claim dispute.
   5. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped.
   6. Listing of impacted claim numbers.
Note: The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

**Recoupment of Payments Initiated More Than 12 Months From the Date of Original Payment**

The Division is prohibited from initiating recoupment of monies from a Provider TIN more than 12 months from the date of original payment of a *clean claim* unless prior approval is obtained from AHCCCS. Retroactive recoveries involving commercial insurance payor sources are not included in this discussion. For Coordination of Benefits involving third party liability recoveries see *ACOM Policy 434 and the Division’s Operations Manual Chapter 434 Coordination of Benefits & Third Party Liability*.

A. To request approval from AHCCCS, the Division submits a request in writing with all of the following information:

   A detailed letter of explanation will be submitted with the following:

   1. How the need for recoupment was identified.
   2. The systemic causes resulting in the need for a recoupment.
   3. The process that will be utilized to recover the funds.
   4. Methods to notify the affected Provider(s) prior to recoupment.
   5. The anticipated timeline for the project
   6. The corrective actions that will be implemented to avoid future occurrences.
   7. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of Providers impacted.

B. An electronic file containing the following:

   - AHCCCS member ID
   - Date of service
   - AHCCCS claim number
   - Date of payment
   - Amount paid
   - Amount to be recouped.

C. A copy of the written communication that will serve as prior notification to the affected Provider(s). The communication includes at a minimum:

   1. How the need for the recoupment was identified.
   2. The process that will be utilized to recover the funds.
3. The anticipated timeline for the recoupment.
4. The Provider’s right to file a claim dispute.
5. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped.
6. Listing of impacted claim numbers.

Note: The written communication must be approved by AHCCCS prior to being sent to the Provider(s).

Cumulative Recoupments in Excess of $50,000 per Provider per Contract Year

The Division continuously tracks recoupment efforts per Provider TIN. When recoupment amounts for a Provider TIN cumulatively exceed $50,000 during a contract year (based on recoupment date), the Division reports the cumulative recoupment monthly as outlined in the AHCCCS Claims Dashboard Reporting Guide and as specified in the Division’s contract.

AHCCCS Responsibility and Authority

AHCCCS reserves the right to evaluate and to present the proposed recoupment action to the affected Providers as part of the approval and or notification process. Communication will be at the timing and discretion of AHCCCS.

The AHCCCS Division of Health Care Management (DHCM) will review all requests for recoupment, evaluating factors such as validity, accuracy, and efficiency of the Division’s processes. DHCM will also evaluate the proposed recoupment for the purposes of minimizing Provider hardship or inconvenience. DHCM will acknowledge all requests in writing through electronic mail upon receipt of the completed file. A written determination will be sent to the Division by electronic mail contingent upon receipt of all required information from the Division.

Data Processes for Recoupment

Upon receipt of approval for recoupment from AHCCCS, the Division has no more than 120-days to complete the project and submit the following as stated in the Division’s contract:

A. Notification of the submission for the voided or replacement encounters (which reaches adjudicated status within 120-days of the approval of the recoupment) and the appropriate associated information for all impacted encounters for recouped claims.

B. Upon completion of the recoupment project, a separate electronic file containing all of the following information for all recouped claims (this is independent of the 837 file(s) submitted through Encounters):
   - AHCCCS member identification number
   - Date of service
   - Original AHCCCS CRN
   - New AHCCCS CRN
• Health Plan allowed amount
• Health Plan paid amount
• Provider identification number.

Note: The Division submits the above information for each adjudicated encounter. Dependent on the size and/or volume of the recoupment request, AHCCCS may require the Division to submit an external file in order to directly update impacted encounters in the timeframe prescribed above.

Failure to submit complete information within the specified timeframe will be considered a violation of the contract and may result in administrative action. AHCCCS will validate the submission of applicable voided and replacement encounters upon completion of this project. As a result of amending the encounter data, AHCCCS may adjust related reinsurance payments, reconciliation payments, or any other amounts paid to the Division that are impacted by the recoupment.

**Data Processes for Refunds**

Upon receipt of refund from a Provider, the Division has 120-days from the date of the refund to void or replace related encounters. All voided or replaced encounters reaches an adjudicated status within the 120-day timeframe.

A. The Division identifies the following for all refunds received and provide this information to AHCCCS upon request:
   1. The systemic causes resulting in the need for the refund and/or an explanation of why the refund occurred.
   2. The corrective actions that will be implemented to avoid future occurrences, if applicable.
   3. Cumulative refund amount, total number of claims and range of dates for the claims impacted by the refund.
   4. List of impacted claim numbers.

**Attestation**

All documentation and data submitted by the Division for purposes of recoupment and refund activities certified by the Division as specified in 42 CFR 438.600 et seq. If it is determined after the recoupment or refund action that information provided to AHCCCS is inaccurate, invalid, or incomplete, or that the Division failed to comply with any provisions of AHCCCS Policy 412 – Claims Recoupment, the Division may be subject to administrative actions.
414 REQUIREMENTS FOR SERVICE AUTHORIZATION DECISIONS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM 414 (with Attachments), AMPM Policy 430

This policy sets forth Division requirements for services authorization decisions Notices of Adverse Benefit Determination (NOA) relating to Title XIX/XXI coverage and authorization of services.

Definitions

A. **Adverse Benefit Determination** - The denial or limited authorization of a service request, or the reduction, suspension, or termination of a previously approved service.

B. **Appeal** - A request for review of an Adverse Benefit Determination.

C. **Calendar days** - Every day of the week including weekends and holidays.

D. **Computation of time in calendar days** - Computation of time in calendar days that begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing member appeal dates only, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend (Saturday or Sunday) or a legal holiday. The first day of the “count” always begins on the day after the event.

E. **Expedited service authorization request** - A request for services in which either the requesting provider indicates, or the Division determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function and requires the authorization decision within 72 hours from the receipt of the service request.

F. **Legal holidays** - Legal holidays, as defined by the State of Arizona are:
   - New Year’s Day – January 1
   - Martin Luther King Jr./Civil Rights Day – 3rd Monday in January
   - Lincoln/Washington Presidents’ Day – 3rd Monday in February
   - Memorial Day – Last Monday in May
   - Independence Day – July 4
   - Labor Day – 1st Monday in September
   - Columbus Day – 2nd Monday in October
   - Veterans Day – November 11
   - Thanksgiving Day – 4th Thursday in November
   - Christmas Day – December 25

When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday.
G. Notice of Adverse Benefit Determination (NOA) - A written notice provided to the member that explains the reasons for the Adverse Benefit Determination made by the Division regarding the service authorization request and includes the information required by this Policy.

H. Notice of Extension (NOE) - A written notice to a member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.

I. Service authorization request - A request by the member, the representative, or a provider for a physical or behavioral health service for the member that requires Prior Authorization (PA) by the Division.

J. Working days - “Working Day” as defined in A.A.C. R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless:

1. A legal holiday falls on one of these days; or
2. A legal holiday falls on Saturday or Sunday and the Division is closed for business the prior Friday or following Monday.

Policy Overview

When the Division decides to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services, the Division must provide a written NOA to the member as described in 42 CFR 438.404.

A. The Division must use the AHCCCS-developed member NOA templates as specified in 42 CFR 438.10(c)(4)(ii). The templates must not be altered except for the areas designated in the template that permit alteration and the removal of the header. Refer to AHCCCS Contractors Operations Manual (ACOM) 414 Attachment A-1 (Notice of Adverse Benefit Determination not Involving Medications Template) for the NOA template for service authorization requests that do not pertain to medications.

B. The Division’s Member Handbook informs members:

1. Of their right to make a complaint to the Division about an inadequate NOA;
2. That if the Division does not resolve the complaint about the NOA to the member’s satisfaction, the member may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at MedicalManagement@azahcccs.gov; and;
3. That the Division and its providers are prohibited from taking punitive action against members exercising their right to appeal.

Right to be represented

The Division acknowledges the member’s right to be assisted by a third-party representative, including an attorney, during an appeal of an Adverse Benefit Determination. A list of legal aid services available to members is provided in ACOM Policy 414, Attachment B (Legal Services Program). The Division’s appeals process registers the
existence of the third-party and the Division ensures that the required communications related to the appeals process occur between the Division and the representative. The member’s representatives, upon request, must be provided timely access to documentation relating to the decision under appeal. Consistent with federal privacy laws, the Division must make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member, however, if the Division questions the authority of the representative or the sufficiency of a written authorization, it must promptly communicate that to the representative.

**Notice of Adverse Benefit Determination Content Requirements**

A. The NOA must contain and clearly explain in easily understood language, at 6th grade or below reading level, the information necessary for the member to understand the Adverse Benefit Determination, the reason for the Division’s determination such that the member may make an informed decision regarding appealing the determination, and how to appeal the decision. If the reason for the denial of a service authorization request is due to the lack of necessary information, the member must be clearly informed of that reason in order to be given the opportunity to provide the necessary information.

B. The NOA must contain and clearly explain in easily understood language, at 6th grade or below reading level, the following information and must be consistent with 42 CFR 438.404:

1. The requested service;
2. The reason or purpose of the requested service;
3. The reasons for the Adverse Benefit Determination the Division has made or intends to make (i.e. denial, limited authorization, reduction, suspension, or termination) with respect to the requested service consistent with 42 CFR 438.404(b)(1);
4. The effective date of a service denial, limited authorization, reduction, suspension, or termination;
5. The right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits as required in 42 CFR 438.404(b)(2);
6. The legal basis for the Adverse Benefit Determination;
7. Where members can find copies of the legal basis, (e.g. the local public library and the web page with links to legal authorities). When a legal authority or an internal reference to the Division’s policy manual is available online, the Division must provide the accurate URL site to enable the member to find the reference online;
8. A listing of legal aid resources;

9. The member’s right to request an appeal and the procedures for filing an appeal of the Division Adverse Benefit Determination, including information on exhausting the Division’s appeals process described in 42 CFR 438.402(b) and the right to request a State fair hearing consistent with 42 CFR 438.402(c);

10. The procedures for exercising the member’s rights as described in 42 CFR 438.404(b)(4);

11. The circumstances under which an appeal process can be expedited and how to request it; and

12. Explanation of the member’s right to have benefits continue pending the resolution of the appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services if the appeal is denied [42 CFR 438.420(d)].

C. It is unacceptable to cite lack of medical necessity as a reason for denial, unless the NOA also provides a complete explanation of why the service is not medically necessary. Failure to provide the reasons and explanation supporting the lack of medical necessity in the Adverse Benefit Determination will result in regulatory action by AHCCCS. Refer to ACOM 414 Attachment C (Guide to Language in Notices of Adverse Benefit Determination) for examples where medical necessity is appropriately used in denying or limiting services.

D. The NOA must state the reasons supporting the denial, reduction, limitation, suspension, or termination of a service. NOAs that do not provide explanation of why the service has been denied, reduced, limited, suspended, or terminated and merely refer the member to a third party for more information are unacceptable. The Division may include a statement referring a member to a third party for more help when the third party can explain treatment alternatives in more detail.

F. Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

1. The Contractor must cite Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Federal law 42 U.S.C. 1396d(r)(5) when denying, reducing, limiting, suspending, or terminating a service for a Title XIX member who is younger than 21 years of age when these provisions are applicable. The Contractor must explain in accordance with this Policy and AHCCCS Medical Policy Manual (AMPM) Policy 430 the denial, reduction, limitation, suspension, or termination of the requested EPSDT service.

2. In such circumstances, the Contractor must specify why the requested service does not meet the EPSDT criteria and is not covered and must also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Federal law to correct or ameliorate defects and physical and mental illnesses and
conditions discovered by the screening services, whether or not such services are covered under the State Plan.

Member Complaints Regarding the Adequacy or Understandability of the Notice of Adverse Benefit Determination

If a member complains about the adequacy of an NOA, the Division must review the initial NOA against the content requirements of this Policy. If the Division determines that the original NOA is inadequate or deficient, the Division must issue an amended NOA consistent with the requirements of this Policy. Should an amended NOA be required, the timeframe for the member to appeal and continuation of services must start from the date of the amended NOA.

Timeframes for Service Authorization Decisions

A. All references to “days” in this Policy mean “calendar days” unless otherwise specified.

B. When a service authorization request is submitted, the Division ensures completion and issuance of the service authorization decision within the following timeframes. Different timeframes apply depending upon whether or not the service authorization request is a standard request, an expedited request, and whether the service request relates to medications. The date/time the Division receives the request is considered the date/time of receipt, whichever is applicable. The date/time is used to determine the due date for completion of the authorization decision, depending on the timeframe applicable to the particular type of service request. The Division may use electronic date stamps or manual stamping for logging the receipt. If an Administrative Services Subcontractor (AdSS) receives the request, the date or time the AdSS receives the request is used for establishing receipt of the request.

C. An expedited authorization request is a request for a service in which either the requesting provider indicates, or the Division determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function. For expedited requests that meet these requirements, the authorization decision is prioritized and shall be completed in the 72-hour expedited timeframe as described in this Section.

D. A standard authorization request is a request for a service that does not meet the definition of an expedited service authorization request. For standard service authorization requests, the date the Division receives the request is considered the date of receipt and is used to determine the due date for completion of the decision.

E. For expedited service authorization requests, the time the request is received is used to determine the completion time for the decision.

F. Standard Authorization Decision Timeframe for Service Authorization Requests

1. The Division must issue service authorization decisions as expeditiously as the member’s condition requires but no later than 14 calendar days from receipt of the request for the service regardless of whether the 14th day falls on a
weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

2. The Division may issue an NOE of up to 14 additional calendar days, if the criteria for a service authorization extension are met as specified in this Policy.

G. Expedited Service Authorization Decision Timeframe for Service Authorization Requests:

1. The Division must issue an expedited service authorization decision as expeditiously as the member’s health condition requires but no later than 72 hours from receipt of the request for service consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6)] regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

2. The Division may issue an NOE of up to 14 additional calendar days, if the criteria for a service authorization extension are met as specified in Section (J) this Policy.

H. Expedited Service Authorization Request Treated as a Standard Request:

When the Division receives an expedited request for a service authorization and the service request fails to meet the requirements for expedited consideration, the Division may treat the expedited authorization request as a standard request. The Division has a process included in the Division’s policy for Prior Authorization (PA) that describes how the individual will be notified of the downgrade change to a standard authorization request and be given an opportunity to provide additional information (Refer to Division of Developmental Disabilities Provider Policy Manual, Chapter 17). The requesting provider must be permitted to send additional documentation supporting the need for an expedited authorization.

I. Service Authorization Decisions Not Reached Within the Timeframes:

A service authorization decision that is not reached within the required timeframes for a standard or expedited request constitutes a denial. The Division must issue an NOA denying the request on the date that the timeframe expires.

J. Service Authorization Decisions Not Reached Within the Extended Timeframes:

A service authorization decision that is not reached within the timeframe noted in the NOE constitutes a denial. The Division must issue an NOA denying the service request on the date that the timeframe expires [42 CFR 438.404(c)(5)].

Timeframes for Completing Notices of Adverse Benefit Determinations

The Division must mail the NOA within the following timeframes:

A. For termination, suspension, or reduction of a previously authorized service, the NOA must be mailed at least 10 calendar days before the date of the proposed
termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice [42 CFR 431.211, 42 CFR 438.404(c)(1)];

B. For Standard Service Authorization decisions that deny or limit services, the Division must provide an NOA:

1. As expeditiously as the member’s health condition requires but no later than 14 calendar days from the receipt of the request, regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, unless there is a NOE. For extension timeframes, refer to NOE Requirements in this Policy [42 CFR 438.404(c)(3) and (4), 42 CFR 438.210(d)(1)];

2. As expeditiously as the member’s health condition requires but no later than 72 hours from receipt of an expedited service authorization request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona unless there is an NOE. For extension timeframes, refer to NOE Requirements in this Policy.

**Notice of Extension Requirements**

**NOE Timeframes**

A. The Division may extend the timeframe to make a Service Authorization Decision for both standard and expedited service authorization requests when the member or provider (with written consent of the member) requests an extension, or when the Division justifies the need for additional information is in the member’s best interest. The NOE shall not be sent until the Division has made sufficient attempts to obtain the necessary information from the requesting provider [42 CFR 438.404(c)(6), 42 CFR 438.210(d)(2)(ii)];

B. For Standard Service Authorization requests, the Division may extend the 14-calendar day timeframe to make a decision by up to an additional 14 calendar days, not to exceed 28 calendar days from the service request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona;

C. For an expedited Service Authorization Request, the Division may extend the 72-hour timeframe to make a decision by up to an additional 14 calendar days, regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona;

D. Refer to Computation of Time in Calendar Days under “Definitions” for further information regarding when the end date falls on a weekend or legal holiday;

E. If the Division extends the timeframe in order to make a decision, in accordance with 42 CFR 438.210(d)(1) the Division must:

   1. Give the member written notice of the reason for the decision to extend the timeframe in easily understood language, at 6th grade or below reading level;
2. Include what information is needed in order to make a determination;

3. Inform the member of the right to file a grievance (complaint) if the member disagrees with the decision to extend the timeframe as described in 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i); and;

4. Issue and carry out the decision as expeditiously as the member’s condition requires and no later than the date the extension expires consistent with 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii).

F. For examples of easily understood NOA language, refer to ACOM Policy 414 Attachment C (Guide to Language in Notices of Adverse Benefit Determination).
415 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN; PERIODIC NETWORK REPORTING REQUIREMENTS

EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. § 36-2901; A.A.C. R9-22-101; 42 CFR 438.207(b); ACOM 407, ACOM 415 (with Attachments), ACOM 439

This policy establishes Division requirements for the Division’s submission of the Network Development and Management Plan and other periodic network reports to AHCCCS.

Network Development and Management Plan

The Division develops and maintains a provider Network Development and Management Plan that assures AHCCCS the provision of covered services will occur as stated in the Contract [42 CFR 438.207(b)]. The Network Development and Management Plan outlines the Division’s process for developing, maintaining, and monitoring an adequate provider network that:

- Is supported by written agreements
- Is sufficient to provide access to all services covered under the Contract
- Satisfies all service delivery requirements.

The Network Development and Management Plan includes, but is not be limited to, a comprehensive description of all elements identified in AHCCCS Contractors Operations Manual (ACOM) 415 Attachment B Network Development and Management Plan Checklist. The Plan also identifies any network gaps and strategies to resolve those gaps.

The Network Development and Management Plan is evaluated, updated, and submitted to AHCCCS with the following, as specified in Contract:

A. ACOM 415 Attachment A, Network Attestation Statement
B. ACOM 415 Attachment B, Network Development and Management Plan Checklist
C. Workforce Development Plan as outlined in ACOM Policy 407
D. Value Based Purchasing/Centers of Excellence Report (VBP/COE Report), no longer than four pages, which includes the following:

   1. Centers of Excellence section that describes:

      a. The Division’s current Centers of Excellence, and why they are significant for the membership of the Division, including an explanation of:

         i. A Center of Excellence for children with specialized healthcare needs as identified in Contract
         ii. An Integrated Pain Management Center of Excellence that addresses the following, as identified in Contract:

            • Behavioral health and physical health needs
• Opioid use disorder.

b. Division efforts to encourage member use of the Centers of Excellence,
c. Goals and outcome measures for the contract year
d. Description of monitoring activities to occur throughout the year
e. Evaluation of the effectiveness of the previous year’s initiatives
f. Summary of lessons learned and any implemented changes
g. Description of the most significant barriers
h. Plan for next contract year.

2. A Value-Based Purchasing section that describes:
   a. Division initiatives to encourage member use of high value providers
   b. An evaluation of Division effectiveness in directing members to high value providers
   c. Division plans to encourage providers determined to offer high value but not participating in VBP arrangements, if any, to participate in VBP contracts
   d. Planned changes for next contract year.

Periodic Network Reporting

A. Provider Changes Due to Rates Report

The Division submits, as specified in Contract, a Provider Changes Due to Rates Report, ACOM 415 Attachment D. The Division ensures reporting by its providers of reduced scope of services and termination of contract—Submission of this attachment is required even when there are no provider changes to report.

The Division submits changes resulting in a material change to network to AHCCCS as outlined in ACOM Policy 439.

B. DDD Therapeutic Services and HCBS Services Network Gap Reporting Roster

The Division submits, as specified in Contract, a DDD Therapeutic Services and HCBS Services Network Gap Reporting Roster. The Roster includes information in the Excel format identified in ACOM 415 Attachment Ea and Attachment Eb.

C. Customized Wheelchair, Customized Hospital Bed, and Augmentative Communication Device Timeliness Report

The Division submits ACOM 415 Attachment F as specified in Contract. For each type of Medical Equipment outlined in the report, the Division establishes a timeliness standard for when a member must receive the Medical Equipment, from the time a complete request for authorization is received, to the time the Medical Equipment, and any installation and training is received. Timeliness standards are reviewed by AHCCCS for appropriateness.
The Division reports its performance against the established standard for Medical Equipment provided in the reporting period, and in a cover letter identifies discrepancies between its standard and performance, strategies to address noncompliance with the standard and any actions taken as a result of this analysis.

The Division reviews its performance against its Medical Equipment standards for potential network gaps and address them in its Annual Network Development and Management Plan.
416 PROVIDER NETWORK INFORMATION

REVISION DATE: 10/1/2019
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12; 42 CFR 438.100; 42 CFR 102

This Policy establishes provider information requirements and the content of the Division’s website. “Provider” is defined as any person or entity that contracts with the Division to provide a covered service to members in accordance with A.R.S. § 36-2901.

Provider Communications

The AHCCCS contract contains requirements for communications between the Division and its provider network. The list below identifies the required content and timing of these communications. The list does not supersede any additional requirements that may be outlined in contract.

A. Provider Manual

The Division develops, distributes and maintains a provider manual, ensuring that each contracted provider is made aware of a website provider manual or, if requested, issued a hard copy of the provider manual. The Division also distributes a provider manual to any individual or group that submits claim and encounter data.

The Division ensures that all contracted providers meet the applicable AHCCCS requirements that relate to covered services and billing.

The provider manual provides information regarding the following:

1. Division’s program and organization
2. Provider responsibility and the Division's expectation of the provider
3. Division’s provider service departments and functions
4. Covered and non-covered services, and requirements and limitations including behavioral health services
5. Emergency room utilization (appropriate and non-appropriate use of the emergency room)
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers must document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program.
7. Dental services coverage and limitations
8. Maternity/Family Planning services
9. Primary Care Physician (PCP) assignments
10. Referrals to specialists and other providers, including access to behavioral health services
11. Grievance system process and procedures for providers and enrollees
12. Billing and encounter submission information
13. Policies and procedures relevant to the providers including, but not limited to:
   a. Utilization management,
   b. Claims submission,
   c. Criteria for identifying provider locations that provide physical access, accessible equipment, and / or reasonable accommodations for members with physical or cognitive disabilities.
14. Reimbursement, including reimbursement for members with other insurance, including dual eligible members (i.e. Medicare and Medicaid)
15. Cost sharing responsibility
16. Explanation of remittance advice
17. Prior authorization and notification requirements, including a listing of services which require authorization
18. Claims medical review
19. Concurrent review
20. Fraud, waste, and abuse
22. Minimum Required Prescription Drug List (MRPDL) information, including:
   a. How to access the MRPDL (electronically and hard copy - by request)
   b. How and when updates are communicated
23. AHCCCS appointment standards
24. Americans with Disabilities Act (ADA) and Title VI requirements, as applicable
25. Eligibility verification
26. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964, and access to interpretation services for members who speak a language other than English (including Sign Language)
27. Coordination of Care requirements, including designation of an Employment Coordinator as the statewide point of contact for the referral of members requesting employment services from the Division

28. Peer review and appeal process

29. Medication management services as described in the contract

30. Member’s right to be treated with dignity and respect as specified in 42 CFR 438.100

31. Notification that the Division has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102

32. Information on how to access or obtain Practice Guidelines and coverage criteria for authorization decisions

33. Information related to payment responsibilities as outlined in ACOM Policy 432

34. (Acute and ALTCS/EPD) Description of the Change of Contractor policies. See ACOM Policy 401 and 403.

B. Website

1. The Division maintains a website that is focused, informational, functional, and has links to the following:
   a. RPDL (both searchable and comprehensive listing), which shall be updated twice per year or as needed and within 30 calendar days of AHCCCS notification
   b. Provider manual
   c. Provider directory that is current and updated within 15 calendar days of a network change, is user friendly and allows members to search by the following provider information:
      i. Name of provider or facility
      ii. Provider or service type
      iii. Specialty
      iv. Languages spoken by the practitioner
      v. Office location (i.e., allow the member to find providers by location such as county, city or zip code)
   d. Performance Measure Results via link to AHCCCS website
   e. Medical Determination Criteria and Practice Guidelines
   f. Contractor provider survey results, as available.
2. For appropriate entities, the Division website also provides the following electronic functionality:
   a. Enrollment Verification
   b. Claims Inquiry (adjustment requests; information on denial reasons)
   c. Accept HIPAA compliant electronic claims transactions
   d. Display Reimbursement Information.

See ACOM Policy 404, Attachment C, Contractor Website Certification Checklist and Attestation for other website-related requirements.

Forty-five (45) calendar days after the start of the contract year, the Division submits Annual Website Certification Checklist and Attestation (See ACOM 404, Attachment C, Contractor Website Certification Checklist and Attestation).

C. Required Notifications

In addition to the updates required below, the Division may require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, the Division will provide prior notification as is deemed reasonable or prudent.

The Division provides written or electronic communication to contracted providers in the following instances:

1. **Exclusion from Network** - Under Federal Regulation 42 CFR 438.12, the Division provides written notice of the reason for declining any written request for inclusion in the network.

2. **Division Policy/Procedure Changes** – For any change in Policy, process, or protocol (such as prior authorization, retrospective review, or performance and network standards) that affects, or can reasonably be foreseen to affect, the Division’s ability to meet Contract performance standards, the Division must notify:

   a. The designated operations compliance officer to which the Division is assigned, sixty (60) days before a proposed change

   b. Affected provider, thirty (30) calendar days before the proposed change

3. **AHCCCS Guidelines, Policy, and Manual Changes** - The Division ensures that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals.

4. **Subcontract Updates** – If a modification to the AHCCCS Minimum Subcontract Provisions, the Division issues a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.
5. **Termination of Contract** – The Division provides, or requires its subcontractors to provide, written notice to hospitals and/or provider groups at least 90 calendar days prior to any contract termination without cause. Contracts between subcontractors and individual practitioners are exempted.

6. **Disease/Chronic Care Management** – The Division disseminates information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.
417  APPOINTMENT AVAILABILITY, MONITORING AND REPORTING

REVISION DATE: 10/01/19
EFFECTIVE DATE: January 16, 2019
REFERENCES: A.R.S. § 8-512.01; 42 CFR 438.206, ACOM 417 Attachment A

PURPOSE: This policy establishes appointment accessibility and availability standards to ensure Administrative Services Subcontractors’ (AdSS) compliance with the Division’s network sufficiency requirements. The standards outlined in this policy establish a common process for the Division to monitor and report AdSS’ provider appointment accessibility and availability to AHCCCS. These policy requirements do not apply to emergency conditions.

Definitions

1800 Report - An AHCCCS-generated document, provided quarterly that identifies Primary Care Physicians (PCPs) with a panel of more than 1800 AHCCCS members.

Established Patient - A member of the Division who has received professional services from the physician or any other physician with that specific subspecialty that belongs to the same group practice, within the past three years from the date of appointment.

New Patient - A member of the Division who has not received any professional services from the physician or another physician with that specific specialty and subspecialty that belongs to the same group practice, within the past three years from the date of appointment.

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

Monitoring Appointment Standards

A. The Division monitors and ensures that services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Division monitors and ensures that the AdSS provides a comprehensive provider network that provides access to all services covered under the Contract for all members of the Division. If the AdSS network cannot provide medically necessary services required under Contract, the Division monitors and ensures that the AdSS adequately and timely covers these services through an out-of-network provider until a network provider is contracted.

B. The Division monitors and ensures adherence to service accessibility standards and the following contractual appointment standards [42 CFR 438.206].

C. The Division uses the results of appointment standards monitoring to ensure adequate appointment availability in order to reduce unnecessary emergency department use.

D. The Division requires the AdSS to maintain written policies and procedures about educating the AdSS’ provider network regarding appointment time requirements. The Division requires that the AdSS develop a corrective action plan:
1. When appointment standards are not met, and
2. In conjunction with the provider, when appropriate [42 CFR 438.206 (c) (1) (iv), (v) and (vi)].

**General Appointment Standards**

The Division monitors and ensures that AdSS are ensuring the following appointment standards are met:

A. **Primary Care Provider Appointments:**
   1. Urgent care appointments as expeditiously as the member’s health condition requires but no later than two business days of request.
   2. Routine care appointments within 21 calendar days of request.

B. **Specialty Provider Appointments, including Dental Specialty:**
   1. Urgent care appointments as expeditiously as the member’s health condition requires but no later than three business days from the request.
   2. Routine care appointments within 45 calendar days of referral.

C. **Dental Provider Appointments:**
   1. Urgent care appointments as expeditiously as the member’s health condition requires but no later than three business days of request.
   2. Routine care appointments within 45 calendar days of request.

D. **Maternity Care Provider Appointments:**

   Initial prenatal care appointments for enrolled pregnant members must be provided as follows:
   1. First trimester - within 14 calendar days of request.
   2. Second trimester within seven calendar days of request.
   3. Third trimester within three business days of request.
   4. High risk pregnancies as expeditiously as the member’s health condition requires but no later than three business days of identification of high risk by the AdSS or maternity care provider, or immediately if an emergency exists.

**General Behavioral Health Appointment Standards**

The Division monitors and ensures that AdSS are ensuring the following appointment standards are met:

A. **Behavioral Health Provider Appointments:**
   1. Urgent need appointments occur as expeditiously as the member’s behavioral
health condition requires but no later than 24 hours from identification of need.

2. Routine care appointments:
   a. Initial assessment occurs within seven calendar days of referral or request for service.
   b. The first behavioral health service following the initial assessment occurs as expeditiously as the member’s behavioral health condition requires but no later than 23 calendar days after the initial assessment.
   c. All subsequent behavioral health services occur as expeditiously as the member’s behavioral health condition requires but no later than 45 calendar days from identification of need.

B. Psychotropic Medications:
   1. The urgency of the need is assessed immediately.
   2. If clinically indicated, an appointment is provided with a Behavioral Health Medical Professional within a timeframe that ensures the member a) does not run out of needed medications, or b) does not decline in his/her behavioral health condition prior to starting medication, but no later than 30 calendar days from the identification of need.

Provider Appointment Availability Review

The Division monitors and ensures that AdSS conduct regular reviews of providers to assess the availability of Routine and Urgent appointments for Primary Care, Specialist, Dental and Behavioral Health providers; including routine and urgent appointments for Maternity Care providers relating to the first, second and third trimesters, and high risk pregnancies.

The Division monitors and ensures that AdSS conduct provider appointment availability reviews in sufficient quantity to ensure results are statistically meaningful and representative of the services provided by the AdSS network. Appropriate methods include:

A. Appointment schedule review where the AdSS validate appointment availability;

B. Secret shopper phone calls where the AdSS anonymously validate appointment availability; and

C. Other methods approved by the Division.

The Division permits the AdSS to supplement these efforts by targeting specific providers identified through performance monitoring systems such as:

- The 1800 report (an AHCCCS generated document, provided quarterly, that identifies PCPs with a panel of more than 1,800 members)
• Quality of care concerns
• Complaints, grievances and the credentialing process

To obtain approval for any additional methods, the AdSS shall submit a request for approval outlining details (including scope, selection criteria, and any tools used to collect the information) to the Division prior to implementing the proposed method, as specified in Contract.

**Tracking and Reporting**

The Division requires that the AdSS track provider compliance with appointment availability quarterly, for both new and established patients, by provider type and appointment type using the Division’s reporting template in the AdSS Policy 417, Attachment A, which has been adopted for use by the Division.

The Division monitors the AdSS’ quarterly submission regarding:

• Compliance with appointment availability
• Results of provider surveys
• Analysis of results, including comparison of previous quarter results
• Identification of issues/barriers
• Solutions to resolve issues/barriers

On an annual basis the Division summarizes the results, trends, interventions with providers, and any planned changes to the methodologies as a component of the Network Development and Management Plan. (See Division Policy 415 regarding submission of the Network Development and Management Plan.)

The Division may review the AdSS’ monitoring and any corrective actions implemented as a result of provider non-compliance with appointment standards.
426 CHILDREN’S REHABILITATIVE SERVICES APPLICATION, DESIGNATION AND COVERAGE

EFFECTIVE DATE: October 1, 2018

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual Policy 426 Children’s Rehabilitative Services Application, Designation and Coverage for the Division policy governing AdSS responsibilities regarding this topic.
435 TELEPHONE PERFORMANCE STANDARDS AND REPORTING

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 435; Attachments A and B; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Telephone (Administrative) Performance Measures

This policy applies to the Division of Developmental Disabilities (DDD) Customer Service Center. This Policy establishes Contractor standards and reporting requirements regarding the Contractor’s performance when handling member and provider telephone calls. This policy does not include performance requirements for Crisis Services Response.

Definitions

A. Average Speed of Answer (ASOA) - The average online wait time in seconds that the member/provider waits from the moment the call is connected in the DDD Customer Service Center phone switch until the call is picked up by a DDD Customer Service Center’s representative or Interactive Voice Recognition System (IVR).

B. Daily First Contact Call Resolution Rate (DFCCR) - The number of calls received in a 24-hour period for which no follow-up communication or internal phone transfer is needed, divided by the total number of calls received in the 24-hour period.

C. Monthly Average Abandonment Rate (MAAR) - This is determined by the number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month and then divided by the number of days in the monthly reporting period.

D. Monthly Average Service Level (MASL) - The total of the month’s calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls abandoned calls in the month and all calls receiving a busy signal in the month (if available).

E. Monthly First Contact Call Resolution Rate (MFCCR) - The sum of the DFCCRs divided by the number of business days in the reporting period.

Telephone Performance Standards

The DDD Customer Service Center is required to track all of the following Telephone Performance Standards for member and provider calls monthly:

A. The ASOA must be 45 seconds or less.

B. The MAAR must be 5% or less.

C. The MFCCR must be 70% or better.

D. The MASL must be 75% or better.
Telephone Performance Measure Reports

The DDD Customer Service Center must submit a monthly Telephone Performance Measures Report showing the DDD Customer Service Center's performance based on the above standards.

If the DDD Customer Service Center is non-compliant with any standard on this deliverable for any given month, the report must contain steps on how the Customer Service Center will follow to reduce the non-compliant performance.
436 NETWORK STANDARDS

REVISION DATES: 10/01/19, 1/16/19
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.R.S. § 32-1201, 36-401-437, 36-551; A.A.C. R9-8, R9-10, R9-33;
42 CFR 438.206(b)(1); AHCCCS ACOM 436 and 415.

This policy applies to the Division of Developmental Disabilities’ (Division) oversight of its
network of providers.

It is the Division’s policy to develop and maintain a provider network that is sufficient to
provide all covered services under the AHCCCS Arizona Long Term Care System (ALTCS) to
its eligible members, 42 CFR 438.206(b)(1). The Division monitors network standards
compliance, including network standards delegated to the Administrative Services
Subcontractors. Performance is analyzed quarterly. Any identified gaps are addressed,
including short- and long-term interventions, in the Division’s Annual Network Development
and Management Plan when established network standards cannot be met.

Definitions

A. Adult Developmental Home (ADH) – A Division approved alternative home and
community based setting that provides room and board, supervision and coordination
of necessary services for adults with developmental disabilities within a family-type
environment for at least one and no more than four adult residents who are ALTCS
members. The Division provides Adult Developmental Homes in lieu of Adult Foster
Care Homes. Vendors providing licensing support and oversite of ADH providers are
registered as PT 39 and each provider is licensed by the DES, Office of Licensing,
Certification and Registration per A.A.C. R6-6-1001 and A.A.C. R6-6-1101.

B. Assisted Living Center (ALC) – An ALTCS approved alternative home and community
based setting that provides supervision and coordination of necessary services to 11
or more residents (as defined in A.R.S. § 36-401). An ALC is a facility using AHCCCS
provider type 49 “Assisted Living Center”.

C. Assisted Living Facility (ALF) – A residential care institution that provides
supervisory care services, personal care services or directed care services on a
continuing basis. All ALTCS-approved residential settings in this category must meet
ADHS licensing criteria as defined in A.A.C. R9-10-8. Of these facilities, ALTCS has
approved three as covered settings. Three types of ALFs are relevant to this policy,
ALC, Assisted Living Homes and AFC Homes.

D. Assisted Living Home (ALH) – An ALTCS approved alternative home and community
based setting that provides supervision and coordination of necessary services to 10
or fewer residents. An ALH uses the AHCCCS provider type 36 “Assisted Living
Home.”

The time and distance for these providers is measured using the Division’s
population of members under 18 years of age.

E. Behavioral Health Outpatient and Integrated Clinic, Adult – A class of healthcare
institution without inpatient beds that provides physical health services and/or behavioral health services for the diagnosis and treatment of patients. For the purposes of this policy, a Behavioral Health Outpatient and Integrated Clinic is defined as a facility operating using AHCCCS provider type 77 “Behavioral Health Outpatient Clinic” and IC “Integrated Clinic”.

The time and distance for these Behavior Health providers are measured using the Division’s population of members 18 years of age or older.

F. Behavioral Health Outpatient and Integrated Clinic, Pediatric – A class of healthcare institution without inpatient beds that provides physical health services and/or behavioral health services for the diagnosis and treatment of patients. For the purposes of this policy, a Behavioral Health Outpatient and Integrated Clinic is defined as a facility operating using AHCCCS provider type 77 “Behavioral Health Outpatient Clinic” and IC “Integrated Clinic”.

The time and distance for these Behavior Health providers are measured using the Division’s population of members under 18 years of age.

G. Behavioral Health Residential Facility – A healthcare institution that provides treatment to an individual experiencing a behavioral health issue, as defined in A.A.C. R9-10-101. A behavioral health residential facility provides a structured treatment setting with 24-hour supervision and counseling or other therapeutic activities for persons with behavioral health needs. For the purpose of this policy, a behavioral health residential facility is defined as a facility operating using AHCCCS provider type B8 “Behavioral Health Residential Facility”.

H. Cardiologist – A medical doctor who specializes in the diagnosis and treatment of diseases of the heart and blood vessels or the vascular system. An adult Cardiovascular Specialist uses AHCCCS provider types 08 “Physician” or 31 “Osteopath” and with the specialty codes 62 “Cardiovascular Medicine” or 927 “Cardiologist.”

The time and distance for these providers is measured using the Division’s population of members 21 years of age or older.

I. Cardiologist, Pediatric – A medical doctor who specializes in the study or treatment of heart diseases and heart abnormalities. A Pediatric Cardiologist uses AHCCCS provider types 08 “Physician” or 31 “Osteopath” and with the specialty codes 062 “Cardiovascular Medicine”, 151 “Pediatric Cardiologist” or 927 “Cardiologist.”

The time and distance for these providers is measured using the Division’s population of members under 21 years of age.

J. Dentist, Pediatric – A medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. §32-1201. A dentist uses AHCCCS provider type 07 “Dentist” with the specialty codes of 800 “Dentist General” or 804 “Dentist Pediatric.”

The time and distance for these providers is measured using the Division’s
population of members under 21 years of age.

K. **District** – A Service District is a section of Maricopa or Pima County defined by ZIP Code for purposes of establishing and measuring minimum network standards for Developmental Disabilities (DD) Group Homes and Assisted Living Facilities. (See County and District Definitions below.)

L. **Group Home for Persons with Developmental Disabilities** – A residential setting for not more than six persons with developmental disabilities, regulated by the Arizona Department of Economic Security. Refer to A.A.C. R9-33-101 et seq. and A.R.S. § 36-551. A DD Group Home uses AHCCCS provider type 25 “Group Home (Developmentally Disabled).”

M. **Hospital** – A class of healthcare institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient. Refer to A.A.C. R9-10-101 et seq. and A.R.S. § 36-401-437. For purposes of measuring network sufficiency, a hospital uses AHCCCS provider types 02 “Hospital” or C4 “Specialty Pier Diem Hospital.”

N. **In Home Care Services** – Home and Community Based “Critical Services” under ACOM Policy 413. These are Attendant Care, Personal Care, Homemaking, and Respite Care.

O. **Multi-Specialty Interdisciplinary Clinic (MSIC)** – An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

P. **Nursing Facility** – A healthcare institution that provides inpatient beds or resident beds and nursing services to persons who need continuous nursing services but who do not require hospital care or direct daily care from a physician. A Nursing Facility is a healthcare institution using AHCCCS provider type 22 “Nursing Home.”

The time and distance for these providers is measured using the Division’s population of members currently residing in their own home.

Q. **Obstetrician/Gynecologist (OB/GYN)** – A healthcare practitioner responsible for the management of female reproductive health, pregnancy and childbirth needs or who possess special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders. An OB/GYN uses the following AHCCCS provider types:

1. Provider type 08 “Physician”, 19 “Registered Nurse Practitioner” or 31 “Osteopath” and with at least one of the specialty codes:
   a. 089 – Obstetrician/ Gynecologist
   b. 090 – Gynecologist
   c. 091 – Obstetrician
   d. 095 – Women’s HC/OB-GYN NP
e. 181 – Surgery-Obstetrical

f. 219 – Surgery-Gynecological

The time and distance for these providers is measured using the Division’s population of female members between 15 and 45 years of age.

R. Own Home – An ALTCS member’s residential dwelling, including a house, a mobile home, an apartment, or similar shelter. A home is not a facility, a setting, an institution or an ALTCS HCBS approved alternative residential setting.

S. Pharmacy – A facility regulated by the State Board of Pharmacy and operating under A.R.S. §32-1901. A Pharmacy uses AHCCCS provider type 03 “Pharmacy.”

T. Primary Care Physician (PCP), Adult – A healthcare practitioner responsible for the management of a member’s health care. An Adult PCP is a provider using the following AHCCCS provider types:

1. Provider types 08 “Physician” and 31 “Osteopath” with the specialty codes:
   - 050 - Family Practice,
   - 055 - General Practice,
   - 060 - Internal Medicine,
   - 089 - Obstetrician and Gynecologist, or,
   - 091 - Obstetrician.

2. Provider type 19 “Registered Nurse Practitioner” with the specialty codes:
   a. 084 - RN Family Nurse Practitioner,
   b. 095 - Women’s HC/OB-GYN NP, or
   c. 097 - RN Adult Nurse Practitioner.

3. Provider type 18 “Physician Assistant” with the specialty code 798 Physician’s Assistant.

   The time and distance for these providers is measured using the Division’s population of members 21 years of age or older.

U. Primary Care Physician (PCP), Pediatric – A healthcare practitioner responsible for the management of a member’s pediatric health care needs. A Pediatric PCP uses the following AHCCCS provider types:

1. Provider types 08 “Physician” or 31 “Osteopath” and with at least one of the specialty codes:
   a. 050 - Family Practice,
b. 150 - Pediatrician, or

c. 176 - Adolescent Medicine.

2. Provider type 19 “Registered Nurse Practitioner” with at least one of the specialty codes:

   a. 084 - RN Family Nurse Practitioner,
   b. 87 - RN Pediatric Nurse Practitioner, or,
   c. 097 - RN Adult Nurse Practitioner.

3. Provider type 18 “Physician Assistant” with the specialty code 798 Physician’s Assistant.

   The time and distance for these providers is measured using the Division’s population of members under 21 years of age.

V. Provider Affiliation Transmission (PAT) File – A data file which provides details of the providers within the Division’s network and is used to measure compliance with this policy.

County and District Definitions

Split ZIP Codes occur in some counties. Split ZIP Codes are those which straddle two counties. Enrollment for members residing in these zip codes is based on the county and to which the entire zip code has been assigned by AHCCCS. The Division is responsible for ensuring that all members residing in the ZIP Code are fully able to access care. Split ZIP Codes are assigned as follows:

<table>
<thead>
<tr>
<th>ZIP CODE</th>
<th>SPLIT BETWEEN THESE COUNTIES</th>
<th>COUNTY ASSIGNED TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>85140</td>
<td>Pinal and Maricopa</td>
<td>Maricopa</td>
</tr>
<tr>
<td>85120</td>
<td>Pinal and Maricopa</td>
<td>Maricopa</td>
</tr>
<tr>
<td>85142</td>
<td>Pinal and Maricopa</td>
<td>Maricopa</td>
</tr>
<tr>
<td>85342</td>
<td>Yavapai and Maricopa</td>
<td>Maricopa</td>
</tr>
<tr>
<td>85390</td>
<td>Yavapai and Maricopa</td>
<td>Maricopa</td>
</tr>
<tr>
<td>85643</td>
<td>Graham and Cochise</td>
<td>Cochise</td>
</tr>
<tr>
<td>85645</td>
<td>Pima and Santa Cruz</td>
<td>Santa Cruz</td>
</tr>
<tr>
<td>85943</td>
<td>Apache and Navajo</td>
<td>Navajo</td>
</tr>
<tr>
<td>86336</td>
<td>Coconino and Yavapai</td>
<td>Yavapai</td>
</tr>
<tr>
<td>86351</td>
<td>Coconino and Yavapai</td>
<td>Coconino</td>
</tr>
</tbody>
</table>
The following ZIP Codes have been reassigned outside of their originally assigned counties:

<table>
<thead>
<tr>
<th>ZIP CODE</th>
<th>ORIGINAL COUNTY ASSIGNED</th>
<th>COUNTY RE-ASSIGNMENT 10/1/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>85192</td>
<td>Gila and Pinal</td>
<td>Graham</td>
</tr>
<tr>
<td>85542</td>
<td>Gila and Pinal</td>
<td>Graham</td>
</tr>
<tr>
<td>85550</td>
<td>Gila and Pinal</td>
<td>Graham</td>
</tr>
</tbody>
</table>

Maricopa and Pima Counties are further subdivided into districts. Below is the definition of these districts:

<table>
<thead>
<tr>
<th>MARICOPA DISTRICT</th>
<th>DESCRIPTION</th>
<th>ZIP CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DISTRICT 1</strong></td>
<td>Phoenix</td>
<td>85022, 85023, 85024, 85027, 85029, 85032, 85054, 85050, 85053, 85085, 85086, 85087, 85254, 85324, 85331</td>
</tr>
<tr>
<td><strong>DISTRICT 2</strong></td>
<td>Carefree, Cave Creek, Fountain Hills and Scottsdale</td>
<td>85250, 85251, 85255, 85256, 85257, 85258, 85259, 85260, 85262, 85263, 85264, 85268</td>
</tr>
<tr>
<td><strong>DISTRICT 3</strong></td>
<td>Phoenix</td>
<td>85012, 85013, 85014, 85015, 85016, 85017, 85018, 85019, 85020, 85021, 85028, 85051, 85253</td>
</tr>
<tr>
<td><strong>DISTRICT 4</strong></td>
<td>Phoenix</td>
<td>85003, 85004, 85006, 85007, 85008, 85009, 85025, 85034, 85040, 85041, 85042, 85044, 85045, 85048</td>
</tr>
<tr>
<td><strong>DISTRICT 5</strong></td>
<td>Buckeye, Goodyear, Phoenix, Tolleson and Gila Bend</td>
<td>85031, 85033, 85035, 85037, 85043, 85322, 85323, 85326, 85338, 85339, 85353, 85337</td>
</tr>
<tr>
<td><strong>DISTRICT 6</strong></td>
<td>Glendale</td>
<td>85301, 85302, 85303, 85304, 85305, 85306, 85308, 85310</td>
</tr>
</tbody>
</table>
### Districts and ZIP Codes

<table>
<thead>
<tr>
<th>DISTRICT 7</th>
<th>Description</th>
<th>ZIP Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Mirage, Peoria, Sun City, Sun City West, Surprise and Wickenburg</td>
<td></td>
<td>85275, 85307, 85309, 85335, 85340, 85342, 85345, 85351, 85355, 85361, 85363, 85373, 85374, 85375, 85379, 85381, 85382, 85383, 85387, 85388, 85390, 85395, 85396</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISTRICT 8</th>
<th>Description</th>
<th>ZIP Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mesa, Tempe</td>
<td></td>
<td>85120, 85201, 85202, 85203, 85204, 85205, 85206, 85207, 85208, 85209, 85210, 85212, 85213, 85215, 85218, 85219, 85220, 85256, 85281, 85282</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DISTRICT 9</th>
<th>Description</th>
<th>ZIP Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chandler, Tempe, Gilbert, Queen Creek and Sun Lakes</td>
<td></td>
<td>85140, 85142, 85143, 85222, 85224, 85225, 85226, 85233, 85234, 85242, 85243, 85248, 85249, 85283, 85284, 85296, 85297</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PIMA DISTRICT</th>
<th>DESCRIPTION</th>
<th>ZIP CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DISTRICT 1</td>
<td>Northwest</td>
<td>85321, 85653, 85658, 85701, 85704, 85705, 85737, 85739, 85741, 85742, 85743, 85745, 85755</td>
</tr>
<tr>
<td>DISTRICT 2</td>
<td>Northeast</td>
<td>85619, 85702, 85712, 85715, 85716, 85718, 85719, 85749, 85750</td>
</tr>
<tr>
<td>DISTRICT 3</td>
<td>Southwest</td>
<td>85601, 85614, 85622, 85629, 85713, 85714, 85723, 85724, 85735, 85736, 85746, 85757</td>
</tr>
<tr>
<td>DISTRICT 4</td>
<td>Southeast</td>
<td>85641, 85706, 85708, 85710, 85711, 85730, 85747, 85748</td>
</tr>
</tbody>
</table>

### Statewide Time and Distance Network Standards

For each county in the assigned service area, the Division monitors its AdSSs to ensure there is a network in place to meet time and distance standards outlined below:

A. Behavioral Health Outpatient and Integrated Clinic, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence,

2. All Other Counties – 90% of membership does not need to travel more than 60 miles from their residence.
The time and distance for these providers is measured using the Division’s population of members 18 years of age or older.

B. Behavioral Health Outpatient and Integrated Clinic

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence,

2. All Other Counties – 90% of membership does not need to travel more than 60 miles from their residence.

The time and distance for these providers is measured using the Division’s population of members under 18 years of age.

C. Behavioral Health Residential Facility

1. Maricopa, Pima - 90% of membership does not need to travel more than 30 minutes or 10 miles from their residence,

2. All Other Counties – The Division shall report the time and distance that 90% of their membership must travel from the member’s original residence to reach a contracted Behavioral Health Residential Facility.

D. Cardiologist, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 30 minutes or 20 miles from their residence.

2. All Other Counties – 90% of membership does not need to travel more than 75 minutes or 60 miles from their residence.

The time and distance for these providers is measured using the Division’s population of members 21 years of age or older.

E. Cardiologist, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 60 minutes or 45 miles from their residence.

2. All Other Counties – 90% of membership does not need to travel more than 110 minutes or 100 miles from their residence.

The time and distance for these providers is measured using the Division’s population of members under 21 years of age.

F. Dentist, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence.

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence.
The time and distance for these providers is measured using the Division’s population of members under 21 years of age.

G. Hospital
1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence.
2. All Other Counties – 90% of membership does not need to travel more than 95 minutes or 85 miles from their residence.

H. OB/GYN
1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence.
2. All Other Counties – 90% of membership does not need to travel more than 90 minutes or 75 miles from their residence.

The time and distance for these providers is measured using the Division’s population of female members 15 to 45 years old.

I. Pharmacy
1. Maricopa, Pima - 90% of membership does not need to travel more than 12 minutes or 8 miles from their residence.
2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence.

J. PCP, Adult
1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence.
2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence.

The time and distance for these providers is measured using the Division’s population of members 21 years of age or older.

K. PCP, Pediatric
1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence.
2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence.

The time and distance for these providers is measured using the Division’s population of members under 21 years of age.
Other Statewide Network Standards

In addition to the time and distance standards outlined above, the Division shall document a sufficient network to meet the service needs of its members based upon the minimum network requirements delineated in ACOM 436 Attachment A (Herein after referred to as Attachment A).

A. DD Group Home, Assisted Living Center and Assisted Living Home Standards

1. The Division shall have contracts with a minimum number of ALC, AFC and ALH providers as identified in Attachment A. The Division contracts with a minimum number of DD Group Homes as identified in Attachment A.

2. Attachment A includes a tab detailing the minimum network requirements for DDD Contractors. Network requirements include minimum contracts within a specific city or group of cities, contracts within specified distances to specific cities, or minimum contracts within a county. In certain instances, locations outside of a county’s boundary have been identified. This is to allow members to access services in the most geographically convenient location possible and to prevent members from traveling much greater distances to obtain care, and at the same time accommodate network availability in each county.

B. Statewide In Home Care Network Standards

1. In order to comply with Home Care network standards for critical in home care services, i.e., Attendant Care, Personal Care, Homemaking, and Respite Care, the Division shall ensure that the total gap hours represent no more than 0.05% of critical services scheduled in a given month as reported in its monthly Gap in Services Log. (See ACOM Policy 413)

C. Multi-Specialty Interdisciplinary Clinic (MSIC) Network Standards

1. The Administrative Services Subcontractor (AdSS) is expected to contract with all MSICs in the state, as well as any MSICs which have provided services to the AdSS’ members.

The AdSS must identify all contracted MSICS in Attachment A, including any multispecialty interdisciplinary care providers it has contracted with and the AHCCCS approval date.

In the event the AdSS and an MSIC fail to negotiate a contract, the AdSS must continue to allow members to utilize the MSIC. In the absence of a contract, the AdSS shall reimburse the MSIC at the AHCCCS MSIC fee schedule.

D. Mobile Crisis Team Requirements are delegated to the Division’s administrative services subcontracted health plans.

1. Health Plans that serve Maricopa County shall require mobile crisis teams to respond on site within an average of 60 minutes of receipt of the call.

2. Health Plans that serve all other areas of the state shall require mobile crisis teams to respond on site within an average of 90 minutes of receipt of the
3. Health Plans will report in Attachment A the minimum, maximum, mean and median response times in their area for each of the months in the reporting quarter.

**Network Oversight Requirements**

A. Minimum Network Standards Reporting Requirements

1. The Division shall submit a completed Attachment A to AHCCCS reporting its compliance with time and distance standards, as applicable. The Division shall report compliance with these requirements for each county in its assigned service area. A separate report shall be submitted for each line of business.

2. The Division must analyze compliance with these standards based upon:
   a. AdSSs through Provider Affiliation Transmission (PAT) File; and
   b. Contracted Qualified Vendor provider network reported through the Division’s Provider Affiliation Transmission (PAT) and the Gap in Services Log.
   c. With the submission of Attachment A, the Division shall include a summary, at a minimum, of the following:
      i. Strategies and efforts to address any areas of non-compliance;
      ii. A summary of exceptions granted to the network standards, as outlined in ACOM 436, and the results of monitoring member access to the services governed under the exception;
      iii. Any areas of non-compliance by its subcontracted health plans with network standards outlined in this policy, including strategies and efforts to address areas of non-compliance.
   d. An assessment of the Subcontracted Health Plans’ Mobile Crisis Team compliance with the response time requirements, addressing any patterns, trends or corrective action taken.

B. Network Planning Requirements

1. The Division shall take steps to ensure these network standards are maintained. If established network standards cannot be met, the Division will identify these gaps and address short- and long-term interventions in the Network Development and Management Plan as outlined in ACOM Policy 415. When an exception has been granted, the Division will address the sufficiency of member access to the area and assess the continued need for the exception.

2. The Division and its subcontracted health plans shall review their networks for
compliance with this policy. The Division shall report to AHCCCS its subcontracted health plans' network gaps, and short- and long-term interventions to address the gaps, in its annual Network Development and Management Plan as outlined in ACOM Policy 415.
438 ADMINISTRATIVE SERVICES SUBCONTRACTS

EFFECTIVE DATE: May 13, 2016

Purpose

This policy establishes guidelines and requirements for Administrative Services Subcontracts, monitoring subcontractor performance, reporting performance review results, and notifying the appropriate entity of subcontractor non-compliance and corrective action plans (CAP).

Administrative Services Subcontracts

An Administrative Services Subcontract is an agreement that delegates any of the requirements of the contract with AHCCCS, including but not limited to:

A. Claims processing, including pharmacy claims
B. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization)
C. Management Service Agreements
D. Service Level Agreements with the Division or one of its subcontractors
E. DDD acute care and behavioral health subcontractors

Providers are not Administrative Services Subcontractors.

Change in Organizational Structure

A change in organizational structure is any of the following:

A. Merger
B. Acquisition
C. Reorganization
D. Change in Articles of Incorporation
E. Joint Venture
F. Change in Ownership
G. State Agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature
H. Change of Management Services Agreement (MSA) Subcontractor
I. Other applicable changes which may cause:

J. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)

K. Changes in critical member information, including the website, member or provider handbook and member ID card

L. A change in legal entity name

**Management Service Agreement**

A Management Service Agreement is a type of subcontract in which the Division delegates all or substantially all management and administrative services necessary for the provision of acute or behavioral health services as required in AHCCCS contract.

**Provider**

A provider is any person or entity that contracts with the Division for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901. Qualified Vendors are Providers.

**Approval of Subcontracts**

The Division submits all Administrative Services Subcontracts with the Administrative Services Subcontract Checklist to the AHCCCS Division of HealthCare Management for prior approval, 60 days before the effective date of the subcontract.

A. The Division retains the authority to direct and prioritize any delegated contract requirements.

B. The Division requires that Administrative Services Subcontractors meet any performance standards applicable to the delegated services as mandated by AHCCCS.

C. The Division ensures the agreement contains a provision stating that a merger, reorganization, or change in ownership requires a contract amendment and prior approval of AHCCCS.

D. The Division ensures that any reorganization related to an MSA Subcontractor is submitted in accordance with ACOM Policy 317. Additionally, the Division will:

   1. Upon request, submit copies of Requests for Proposals (RFPs) at the time they are formally issued to the public including any RFP amendments.

   2. Submit final, signed copies of each contract which it enters into with subcontractors and any subsequent amendments within 30 days of signature date.

   3. Ensure its subcontractors communicate with the provider network regarding program standards, changes in laws, policies and contract changes.
**Monitoring And Reporting**

A. The Division monitors the Administrative Services Subcontractor’s performance on an ongoing basis and completes a formal review at least annually (42 CFR 438.230).

B. The formal review includes a review of delegated duties, responsibilities, and financial position. Administrative Services Subcontractors who are state agencies or sovereign nations are not subject to a financial review.

1. The Division prepares written findings of the review.
2. The Division requires the subcontractor to prepare a written response to findings of non-compliance.
3. The Division increases monitoring activities until compliance is achieved and maintained.
4. The Division notifies AHCCCS within 30 days of the discovery of an Administrative Service Subcontractor’s non-compliance.

C. The notification includes:

1. The subcontractor’s name
2. Delegated duties and responsibilities
3. Identified areas of non-compliance and whether the non-compliance affects member services or causes a quality of care concern
4. The scope and estimated impact of the non-compliance upon members
5. The known or estimated length of time that the subcontractor has been in non-compliance
6. The Division’s Corrective Action Plan (CAP) or strategies to bring the Administrative Services Subcontractor into compliance
7. Sanction actions that may be taken because of the non-compliance
8. The Division informs AHCCCS of activities that are occurring to bring the subcontractor into compliance.

**Administrative Services Subcontractor Evaluation Report**

The Division submits the annual Administrative Services Subcontractor Evaluation Report within 90 days of the start of the AHCCCS contract.

A. The Administrative Services Subcontractor Evaluation Report includes the following:

1. The name of the subcontractor
2. The delegated duties and responsibilities
3. The date of the most recent formal review of the duties, responsibilities and financial position, as appropriate, of the subcontractor.

4. A comprehensive summary of the evaluation of the performance (operational and financial as appropriate) of the subcontractor, including the type of review performed.

5. The next scheduled formal review date.

6. All identified areas of deficiency; including, but not limited to those which:
   a. Affect member services; and/or
   b. Cause a quality of care concern.

7. CAP Information, including:
   a. Any corrective action plans that occurred due to monitoring since the last Administrative Services Subcontractor Evaluation Report.
   b. Any Division or subcontractor CAPs resulting from the annual formal review; and
   c. Date reported to AHCCCS.
   d. Current status of CAPs.

**Additional Requirements**

A. All Administrative Services Subcontracts reference and require compliance with the AHCCCS Minimum Subcontract Provisions available on the AHCCCS website.

B. When a modification to the AHCCCS Minimum Subcontract Provisions occurs, the Division issues a notification and amends Administrative Services Subcontracts.

C. All Administrative Services Subcontracts must reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436 and SMDL09-001. Administrative Services Subcontractors disclose to the Division the identity of any excluded person.

D. All Administrative Services Subcontracts entered into by the Division are subject to review and approval by AHCCCS.

E. All Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the corresponding AHCCCS Medicaid Contract.

F. The Division maintains a fully executed original or electronic copy of all Administrative Services Subcontracts, which is be accessible to AHCCCS within five business days of the request by AHCCCS according to contract requirements.
G. The Division ensures that all member communications furnished by the Administrative Services Subcontractor include the Division’s name.

H. Before entering into an Administrative Services Subcontract, the Division evaluates the prospective Administrative Services Subcontractor’s ability to perform the delegated duties.

I. In the event the Division terminates a subcontract, the Division ensures compliance with all aspects of the AHCCCS Medicaid Contract notwithstanding the subcontractor termination, including availability and access to all covered services and provision of covered services to members within the required timeliness standards.

Attachment A, Administrative Services Subcontract Checklist

See the ACOM webpage for Attachment A of this policy

Attachment B, Administrative Services Subcontractor Evaluation Report Template

See the ACOM webpage for Attachment B of this policy
439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: June 10, 2016
REFERENCES: 9 A.A.C. 22, Article 1; 42 CFR 438.207, 42 CFR 438.10(f) (4), 42 CFR 438.10(f) (5).

The Division ensures that performance and provider network standards are met to support a member’s needs, as well as the needs of the membership as a whole. Changes to business operations or to the provider network are evaluated for the impact to members and providers.

Identifying A Provider Network and/or Business Operations Material Change

A. For changes impacting members and/or providers, the Division evaluates the impact of the change by geographical service area and as a whole using established criteria and/or methodology for determining the impact of the change.

B. Provider Network changes may include, but are not limited to:
   1. Changes in services,
   2. Geographic service areas, or
   3. Payments.

C. Changes may also include the addition or change in:
   1. Pharmacy Benefit Manager (PBM),
   2. Dental Benefit Manager,
   3. Acute Health Plan,
   4. Provider Contracts (e.g. group homes, nursing facility), and
   5. Any other delegated agreements.

D. Business Operations changes may include, but are not limited to:
   1. Policy,
   2. Process, and
   3. Protocol, such as prior authorization or retrospective review.

E. Changes may also include the addition or change in:
   1. Claims Processing system,
2. System changes and upgrades,
3. Member ID Card vendor,
4. Call center system,
5. Management Service Agreement (MSA), and
6. Any other Administrative Services Subcontract.

F. The Division will submit approval for a material change to AHCCCS, at least 60 days in advance of the material change.

G. Any alteration or development within the provider network that may reasonably be foreseen to affect the quality or delivery of services provided will be communicated to affected providers at least 30 days in advance of the change as identified in Operations Policy Manual Chapter 60, Notification to Providers.

H. The Division will provide written notice to members within 15 days after receipt or issuance of a provider termination notice.

General Notifications

A. The Division provides notification via provider meetings, email (e.g., Vendor Blast), or US mail:
   1. For routine changes and updates to AHCCCS Guidelines, Policy, Manual Changes, and any other information that AHCCCS may require the Division to disseminate on behalf of the Administration.
   2. For routine changes and updates to Division Guidelines, Policy/Provider Manual.
   3. For changes to the AHCCCS Minimum Subcontract, within 30 calendar days of the published change.
   4. To disseminate information designed to bring the providers into compliance with Disease/Chronic Care Management practice guidelines.

B. Qualified Vendors are required to maintain and update Primary Contract Contact information to receive provider notifications.

C. Communication with Independent Providers is via US mail.

D. Communication with Administrative Services Subcontractors (AdSS) is not duplicated if the AdSS is also contracted with AHCCCS.
446 GRIEVANCES AND INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS

REVISION DATE: 12/04/2019
EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS Contractor Operations Manual (ACOM), Policy 446

This Policy applies to the Division of Developmental Disabilities and their subcontractors and outlines procedures related to grievances and investigations conducted by AHCCCS and the subcontractors under A.A.C. R9-21-402 et seq. concerning persons with a Serious Mental Illness (SMI).

A. This Policy applies to grievances or requests for investigation asserted by, or on behalf of, persons designated with a SMI to the extent the allegation asserts a violation relating to the right to receive services, supports and/or treatment that are state-funded and are no longer funded by the state.

1. For persons designated as SMI, AHCCCS, the Division, and its subcontractor conduct investigations into allegations of physical abuse, sexual abuse, violations of SMI rights, and conditions that are dangerous, illegal, or inhumane. Investigations may also be conducted in the event of a member’s death that occurs in a mental health agency or as a result of an action of a person employed by a mental health agency.

   a. Refer to AHCCCS Contractor Operations Manual, Chapter 400-Operations, 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness for full details and requirements of such grievance investigations.

2. AHCCCS, or the Contractor before whom a grievance or request for investigation is pending, must immediately take whatever action may be reasonable to protect the health, safety, and security of any member, complainant, or witness.

B. Grievances involving an alleged rights violation, or a request for investigation involving an allegation where a condition requiring investigation exists, which occurred in an agency operated by a Division Subcontractor or one of its subcontracted providers and which does not involve a member’s death or an allegation of physical or sexual abuse, must be filed with and investigated by the subcontractor.

C. The DDD Customer Service Center must refer any grievances or requests for investigation related to physical or sexual abuse or death to AHCCCS to begin the investigative process.

D. Support Coordinators must complete DDD-2044A FORENG (11-19) Serious Mental Illness Grievance and Appeal Form and send the form to DDD Customer Service Center (CSC) for the Division’s internal use when a member with an SMI designation wants to file a grievance or appeal. This serves as the Division’s notice of the grievance and appeal. The notice will allow the Division to effectively monitor the grievance or appeal and ensure it is resolved by the proper entity and within the...
E. Once notified, CSC will open a grievance in the Resolution System (RS) for violations related to member’s rights.

1. The grievance procedure must follow the same procedure as other CSC grievances.

2. The purpose of this grievance policy is to ensure the subcontractor is investigating the matter properly and in a timely fashion, pursuant to the clauses outlined in the AHCCCS Operations Manual, Chapter 400, 446 – Grievances and Investigations Concerning Persons with Serious Mental Illness.

F. A grievant or the DDD member who is the subject of the grievance, who disagrees with the final decision of the subcontractor may file a request for an administrative appeal with AHCCCS within 30 days from the date of their receipt of the subcontractor’s decision. The request for administrative appeal must specify the basis for disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the subcontractor decision.

G. When an administrative appeal is filed, the subcontractor must forward the full investigation case record, which includes all elements described in A.A.C. R9-21-409(D)(1), to AHCCCS. The failure of the subcontractor to forward a full investigation case record that supports the subcontractor’s decision may result in a summary determination against the subcontractor. The subcontractor must prepare and send with the investigation case record, a memo which states:

1. Any objections the subcontractor has to the timeliness of the administrative appeal,

2. The subcontractor’s response to any information provided in the administrative appeal that was not addressed in the investigation report, and

3. The subcontractor’s understanding of the basis for the administrative appeal.

H. If an extension of any time frame related to the grievance process is needed, it must be requested and approved in compliance with A.A.C. R9-21-410(B). Specifically:

1. The subcontractor investigator or any other subcontractor official responsible for responding to grievances must address the extension request to the subcontractor Director or designee.

2. The AHCCCS investigator or any other AHCCCS official responsible for responding to grievances must address the extension request to the AHCCCS Deputy Director or designee.

3. A subcontractor request for an extension to complete an investigation for grievances remanded pursuant to A.A.C. R9-21-407(B)(2) or any other time period established by AHCCCS decisions relating to a grievance must be addressed to the AHCCCS Deputy Director or designee.

4. Requests for extension must be in writing, with copies to all parties.
5. An extension of time may only be granted upon a showing of necessity and a showing that the delay will not pose a threat to the safety or security of the member.

6. The request must explain why an extension is needed and propose a new time limit which does not unreasonably postpone a final resolution of the matter.

7. Such request must be submitted to and acted upon prior to the expiration of the original time limit. Failure of the relevant official to act within the time allowed constitutes a denial of the request for an extension.

I. Within 15 days of receipt of a timely filed administrative appeal, AHCCCS must review the appeal and the investigation case record and may discuss the matter with any of the persons involved or convene an informal conference, and must prepare a written, dated decision.

1. A grievant or person who is the subject of the grievance who is dissatisfied with a decision of AHCCCS may request an administrative hearing before an administrative law judge within 30 days of the date of receipt of the decision.

J. American Indian Health Program (AIHP) who serve members that are diagnosed with an SMI diagnosis will follow the same grievance process as outlined above.

K. In addition to a grievance or request for investigation which may be filed pursuant to this Policy and A.A.C. Title 9, Chapter 21, Article 4, a separate investigation into the death of a person receiving services must be conducted as described in AMPM Policy 960.

L. Grievance Investigation Records: AHCCCS and the subcontractor will maintain records in the following manner:

1. All documentation received related to the grievance and investigation process will be date stamped on the day received.

2. A complete grievance investigation case record must be maintained for each case.

3. Copies of all information generated or obtained during the investigation.

4. All grievance and investigation files in a secure designated area and retain for at least five years.

5. A public log of all grievances or requests for investigation in accordance with A.A.C. R9-21-409(E).

6. Confidentiality and privacy of grievance and investigations records.

7. The complete grievance investigation case must include:
   a. The original grievance/investigation request letter and the AHCCCS Appeal or SMI Grievance Form, and
   b. Copies of all information generated or obtained during the
8. The investigator’s report that includes:
   a. A description of the grievance issue,
   b. Documentation of the investigative process,
   c. Names of all persons interviewed,
   d. Written documentation of the interviews,
   e. Summary of all documents reviewed,
   f. The investigator’s findings.
   g. Conclusions and recommendations.
   h. A copy of:
      i. The acknowledgment letter,
      ii. Final decision letter,
      iii. Corrective action documentation, and
      iv. Any information/documentation generated by an appeal of the grievance decision.
449 BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DEPARTMENT OF CHILD SAFETY CUSTODY AND ADOPTED CHILDREN

EFFECTIVE DATE: November 29, 2018
REFERENCES: A.R.S. § 8-451; A.R.S. § 8-512.01; Section F3, Contractor Chart of Deliverables

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Operations Manual Policy 449 Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children for the Division policy governing AdSS responsibilities regarding this topic.
1001-A  BASIC HUMAN AND DISABILITY RELATED RIGHTS

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S §§ 23-363, 36-551(01)(0), 36-554(A)(l 0), 36-568(01), 41-3801, 8-533; 41-1492 et seq., 41-1959; A.A.C. R6-6-102(C), R6-6-104, R6-6-107, R6-6-804(9), R6-6-901, R6-6-901-910 et seq., R6-6-1801 et seq., R6-6-2002-2003; 42 CFR 438.420(a).

Arizona Revised Statutes (A.R.S.) clearly recognizes that a person with a developmental disability has the rights, benefits, and privileges guaranteed by the constitutions and laws of the United States and the State of Arizona.

The rights of a person with a developmental disability receiving supports and services through the Division include the:

A. Right to an initial Individual Support Plan/Individualized Family Services Plan (ISP/IFSP) planning document prior to receiving supports and services;
B. Right to participate in the ISP/IFSP, periodic evaluations, and whenever possible, the opportunity to select among appropriate alternative supports and services;
C. Right (once accepted for supports and services) to participate and share in decision making, and to receive a written ISP based upon relevant results of the placement evaluation;
D. Right to information regarding the supports and services available through a provider and about related charges, including any fees for supports and services not covered by a third-party payor;
E. Right to a periodic review of the ISP/IFSP planning document;
F. Right to be given written notice of his/her rights;
G. Right to exercise his/her rights as a citizen;
H. Right to live in the least restrictive setting. A least restrictive setting refers to an environment in which a member strives to reach his/her full potential in accordance to the tenets of self-determination;
I. Right to protection from physical, verbal, sexual, psychological abuse, or punishment;
J. Right to equal employment opportunity;
K. Right to fair compensation for labor;
L. Right to own, rent, or lease property;
M. Right to marry and have children;
N. Right to be free from involuntary sterilization;

O. Right to express human sexuality and receive appropriate training;

P. Right to consume alcoholic beverages if 21 years of age or older unless contraindicated by orders of his/her primary care provider or the court;

Q. Right to presumption of legal competency in guardianship proceedings;

R. Right to be free from unnecessary and excessive medication;

S. Right to be accorded privacy during treatment and care of personal needs;

T. Right to confidentiality of information and medical records;

U. Right of a school age member to receive publicly supported educational services;

V. Right of a child to receive appropriate supports and services, subject to available appropriations, which do not require the relinquishment or restriction of parental rights or custody, except as prescribed in A.R.S. § 8-533, which describes the grounds needed to justify the termination of the parent-child relationship;

W. Right to consent to or withhold consent from participation in a research project approved by the Division management team or any other research project; right to knowledge regarding the nature of the research, potential effects of a treatment procedure as part of a research project; right to confidentiality; and the right to withdraw from the research project at any time;

X. Right of a person who believes his/her, rights have been violated to petition the Superior Court for redress, unless other remedies exist under federal or State laws;

Y. Right to withdraw from programs, supports and services, unless the member was assigned to the Department by the juvenile court or placed in a secure facility by the guardian and court;

Z. Right to an administrative review, if in disagreement with a decision made by the Division, by filing a verbal or written request for such with the DDD Office of Compliance and Review, and the right to appeal the decision;

AA. Right to contact the Human Rights Committee;

BB. Right to be free from personal and financial exploitation; and,

CC. The right to have care for personal need provided, except for cases of emergency, by a direct care staff of the gender chosen by the responsible person, this choice shall be specified in the Planning Document.
1001-B RESPONSIBILITIES OF INDIVIDUALS APPLYING FOR AND/OR RECEIVING SUPPORTS AND SERVICES

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

Applying for and/or receiving supports and services individuals with developmental disabilities are to be supported in exercising the same rights and choices and afforded the same opportunities enjoyed by other citizens. The Division provides this support by following the principles of self-determination. Self-determination is the ability of a member to make choices that allow him/her to exert control over his/her life and destiny, to reach the goals he/she has set, and take part fully in the world around him/her. To be self-determined requires that a member has the freedom to be in charge of his/her life, choosing where to live, who to spend his/her time with and how to spend his/her time. Decisions made by the member about his/her quality of life shall be without undue influence or interference of others. Self-determination also necessitates that the member has the resources needed to make responsible decisions.

Self-determination is necessary because people who have disabilities often desire greater control of their lives so they can experience the life they envision for themselves, one that is consistent with their own values, preferences, strengths and needs. For individuals receiving services through the Division, one way to exert greater control of their lives is to choose the supports and services they receive and who provides that support. The Division offers many options for a member wanting to make more choices about services and supports, such as:

A. Selecting a Support Coordinator;
B. Selecting and directing their planning process, either an Individual Support Plan and/or a Person-Centered Plan;
C. Selecting service providers, both qualified vendors and individual independent providers;
D. Hiring, managing, and firing service providers;
E. Using a fiscal intermediary to manage the financial aspects of having a service provider who is his/her employee; and,
F. Having the spouse serve as his/her provider.
1001-C  RIGHTS OF PERSONS WITH DEVELOPMENTAL DISABILITIES LIVING IN RESIDENTIAL SETTINGS

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S §§ 23-363; A.A.C. R6-6-901 et seq., R6-6-107; CFR 438.420(a).

Additional rights of persons with developmental disabilities who reside in residential settings such as Group Homes, Adult and Child Developmental Homes, or an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) include the basic human and disability-related rights listed previously. Because of the special circumstances of living in a residential facility, specific rights have been delineated. These rights include the:

A. Right to be informed of the rules of the residential setting in which he/she is living;
B. Right to impartial access to treatment and/or accommodations;
C. Right to a safe, humane, and clean physical environment;
D. Right to communicate with those responsible for his/her care;
E. Right to choose his/her personal care provider from the health plan(s) available;
F. Right to be informed of his/her medical condition, of any technical procedures that will be performed, of the identity of the persons who will perform the procedures, attendant risks of treatment and the right to refuse treatment;
G. Right to be free from unnecessary drugs and physical restraints, except as authorized in writing by a physician for a specified time period and in accordance with the Division rules regarding behavior supports;
H. Right to a physical examination, prompt medical attention, and to adequate food and water;
I. Right to his/her own bed;
J. Right to personal clothing and possessions as space permits, unless this infringes on the rights of others or is medically contraindicated;
K. Right to be accorded privacy with regard to written correspondence, telephone communication, and visitors;
L. Right of a husband and wife who both reside in a facility to share a room;
M. Right to privacy during visits by a spouse;
N. Right to refuse to talk with or see someone;
O. Right to participate in social, religious, and community group activities;
P. Right to manage his/her own financial affairs and to be taught to do so to the extent of his/her capabilities;

Q. Right to refuse to perform services for the facility, but if he/she does provide services, right to be compensated at prevailing wages commensurate within state and federal laws and as prescribed by the Industrial Commission;

R. Right to have the Division supervisors advised of any unusual incident.

S. Right to file a grievance not only with the Division but also with his/her health plan, the Arizona Long Term Care System (ALTCS) and Arizona Health Care Cost Containment System (AHCCCS);

T. Right to the least amount of physical assistance necessary to accomplish a task; and,

U. Right to have care for personal needs provided, except in cases of emergency, by a direct care staff of the gender chosen by the individual/responsible person. This choice shall be specified in the ISP/IFSP planning document.
1001-D PROGRAM VALUES AND GUIDING PRINCIPLES

EFFECTIVE DATE: October 1, 2019
INTENDED USER(S): Health Care Services, Quality Management, Support Coordinators

Purpose: To outline the Division’s Arizona Long Term Care Services-Developmental Disabilities (ALTCS-DD) program values and guiding principles in providing long term services and supports to members with intellectual and developmental disabilities.

Program Values

The mission of the Division of Developmental Disabilities (DDD, the Division) is to empower Arizonans with developmental disabilities to lead self-directed, healthy, and meaningful lives. The Division’s provision of services and supports shall reflect the following member values:

A. Choice: Members have the freedom to choose how they want to live their lives. They have a right to an everyday life; a life that is no different than that of all other Arizonans.

B. Dignity: The Division affirms the primary importance of allowing members to exercise their moral right of self-determination. Members also have the right to take reasonable risks which are essential for dignity and self-esteem.

C. Independence: Members must be able to live in homes of their choice and choose the supports they need.

D. Individuality: Members have the right to an individualized plan which takes into account their right to participate in family, community, and work, and supports their hopes, dreams, and goals.

E. Privacy: The Division respects the member’s right to privacy in their daily life and in the treatment and care of their personal needs; privacy that is no different than that of all other Arizonans.

F. Self-determination: Members have the authority to exert control over their lives, to direct their services, and to act on their own behalf.

Program Guiding Principles

The Division shall manage and deliver services and supports to members in a manner which is consistent with the following guiding principles:

A. Member-Centered Services

The member is the primary focus. The member, member’s family and/or responsible person, as appropriate, are active participants in the planning, identification and evaluation of physical, behavioral, and long term services and supports. Services are mutually selected through person-centered planning to assist the member in attaining his/her goal(s) for achieving or maintaining his/her highest level of self-sufficiency. Up-to-date information about the ALTCS-DD program, choices of options and a mix of
services is readily available to members and presented in a manner that facilitates the member’s ability to understand the information.

B. Employment First Philosophy

The Division supports Employment First Principles, Policy and Practice, which include the following:

1. Competitive integrated employment is the preferred daily service and outcome for all working age Arizonans who have disabilities.

2. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.

3. Employment First supports an overarching goal that eligible individuals with disabilities will have access to integrated work settings most appropriate for them, including the supports necessary to help them succeed in the workplace.

4. Employment First does not mean employment only and does not deny individual choice.

5. Employment First does not eliminate service options currently available but is intended to increase employment opportunities.

C. Member-Directed Options for Accessing Cost-Effective, Covered Services

Members are afforded the opportunity to manage their personal health and development by making decisions to the maximum extent possible about how best to have needs met including who will provide the service and when and how the services will be provided.

D. Person-Centered Planning

Person-Centered Planning is a continuous problem solving process used to assist members to plan for their future. The focus is on helping members to develop personal relationships, participate in the community, increase control and autonomy over their own lives and develop the skills and abilities needed to achieve their goals. Person-Centered Planning maximizes member-direction and supports the member in making informed decisions, so that he/she can lead/participate in the process to the fullest extent possible. The Planning Document developed through this process safeguards against unjustified restrictions of member rights, and ensures members are provided with the necessary information and supports in order to gain full access to the benefits of community living to the greatest extent possible. The member’s DDD Support Coordinator, in collaboration and coordination with the DDD Health Plans, ensures responsiveness to the member’s needs and choices regarding service delivery, personal goals, and preferences. The member and family/responsible person, as appropriate, and providers involved in the support, care and treatment of the member, have immediate access to the member’s Planning Documents to promote coordinated, integrated care.

E. Consistency of Services and Supports
An accessible and consistently available network of services and supports is developed to ensure the delivery, quality and continuity of services. Services and supports are provided in accordance with the Planning Document as agreed to by the member and as authorized by the Division, consistent with coverage responsibility.

F. Accessibility of Network

Network sufficiency supports choice in individualized member care and availability of services. Provider networks are developed to meet the unique needs of members with a focus on accessibility of services for members with disabilities, cultural preferences, and individual health care needs. Services are available to members to the same extent that services are available to individuals who are not receiving services through the Medicaid system.

G. Most Integrated Setting

Members live in the most integrated and least restrictive setting and have full access to the benefits of community living. To that end, members are afforded the choice of living in their own home or choosing an alternative Home and Community Based Setting (HCBS) rather than residing in an institution. Members receive comprehensive services in the most integrated and least restrictive setting, allowing them to be fully integrated into their communities. To that end, members shall be afforded the choice to receive HCBS in community settings where individuals who do not have disabilities spend their time.

H. Collaboration with Stakeholders

Ongoing collaboration with members and family/responsible person, as appropriate, service providers, community advocates, other member-serving agencies, and the Division facilitates continuous improvement of the ALTCS-DD Program.

I. Alignment of Care

Alignment of care for members is well-coordinated, integrated care. The Division and stakeholders have established that reducing or eliminating fragmentation of care for members requires focused efforts to coordinate physical and behavioral health care with Long term services and supports and community supports.

To create greater alignment and care coordination, a single, shared Planning Document, developed by the DDD Support Coordinator with the participation of the DDD Health Plans care management staff, as appropriate, serves as the foundation for care and shall be made available to all involved providers.

J. Integrated Services

K. An integrated care system shall operate to holistically assess and seamlessly provide needed services within existing community programs. An integrated system shall reflect that successful member outcomes are a shared responsibility for all involved in the care and treatment of the member, leveraging the strengths of the Division, the DDD Health Plans and respective provider disciplines.
1002  VOTER REGISTRATION

REVISION DATE:  7/3/2015
EFFECTIVE DATE:  July 31, 1993

All support coordination staff must comply with the Arizona Department of Economic Security Policy DES 1-01-24, regarding the National Voter Registration Act of 1993, and applicable state statutes, by offering individuals applying for services the opportunity to register to vote.

Staff will accept the verification of U.S. Citizenship that the consumer presents, but are NOT required to verify that it is an acceptable U.S. Citizenship document.

Staff will sign the acknowledgement form to indicate they have reviewed and understand the policy. The acknowledgement must be signed by new employees within 60 days of hire. The signed copy is maintained in the Supervisor's file.
1003 DISTRICT INDEPENDENT OVERSIGHT COMMITTEES

REVISION DATES: 7/10/19, 7/3/15
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 41-3804

Independent Oversight Committees are local groups of citizens who provide independent oversight in matters related to the rights of persons with developmental disabilities who are served by the Division of Developmental Disabilities (Division).

A. INDEPENDENT OVERSIGHT COMMITTEE DUTIES

1. Each Independent Oversight Committee must meet at least quarterly each calendar year, or as often as necessary as determined by the chairperson, in accordance with the bylaws of the committee.

2. Each Independent Oversight Committee provides independent oversight to ensure the rights of members are protected, including but not limited to:
   a. Administration of medication that changes recipient’s behavior directly or as a side effect.
   b. Aversive or intrusive programs.
   c. Research proposals in the field of developmental disabilities that directly involve individuals receiving supports and services.
   d. Incidents of possible abuse, neglect, or denial of an individual’s rights.

NOTE: Any suspected violation of the rights of a person with developmental disabilities should be identified to the appropriate Independent Oversight Committee.

3. In addition to protecting the rights of individuals, the Independent Oversight Committee must:
   a. Submit, in writing, to the Arizona Department of Administration (ADOA) Director, any objections it has to actions by employees of the Division or employees of service providers.
   b. Issue an annual report summarizing its activities and making recommendations of changes it believes the Division should consider implementing.

NOTE: There are several Independent Oversight Committees in the state, each serving one or more counties. For further information on the Independent Oversight Committee in your area, contact your District Administrative Office.
B. INDEPENDENT OVERSIGHT COMMITTEE MEMBERSHIP

1. Candidates for initial membership on a committee are recruited by the Housing, Engagement, Resource and Opportunity (HERO) Unit, Department of Economic Security Volunteer Services, and ADOA. The ADOA Director appoints committee members from recommendations made by the appropriate Independent Oversight Committee through the Independent Oversight Committee Division of Developmental Disabilities liaisons.

2. Each committee is comprised of at least seven (7) and not more than fifteen (15) persons with expertise in one or more of the following areas:
   - Psychology
   - Law
   - Medicine
   - Education
   - Special education
   - Social Work
   - Criminal Justice

3. Each committee shall include at least two parents of developmentally disabled members who receive services from the Division.

4. No employee of the Department of Economic Security or of a service provider, that is associated with an existing Independent Oversight Committee, may be a voting member of a committee.

5. When there is a vacancy in an existing committee's membership, nominees may be presented to the committee by advocacy groups, committee members, or the District Program Manager/Program Administrator. Upon recommendation by the committee, by majority vote, the ADOA Director appoints a person to fill the vacancy.
1004-A INFORMED CONSENT

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-551 (15) and 36-561.

As one means of protecting the rights of consumers, the Division requires written consent from the individual/responsible person for release of confidential information. Consents may also be required for participation in events, medical treatments, and activities. A.R.S. § 36-551 (15) defines consent as voluntary informed consent. Consent is voluntary if not given as the result of coercion or undue influence.

Consent is informed if the person giving the consent has been informed of and comprehends the nature, purpose, consequences, risks, and benefits of the alternatives to the procedure; and, has been informed and comprehends that withholding or withdrawal of consent will not prejudice the future provision of care and supports and services to the individual. In case of unusual or hazardous treatment procedures performed pursuant to A.R.S. § 36-561, subsection A, experimental research, organ transplantation and non-therapeutic surgery, consent is informed if, in addition to the foregoing, the individual/responsible person giving the consent has been informed of and comprehends the method to be used in the proposed procedure.

All consents must be time or event-limited. Consent may be withdrawn at any time by giving written notification to the individual's Support Coordinator.

Consumer's Competency Questioned

When a consumer's ability to make decisions about medical treatment/procedures is questioned, the matter must be forwarded to the Division's Medical Director for consideration.
**CONSENT TO MEDICAL TREATMENT OF MINORS, INCAPACITATED MINORS, OR INCAPACITATED ADULTS**

**REVISION DATE:** 9/30/2016, 7/3/2015, 5/1/2014  
**EFFECTIVE DATE:** July 31, 1993  
**REFERENCES:** A.R.S. §§ 14-5101, 14-5104, 14-5207, 14-5209, 14-5310, 14-5312, 14-5503, 14-5602, 14-5602, 36-2271, 36-3231, 44-133.

**Consent to Medical Treatment of Minors**

Generally, the parent or guardian of a minor must provide written consent for medical treatment, however, Arizona law allows other individuals to provide consent to medical treatment of a minor when a parent or guardian is unavailable.

A. A member may consent to the medical treatment of a minor if the member has a properly executed power of attorney from the minor's parent or guardian delegating the power to consent to medical treatment. The delegation of power may be for not more than six (6) months.

B. If time allows, a temporary guardian may be appointed by the court to consent to medical treatment, but the authority of the temporary guardian is limited to six (6) months. Where no one is available to act as a temporary guardian, a public fiduciary may be appointed by the court.

C. In cases of emergency, where a parent or guardian cannot be located after reasonably diligent efforts, consent may be given by a person standing *in loco parentis* to the minor. *In loco parentis* means a person who takes the parent's place by undertaking temporary care and control of a minor in the absence of a parent. For example, this might be a person who is a relative, caregiver, or teacher of the minor.

D. If no one can be located who stands in *loco parentis* to the minor, a physician can determine that an emergency exists, and that a parent or guardian cannot be located or contacted after reasonable diligent effort. The physician can then perform a surgical procedure on the minor if necessary to treat a serious disease, injury, drug abuse, or to save the life of the minor.

E. As a general rule, the Division Support Coordinators cannot sign a medical consent for treatment of minors except for children in foster care.

**Consent to Medical Treatment of Incapacitated Minors**

The general rule is that the parent or guardian of a minor must provide written consent for medical treatment, however, Arizona law allows other individuals to provide consent to medical treatment of a minor when a parent or guardian is unavailable.

A. A member may consent to the medical treatment of a minor if the member has a properly executed power of attorney from the minor's parent or guardian delegating the power to consent to medical treatment. The delegation of power may be for not more than six (6) months.
B. If time allows, a temporary guardian may be appointed by the court to consent to medical treatment, but the authority of the temporary guardian is limited to six (6) months. Where no one is available to act as a temporary guardian, a public fiduciary may be appointed by the court.

C. In cases of emergency, where a parent or guardian cannot be located after reasonably diligent efforts, consent may be given by a person standing in *loco parentis* to the minor. In *loco parentis* means a person who takes the parent's place by undertaking temporary care and control of a minor in the absence of a parent. For example, this might be a person who is a relative, caregiver, or teacher of the minor.

D. If no one can be located who stands in *loco parentis* to the minor, a physician can determine that an emergency exists, and that a parent or guardian cannot be located or contacted after reasonable diligent effort. The physician can then perform a surgical procedure on the minor if necessary to treat a serious disease, injury, drug abuse, or to save the life of the minor.

E. As a general rule, the Division Support Coordinators cannot sign a medical consent for treatment of minors except for children in foster care.

**Consent to Medical Treatment of Incapacitated Adults**

An adult cannot consent to medical treatment if he/she lacks the understanding or capacity to make or communicate responsible decisions. One of the duties of a guardian is to make reasonable efforts to secure medical services for a member of the Division who is his/her ward. If a permanent guardian is unavailable (due to death, resignation, etc.), Arizona law allows other identified individuals to sign the consent for medical treatment of an incapacitated adult.

A. A.R.S. § 36-3231 defines surrogate decision makers priorities and limitations. In the following order of priority, these individuals may act as a surrogate to sign the consent for medical treatment of an incapacitated adult when no guardian is available.

1. The spouse of the incapacitated adult;
2. An adult child;
3. A parent;
4. A domestic partner (assuming the Member is not married and no other person has a financial responsibility for the individual);
5. A brother or sister;
6. A close friend. A close friend means an adult who has shown special care and concern for the individual, who is familiar with the individual's health care views and desires, and who is willing and able to become involved and act in the individual's best interest; and,
7. A health care provider is required to make a reasonable effort to locate and
follow a health care directive. A health care provider shall also make reasonable efforts to locate the above designated individuals. In order to assist the reasonable efforts of health care providers, the Division Support Coordinators should have available, at all times, a complete list of the names, addresses, and phone numbers of these designated individuals who may be contacted for purposes of signing a consent for medical treatment. A copy of the list may be provided to treating medical personnel, as necessary, to assist them in locating a person authorized to sign the consent for medical treatment if a guardian is unavailable. If none of these persons is available, the appointment of a public fiduciary by the court may be requested.

B. A guardian has authority to execute the consent. If the guardian has executed a health care power of attorney that authorizes another person to make health care decisions on behalf of the incapacitated person, the person named in that power of attorney has authority to execute the consent. The power of attorney is valid for not more than 6 months.

C. In an emergency, if time allows, a temporary guardian may be appointed by the court to sign a consent for medical treatment or the court may immediately exercise the power to consent to medical treatment prior to notice and hearing. If no one is available to serve as a temporary guardian, the court may appoint a public fiduciary.

D. When an immediate, life threatening emergency exists and there is neither time to get to court nor time to contact the individuals who may lawfully sign a consent, an attending physician, after consultation with a second physician, may make the health care treatment decision without a signed consent.

E. The Division Support Coordinators cannot sign a medical consent for treatment of incapacitated adults.

F. A surrogate may make decisions about mental health care treatment on behalf of a patient if the patient is found incapable. However, a surrogate who is not the patient's agent or guardian shall not make decisions to admit the patient to a level one behavioral health facility licensed by the department of health services, except as provided in subsection E of this section or section 14-5312.01, 14-5312.02 or 36-3231. Subsection E: If the admitting officer for a mental health care provider has reasonable cause to believe after examination that the patient is incapable as defined in section 36-3231, subsection D and is likely to suffer serious physical harm or serious illness or to inflict serious physical harm on another person without immediate hospitalization, the patient may be admitted for inpatient treatment in a level one behavioral health facility based on informed consent given by any surrogate identified in subsection A of this section. The patient shall be discharged if a petition for court ordered evaluation or for temporary guardianship, requesting authority for the guardian to consent to admission to a level one behavioral health facility has not been filed within forty-eight hours of admission or on the following court day if the forty-eight hours expires on a weekend or holiday. The discharge requirement prescribed in this section does not apply if the patient has given informed consent to voluntary treatment or if a mental health care provider is prohibited from discharging the patient under federal law.
1005-A GUARDIANSHIP AND CONSERVATORSHIP OR SURROGATE PARENT

REVISION DATE: 9/30/2016, 9/1/2014
EFFECTIVE DATE: July 31, 1993

REFERENCES: A.R.S. §§

Guardianship is a legal method that is used to insure that a person who is unable to make reasoned decisions has someone specifically assigned to make decisions on his/her behalf. A guardian must be appointed by a court. A conservator refers to a person appointed by a court to manage the estate of a protected person. A person may have a guardian, a conservator or both appointed by the court.

Guardianship or conservatorship for persons with developmental disabilities shall be:
A. Utilized only as is necessary to promote the well-being of the individual;
B. Designed to encourage the development of maximum self-reliance and independence in the individual; and,
C. Ordered only to the extent necessitated by the individual’s actual mental, physical and adaptive limitations.

Appointment of a Guardian or Conservator

Only a court can determine that someone needs a guardian. Neither the family nor a Support Coordinator can unilaterally or jointly make that determination. However, the individual himself/herself, a family member, or any person interested in his/her welfare may petition the court (file a request for a hearing in a State court) for a finding of incapacity and the consequent appointment of a guardian. The court will appoint an attorney to represent the allegedly incapacitated person in the hearing unless the individual has his/her own attorney.

It should be noted that under Arizona law, a person with a developmental disability is presumed legally competent in guardianship proceedings until the court makes a determination to the contrary.

The person alleged to be incapacitated shall be interviewed by a person appointed by the court (called a court visitor) and examined by a court appointed physician, psychologist, or a registered nurse who will submit written reports to the court. In addition, the court visitor shall interview the person seeking appointment as guardian, and visit the home of both the individual and the proposed guardian.

During the hearing, the individual who is the subject of the hearing, has the right to be represented by an attorney, to be present at the hearing, to see or hear all evidence, to present evidence, to cross-examine witnesses, and to trial by jury. If the individual alleged to be incapacitated or his/her counsel requests, the issue may be determined at a closed
Before a guardian can be appointed, the court must be satisfied "by clear and convincing evidence" that the appointment of a guardian or conservator is necessary to provide for the demonstrated needs of the individual.

In case of an emergency situation, the court can appoint a temporary guardian and/or a temporary conservator.

If the appointment of a guardian or conservator is required for a American Indian who is a member of an Indian Tribe and who has significant contacts with that tribe, but who is not an Indian child within the scope of federal law, the Arizona Administrative Code requires that the appointment of a guardian or conservator shall first be requested through the appropriate tribal court, if any, unless the request through the tribal court is not in the recipient's best interests as determined by the Individual Support Plan (ISP) team.

Who May be Guardian

Any competent person may be appointed guardian by the Court. Persons who are not disqualified have priority for appointment as guardian in the following order:

A. Spouse;

B. Individual or corporation nominated by the person, if in the opinion of the court, the person has sufficient mental capacity to make an intelligent choice for guardian;

C. An adult child;

D. A parent, including a person nominated by will or other writing signed by a deceased parent;

E. A relative with whom the individual has resided for more than six months prior to the filing of the petition;

F. The nominee of a person who is caring for the person or paying benefits to him/her; or,

G. A public or private fiduciary, professional guardian, conservator.

The court may give preference for the appointment of a family member unless this is contrary to the expressed wishes of the individual or is not in his/her best interest as determined by the court.

Persons who wish to be considered for appointment as a temporary or permanent guardian or conservator must provide the court with all required information. Specifically, the proposed guardian must disclose any interest in any enterprise providing health care or comfort care services to any individual.
Duties of a Guardian

A guardian's duties include, but are not limited to:

A. Encouraging the individual to develop maximum self-reliance and independence;

B. Working toward limiting or terminating the guardianship and seeking alternatives to guardianship;

C. Finding the most appropriate and least restrictive setting for the individual consistent with his/her needs, capabilities and financial ability;

D. Making reasonable efforts to secure medical, psychological, and social services for the individual;

E. Making reasonable efforts to secure appropriate training, education, and social and vocational opportunities for the individual;

F. Taking care of his/her ward's clothing, furniture, vehicles, and other personal effects;

G. Giving consents or approvals for medical or other professional care that may be necessary; and,

H. Completing all reports required by the court.

To encourage the self-reliance and independence of the individual (the ward), the court may grant him/her the right to handle part of his/her money or property without the consent or supervision of a conservator. This may include allowing the individual to maintain appropriate accounts in a bank or other financial institution.

Procedures

As part of the annual review, the ISP team shall evaluate the possible need for a guardian and/or conservator for an individual receiving services through DES/DDD. This information must be noted on the ISP form DD-217 - 2 (Team Assessment Summary, cont) under guardianship status.

When there is serious doubt regarding the ability of the individual applying for services or receiving services to make or communicate responsible decisions, every effort must be made to have a judicial determination made regarding the need for guardianship and/or conservatorship.

In the case of minor child where there is no parent or interested party who is willing and able to serve as guardian, the Support Coordinator should refer the child to Department of Child Safety (DCS).

If an individual is 18 years of age or older, the parents are not the guardians unless they have been so appointed by the court. Thus, parents cannot continue to sign medical consent forms, etc. for their children who have become of legal age. The parents may wish to pursue guardianship status.
If the Support Coordinator and/or the ISP team believes that a determination of legal competency should be pursued, the Support Coordinator should:

A. Explain the need to the individual and/or family;
B. Work with the individual/and or family to help them understand the process necessary for obtaining a guardian and/or a conservator;
C. Refer the individual and/or family for help, if it is needed, in securing an attorney to handle the proceedings; (referrals, for example, to: Arizona Center for Law in the Public Interest, Community Legal Services, The Arc);
D. If the individual/family is unwilling or unable to seek guardianship, the Support Coordinator must pursue guardianship by:
   1. Writing a letter to the county public fiduciary where the individual receives services explaining the situation; and/or
   2. Contacting Adult Protective Service (APS) for assistance.

**Surrogate Parent**

Parental involvement in the planning of a child's Individual Education Plan (IEP) is a federal requirement. For a child who is without a parent willing/able to participate in the child's educational process, federal and State laws provide for the appointment, by the court, of a surrogate parent to represent a child in decisions regarding special education.

A petition for a surrogate parent for a child with disabilities may be made if any of the three following conditions have been met:

A. No parent can be identified;
B. A public agency cannot determine the whereabouts of a parent after having made three reasonable attempts; or,
C. The child is a ward of the State and the biological parent is unwilling or unable to consent to special education placement.

A person who is an employee of a State agency which is involved in the education or care of the child is not eligible to be a surrogate parent. Thus, a Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) Support Coordinator cannot be a surrogate parent. Moreover, a DES/DDD Support Coordinator cannot sign an authorization for a special education evaluation or an authorization for services for a child who has a developmental disability.

**Procedures**

If a child who is receiving services through DES/DDD has a surrogate parent, this information must be noted on the Individual Support Plan (ISP) form **DD-217 - 2 Team**
Assessment Summary, continued under guardianship status and reviewed annually. In addition, the surrogate parent must be part of the ISP team.

A foster parent who wants to be a surrogate parent should work with the Support Coordinator in making a request to the courts. While a foster parent may petition the court to receive an appointment as a surrogate parent, the court is responsible for determining whether a particular individual is able to act as a foster parent, and also represent the best interest of the child as a surrogate parent.

If the Support Coordinator believes a surrogate parent is necessary, e.g., the natural parents have relinquished their rights, the Support Coordinator should seek to have a surrogate parent appointed so that decisions regarding the child's education can be made in a timely manner.

The Arizona Department of Education (ADE) has information regarding surrogate parents and usually has a list of persons who have volunteered to be surrogate parents and have already received the required training.
1005-C  AUTHORIZED REPRESENTATIVE FOR ALTCS BENEFITS

REVISION DATE:  9/1/2014
EFFECTIVE DATE:  July 31, 1993

If there is a legal representative, that person must file the application for Arizona Long Term Care Service (ALTCS) benefits or authorize someone else to be the authorized representative. This is a person who is authorized in writing by an applicant or legal representative to represent him/her in the application process.

The authorized representative signs an affirmation to having knowledge of the applicant's circumstances, has been informed and understands the responsibilities which include:

A. Providing complete and accurate information to the best of his/her knowledge regarding the applicant's income, resources, household composition, citizenship, residency, and medical insurance coverage;

B. Providing all documents needed to determine eligibility;

C. Notifying the local ALTCS office of any change in the applicant's circumstances within 10 working days of their occurrence;

D. Signing any and all forms necessary for completing the application and verifying eligibility; and

E. Identifying and filing insurance claims and assigning insurance benefits to Arizona Health Care Cost Containment System (AHCCCS).

Generally, a family member or a legally appointed guardian assumes the responsibility of being an authorized representative for an individual applicant. While a Support Coordinator may assist in the process of making application, the Support Coordinator should not be the authorized representative unless absolutely no one else is available. Before agreeing to becoming an authorized representative for an individual applying for ALTCS benefits, the Support Coordinator must have approval from the Support Coordinator's District Program Manager (DPM) or designee (ALTCS Eligibility Policy and Procedure Manual).
1005-D  REPRESENTATIVE PAYEE

REVISION DATE:  9/1/2014
EFFECTIVE DATE:  July 31, 1993

A representative payee is an individual who handles Social Security payments and
Supplemental Security Income (SSI) payments for an individual who is unable to handle
his/her own finances. The Social Security Administration makes the final decision on who
is best suited to become the representative payee for an individual. A beneficiary who
has a payee may be receiving either a Social Security check or an SSI check, or both.

The Social Security Publication No. 05-10076 entitled "A Guide For Representative Payees:
Social Security and SSI" provides an overview of the duties of a representative payee.
This pamphlet can be requested from a local social security office. In general, the duties
of a representative payee are to decide how benefits can best be used for the beneficiary's
personal care and well-being, to keep an accounting of the funds received, and complete
all paperwork and forms required by the Social Security Administration.

In the case of a child with a developmental disability who has been adjudicated a ward of
the court and is placed in foster care who is also eligible for SSI, Department of Economic
Security (DES) becomes the representative payee. In this one instance, the Support
Coordinator is responsible to make the application on behalf of DES to the Social Security
Administration as the representative of DES.

In all other situations, DES/Division of Developmental Disabilities (DDD) believes that
parents, relatives, public fiduciaries, and advocacy groups may be in less of a conflict of
interest situation that the agency in handling funds for an individual for whom it is providing
services. DES/DDD may not become a representative payee for individual receiving
services unless permission has been granted by his/her District Program Manager (DPM) or
designee.

Procedures

If an individual with a developmental disability is receiving services through DES/DDD and
has a representative payee, this information must be noted on the Individual Support Plan
(ISP) form DD-217-2 Team Assessment Summary, contained under guardianship statutes.
In addition, the representative payee must be part of the ISP team, and must actively
participate in the completion of ISP form DD-221 Individual Spending Plan. The ISP form
DD-221 Spending Plan also must be completed as part of the annual ISP if DES/DDD is
the representative payee.
1006 HEALTH CARE DIRECTIVES / ADVANCE DIRECTIVES (AHCD)

EFFECTIVE DATE: July 31, 1993

Arizona Health Care Cost Containment System (AHCCCS) policy requires the Support Coordinator to ask the adult member if he or she has an advance directive. The Division will prevent discrimination against a member and will not place conditions on the provisions of care to the member, because of his/her decisions to execute or not execute an advance directive. There are three types of advance directives: (1) a health care power of attorney, (2) a living will, and/or (3) a pre-hospital medical care directive. If the member does not have an advance directive, the Support Coordinator will offer guidance on how the adult member may complete an advance directive.

Health Care Power of Attorney

A health care power of attorney is a written statement executed by an adult who has the capacity to make such decisions naming another person (surrogate) to make health care decisions if that adult cannot make or communicate his/her wishes. A valid health care power of attorney must meet the requirements set forth in:

A.R.S. § 36-3221 – Healthcare Power of Attorney; scope; requirements; limitations;
A.R.S. § 36-3222 – Healthcare Power of Attorney; amendments;
A.R.S. § 36-3223 – Agents; powers and duties; removal; responsibility;
A.R.S. § 36-3224 – Sample Healthcare Power of Attorney; and,
A.R.S. § 36-3231 – Surrogate decision makers; priorities; limitations.

Living Will

A living will is a written document executed by an adult who has the capacity to make such decisions in order to control the treatment/decisions made on that adult’s behalf. The living will must meet the requirements set forth in:

A.R.S. § 36-3261 – Living Will; verification; liability; and
A.R.S. § 36-3262 – Sample living will.

Prehospital Medical Care Directive

A Prehospital Medical Care Directive is commonly known as a Do Not Resuscitate (DNR). A DNR is a document signed by an adult that includes a DNR order written by a physician indicating to health care providers, emergency medical system personnel, and, as provided in A.R.S. § 36-3251(L), direct care staff persons, that the member signing the DNR, who had the capacity to make such decisions at the time of signing the document, does not want cardiopulmonary resuscitation (CPR) if that member suffers from a cardiac or respiratory arrest. A valid DNR must meet the requirements set forth in A.R.S. § 36-3251 – Prehospital Medical Care Directives.

Do Not Resuscitate (DNR) Order for Unemancipated Minors

Implementation of a Do Not Resuscitate (DNR) order for an unemancipated minor must include documented communication between the member’s health care provider and at
least one legal guardian or parent. This communication must include a discussion of the minor’s care plan including implementation of a DNR and what the DNR means for the minor and the rights provided to the parents or guardian regarding transfers and policy requests.

It is required that a witness, other than the parent or guardian, be present during the discussion and be willing to confirm the communication took place. The medical provider must immediately document in the member’s medical record, who the communications was with, who witnessed the communication, and date and time the communication took place. The parent/guardian will be required to sign a written acknowledgement that this communication took place.

**Procedures**

A. The Support Coordinator must offer/provide the member with a copy of the *Decisions About Your Health Care* pamphlet. The member/responsible person must sign an acknowledgment stating that he/she is in receipt of this pamphlet or has refused the pamphlet. This acknowledgement is to be maintained in the member’s case file.

B. Annually, the Support Coordinator must ask the member if he/she has any of the three advance directives. If the member has completed one or more of these documents, the Support Coordinator must ask the member to provide a copy of all of the documents for his/her case file. The Support Coordinator must note the existence of an advance directive on the annual planning document. The Support Coordinator/member/family/provider agency shall provide a copy of any advance directive to the Primary Care Provider (PCP). If a member moves the Support Coordinator/member/family/provider agency shall send a copy of any advance directive with the member.

C. If the member/responsible person does not have any advance directives, the Support Coordinator must tell the member/responsible person where to find information and encourage the member/responsible person to consult with his/her health care provider regarding advance directives.

D. Pursuant to A.R.S.§ 36-3251(L), when the physician of the member who has a valid Prehospital Medical Care Directive has ordered hospice plan of care, a direct care staff person may comply with a Prehospital Medical Care Directive (commonly known as a DNR). “Direct care staff person” is defined in A.R.S. § 36-3251(N)(1) as a person who is employed or contracted to provide direct care services pursuant to Title 36, Chapter 5.1.

E. The provider agency must have a policy in effect indicating whether the direct care staff is required to call 9-1-1 and provide CPR or whether they may follow the DNR in a situation when a member is on hospice, has a DNR, and is found without pulse or respirations. The provider agency’s policy must comply with A.R.S. § 36-3251.

F. The following apply, as appropriate:

1. **Has a DNR and not in Hospice:** Direct care staff persons will call 9-1-1 and provide CPR until there is a licensed healthcare provider present to execute a current and known advance directive.

2. **Has a DNR and in Hospice:** When the member is on a physician-ordered hospice plan of care and has a properly executed Prehospital Medical Care
Directive (DNR), the direct care staff may comply with the Prehospital Medical Care Directive (DNR).

3. No DNR: Direct care staff persons will call 9-1-1 and provide CPR until there is a licensed healthcare provider present.

G. Licensed healthcare staff (e.g., Medical Doctor, Registered Nurse, Licensed Practical Nurse, Emergency Medical System Personnel) will follow any advance directive when known.

H. Except in the case of a court-ordered DNR, the custodial parent of a minor or a legal guardian, if present, may choose to follow the advance directive or may choose to overrule it, and request CPR and 9-1-1. Staff will comply with the custodial parent or legal guardian’s request, documenting that request as soon as possible after Emergency Medical System Personnel has taken over care of the member.

I. These procedures apply to DDD and contracted personnel. If in doubt, call 911 and start CPR.
2001 PLANNING TEAM MEMBERS’ ROLES AND RESPONSIBILITIES

REVISION DATES: 10/1/19, 10/1/14
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36.551.01; A.A.C. R6-6-101

PURPOSE: To establish the planning team members and their roles and responsibilities.

A. Planning Team Members

The members of the planning team will vary depending upon the needs and wishes of the member, member’s family, or responsible person, as appropriate. At a minimum the planning team members will include:

1. The member;
2. The member’s parent(s), if the member is a minor, or legal guardian, if any;
3. The Division Support Coordinator or other designated Division representative;
4. The member’s advocate, if any, or the individual assigned to provide Special Assistance, if applicable;
5. Representatives of any service currently authorized or assessed, including:
   a. Health Plan Care Manager, if one is assigned to the member;
   b. The DDD Health Plan Liaison, if it is believed a referral should be made for a Care Manager;
   c. The Behavior Health Case Manager, if applicable;
   d. Qualified Vendor authorized to provide a service;
   e. Department of Child Safety Case Manager, if member has an open case with DCS; and
   f. Any other individuals the member/responsible person or the Division select.
6. Additional team members may participate in the planning team meeting:
   a. Direct support professionals who work directly with the member served in Residential, Employment or Day Program services;
   b. An individual qualified to address the health and medical needs of a member who is medically involved. The Support Coordinator and District/Division nurse will determine which Division staff or providers meet this qualification.
B. Planning Team Members’ Roles and Responsibilities

Each planning team member plays a key role in developing a member’s Planning Document using a person-centered approach. To ensure the member’s strengths and needs are reviewed at each planning meeting, resulting in a plan that meets the medical, functional, social and behavioral health needs of the member in the most integrated setting, the following planning team members will engage in their outlined roles and responsibilities as a member of the planning team: (All planning team members will emulate the values and guiding principles of the program.)

1. The member, or the member’s parent or responsible person if the member is unable to, shall do the following:
   a. Inform the Support Coordinator of any substantial changes in his/her health and well-being between meetings;
   b. Actively participate in the planning meeting by providing information about his/her medical, dental and behavior health status, and his/her strengths, needs and preferences;
c. Inform the Support Coordinator of what is going well for him/her and what concerns he/she has regarding the authorized services and supports; and

d. Ask questions he/she may have about services and supports; and share how the team can best assist him/her in reaching the goals.

2. At a minimum the Support Coordinator will:

a. Maintain communication with the member, the member’s family, or legal guardian, and all other team members between meetings to ensure all team members are aware of the meetings’ topics and are prepared to participate;

b. Facilitate the meeting to ensure all team members have an opportunity to participate and the meeting stays on topic and on time;

c. Help the member and member’s family to feel comfortable with the planning process;

d. Answer questions asked by the other team members; and

e. Inform service providers of their roles and responsibilities when the providers seem unsure of their role during the meeting.

3. Representatives of any service currently authorized or assessed will:

a. Actively participate in the planning meetings by lending their perspective on the member’s progress, potential emerging risks, and any identified gaps in services. This could include discussing progress reports, teaching strategies and/or other documentation the service provider has;

b. Work collaboratively with the planning team to identify needed priorities and outcomes based on the member’s progress and potential risks; and

c. Assist with action items identified with the team.
2002 PLANNING MEETINGS

REVISION DATES: 10/1/19, 10/10/18, 4/18/18, 10/21/16, 10/01/14
EFFECTIVE DATE: July 3, 1993
REFERENCES: AHCCCS AMPM Chapter 1620-E

PURPOSE: To outline the timeframe requirements for the initial planning meeting and subsequent planning meetings for members eligible for Arizona Long Term Care Services (ALTCS), Targeted Support Coordination (TSC) and Developmental Disabilities (DD) Only.

Member Attendance

The member must be present at all planning meetings. If the responsible person requests an alternate site for the planning meeting, the Support Coordinator must document the request and the reason in the progress notes. Planning meetings at an alternative site should be the exception and not at the convenience of the Support Coordinator or provider. If the planning meeting occurs at an alternative site, the member must be present. If the member is not present for this alternative site meeting, the Support Coordinator must visit the member's residence and the member must be present for this visit. Both the planning meeting and the visit to the member's residence must occur prior to the planning meeting due date.

Initial Planning Meeting (Newly Eligible)

The timeframe requirements for the initial planning meeting are based on the date the Division is notified of the member’s eligibility. Eligibility notification may be delivered via Focus, Focus Reports, telephonically, email from AHCCCS, or Pre-Admission Screening (PAS) Report. All initial planning meetings must be completed within the timeframes listed below.

A. ALTCS the Support Coordinator will:

1. Contact the responsible person within five days of eligibility notification to schedule the meeting;
2. Hold the planning meeting in person within 10 days of eligibility notification;
3. Complete the following documents as appropriate:
   a. The ALTCS Planning Document Packet when Targeted/DD Annual Plan has already been completed;
   b. The reassessment of the Planning Document and Service Evaluation when the ALTCS Planning Document Packet has already been completed;
   c. The ALTCS Planning Document Packet when the member is newly DD eligible and became ALTCS eligible prior to the initial meeting; and
   d. Any other required paperwork.
B. TSC the Support Coordinator will:

1. Contact the responsible person within five days of eligibility notification to schedule the Targeted Planning Meeting.

2. Hold the Targeted Planning Meeting in person within 10 days of eligibility notification:
   a. When the member is newly TSC eligible, and the other scenarios do not apply, complete Targeted/DD Annual Plan;
   b. When Targeted/DD Annual Plan has already been completed, and the next scheduled planning meeting is due, complete reassessment of the Planning Document. When the next planning meeting is not due, complete a narrative of the Targeted Planning Meeting and file with the Targeted/DD Annual Plan;
   c. When the ALTCS Planning Document Packet has already been completed, and the member becomes eligible for TSC, and the next scheduled planning meeting is not due within the initial 10-day timeframe, complete a narrative of the planning meeting and file with the ALTCS Planning Document Packet; and
   d. Complete any other required paperwork as appropriate.

C. DD Only the Support Coordinator will:

1. Contact the responsible person within 10 days of eligibility notification to schedule the meeting;

2. Hold the planning meeting in person within 30 days of Focus eligibility notification; and


**Subsequent Planning Meetings**

The Support Coordinator will complete all subsequent planning meetings following the time frames listed below:

A. ALTCS

1. Acute Care Only (No long-term care services) the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the reassessment/ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.
2. Home and Community Based Services (HCBS) the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

3. Child/Adult Developmental Home, regardless of age, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

4. Group Home age 12 and under the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

5. Group Home over age 12, no behavioral health involvement, the Support Coordinator will:
   a. Hold meetings every 180 days after initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

6. Group Home over age 12, behavioral health involvement, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and

7. Group Home over age 12, medically involved, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.
8. Nursing Facility or Intermediate Care Facility the Support Coordinator will:
   a. Hold meetings every 180 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

9. Assisted Living Centers the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

10. Foster Care the Support Coordinator will:
    a. Hold meetings as required by the member’s placement and eligibility;
    b. Complete required paperwork as required by the member’s placement and eligibility; and
    c. Complete any other required paperwork as appropriate.

11. Member starts a new day or employment program: Within 30 calendar days of starting a new program.

12. Member moves from one placement type to a different placement type: Within 10 business days of the move.

13. Member moves from a placement type to the same placement type: Within 30 calendar days of the move.

B. Targeted Support Coordination

1. All TSC members the Support Coordinator will:
   a. Hold face-to-face meetings every 90 days (two visits) for the first six months after initial eligibility; and
   b. Ask the member/responsible person the preference for type and frequency of ongoing meetings at the second 90-day review.

2. No Long-term Care Services the Support Coordinator will contact the responsible person by the type and frequency of contact requested:
   a. In-Person Contact the Support Coordinator will:
      i. Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate; and
ii. Complete any other required paperwork as appropriate.

b. Letter Contact the Support Coordinator will:
   i. Send a letter to the member/responsible person that is appropriate to the member’s needs/circumstances. The letter may contain:
      • Follow-up questions based on previous meetings;
      • Questions about any changes since the member’s last meeting, such as contact information and member’s needs;
   ii. Mail the letter by regular and registered mail, return receipt requested; and
   iii. Update the review/ISP date in Focus with the date the letter was mailed.

c. Phone Contact the Support Coordinator will:
   i. Complete the Annual Plan – Targeted/DD Only or reassessment;
   ii. Mail completed paperwork to member/responsible person for signature within 15 working days of the phone call; and
   iii. Update the review/ISP date in Focus with the date of the phone call.

3. HCBS, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

4. Child/Adult Developmental Home, regardless of age, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet as appropriate; and
   c. Complete any other required paperwork as appropriate.

5. Group Home age 12 and under the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
c. Complete any other required paperwork as appropriate.

6. Group Home over age 12, no behavioral health involvement, the Support Coordinator will:
   a. Hold meetings every 180 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

7. Group Home over age 12, behavioral health involvement, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

8. Group Home over age 12, medically involved, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

9. Nursing Facility or Intermediate Care Facility the Support Coordinator will:
   a. Hold meetings every 180 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

10. Assisted Living Centers the Support Coordinator will:
    a. Hold meetings every 90 days after the initial/annual meeting;
    b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
    c. Complete any other required paperwork as appropriate.

11. Foster Care the Support Coordinator will:
    a. Hold meetings as required by the member’s placement and eligibility;
    b. Complete required paperwork as required by the member’s placement
and eligibility; and

   c. Complete any other required paperwork as appropriate.

12. Member starts a new day or employment program: Within 30 calendar days of starting a new program.

13. Member moves from one placement type to a different placement type: Within 10 business days of the move.

14. Member moves from a placement type to the same placement type: Within 30 calendar days of the move.

C. Developmental Disabilities (DD) Only

1. No Long-Term Care services the Support Coordinator will:
   a. Ask the member/responsible person the contact preference for ongoing meetings after one year of eligibility (two face-to-face 180-day meetings);
   b. Hold type of preferred meeting at least annually after one year of eligibility; and
   c. The Support Coordinator will contact the responsible person by the type of contact requested:
      i. In-Person Contact the Support Coordinator will:
         • Complete the Annual Plan – Targeted/DD Only or Reassessment, as appropriate; and
         • Complete any other required paperwork as appropriate
      ii. Letter Contact the Support Coordinator will:
         • Send a letter to the member/responsible person that is appropriate to the member’s needs/circumstances. The letter may include:
            o Follow-up questions from previous meetings.
            o Any changes since the last meeting?
            o Any changes to contact information?
         • Mail the letter by regular and registered mail, return receipt requested.
         • Update the review/ISP date in Focus with the date the letter is mailed.
      iii. By Phone Contact the Support Coordinator will:
• Complete the Annual Plan – Targeted/DD Only or Reassessment;
• Mail completed paperwork to member/responsible person for signature within 15 working days of the phone call; and
• Update the review/ISP date in Focus with the date of the phone call.

d. After the first year of eligibility (two face-to-face 180-day reviews), a file review will be completed 180 days after the annual. The file review is not completed based on the contact preference; however, a phone call may be required to obtain information. A file review shall consist of a review of the Annual Plan and:
   i. Re-determination of eligibility;
   ii. Updating Focus with the date of the file review and any other relevant information. Obtaining school records, if schoolage;
   iii. Referrals to community resources; and
   iv. Documentation that the file review was completed.

2. HCBS, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

3. Child/Adult Developmental Home, regardless of age, the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

4. Group Home age 12 and under the Support Coordinator will:
   a. Hold meetings every 90 days after the initial/annual meeting;
   b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and
   c. Complete any other required paperwork as appropriate.

5. Group Home over age 12, no behavioral health involvement, the Support Coordinator will:
a. Hold meetings every 180 days after initial/annual meeting;

b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and

c. Complete any other required paperwork as appropriate.

6. Group Home over age 12, behavioral health involvement, the Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and

c. Complete any other required paperwork as appropriate.

7. Group Home over age 12, medically involved, the Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and

c. Complete any other required paperwork as appropriate.

8. Nursing Facility or Intermediate Care Facility the Support Coordinator will:

a. Hold meetings every 180 days after the initial/annual meeting;

b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and

c. Complete any other required paperwork as appropriate.

9. Assisted Living Centers the Support Coordinator will:

a. Hold meetings every 90 days after the initial/annual meeting;

b. Complete the Reassessment/Residential ISP Update Packet, as appropriate; and

c. Complete any other required paperwork as appropriate.

10. Foster Care the Support Coordinator will:

a. Hold meetings as required by the member’s placement and eligibility;

b. Complete required paperwork as required by the member’s placement and eligibility; and

c. Complete any other required paperwork as appropriate.
11. Member starts a new day or employment program: Within 30 calendar days of starting a new program.

12. Member moves from one placement type to a different placement type: Within 10 business days of the move.

13. Member moves from a placement type to the same placement type: Within 30 calendar days of the move.

14. Inactive Status: The Support Coordinator will contact member/responsible person annually by phone.

**Scheduling Subsequent Meetings**

Except for the initial planning meeting, subsequent meetings shall be scheduled and written notice given at the end of each planning meeting. Within three days the Support Coordinator will send out a calendar invite for the next planning meeting. In addition, the Support Coordinator shall provide the team members written notice of upcoming annual planning meetings at least 10 days in advance. The Support Coordinator shall document all attempts to schedule planning meetings at the required or requested TSC intervals. The Support Coordinator shall document the reason in the progress note when the responsible person delays, cancels or reschedules the meeting.

The date and time of the meetings should be at the convenience of the member and the responsible person. In addition, the Support Coordinator shall take into consideration other meetings the member and responsible person are required to attend, such as the Child and Family Team and the Adult Recovery Team meetings. The Support Coordinator shall work with the subcontracted health plan and the providers to combine meetings whenever possible in order to minimize the number of meetings the member and member’s family are required to attend. If a meeting is serving more than one purpose, the Support Coordinator will discuss with the provider and subcontracted health plan the agenda and how the meeting will be facilitated to ensure that all respective goals will get accomplished.

**Focus ISP Date (Set in stone date)**

The meeting date on which the initial plan was developed becomes the Focus ISP date. The annual planning meeting may be held up to five working days before the Focus ISP date every subsequent year. An annual meeting held more than five working days prior to the Focus ISP date is considered a review meeting, not the annual planning meeting. Review meetings may be held at any time prior to their due date. All planning meeting due dates are based on the mandated review cycle.

**Meeting Location**

(Reference: AHCCCS AMPM Chapter 1620-E)

Review visits are to be conducted where the member receives services, including service settings both inside and outside of the member’s home as described below. At a minimum, the Support Coordinator will conduct review visits with a member in the member’s home at least twice annually in order to evaluate the living environment, identify potential barriers to quality care, and assess for unmet needs.

If a member receives services outside of the home, at a minimum, a review visit must be
conducted at one of the member’s service setting locations. At the election of the member or member’s responsible person, remaining visit may be conducted at an alternative location that is not a service setting. If the responsible person requests an alternative site for the planning meeting, the Support Coordinator must document the request and the reason in the member’s progress notes. The location of each review visit, whether at a service setting location or an alternative site, must be determined by the member or member’s responsible person and not for the convenience of the Support Coordinator or providers.

If a Support Coordinator is unable to conduct a review visit as specified above due to the refusal by the member or member’s responsible person to comply with these provisions, services cannot be evaluated for medical necessity and will not be authorized. A Notice of Adverse Benefit Determination must then be issued to the member setting forth the reasons for the denial or discontinuance of services.

**Special Meetings**

The planning team may meet to review and revise the Planning Document at any time when there is change. The planning team must reconvene in the following circumstances:

A. When there is a change in the member’s medical treatment or physical condition that significantly affects daily living and is not of a short-term or emergency nature;

B. Prior to any transfer to/from a residential setting operated or funded by the Division;

C. When there is a change that affects the continued implementation of the Planning Document;

D. When the results of a grievance/appeal process requires a review and/or revision of the current Planning Document; and

E. For members living in a licensed residential setting, when an emergency measure, including a one-time emergency use of behavior-modifying medication ordered by a physician, is used to manage a behavior two or more times in a 30-day period or with any identifiable pattern, or when required by the results of Program Review Committee or Independent Oversight Committee reviews of behavior plans.

**Mandatory Reporting**

A. Abuse/Neglect: If, during the course of a Plan Review or any other contact with the member, the Support Coordinator identifies any instance of abuse or neglect, he/she is required by law to report this to a police officer or protective services worker.

B. Quality Assurance: Support Coordinators may become aware of quality assurance issues during the course of their work, i.e., residential licensing standards that are out of compliance; inappropriate implementation of individual programs; untimely medical checkups; or serious incidents not being reported. The Support Coordinators must verbally report problems to provider relations or quality assurance staff.
Support Coordinators, when completing a Planning Document, must use a person-centered approach, taking into consideration natural and community resources, acute care services, home and community based services, behavioral health services, and what is important to the member now (priorities) and in the future (vision), and:

A. Provide information to assist members/responsible persons in making informed decisions and choices.
B. Provide members with flexible and creative service delivery options.
C. Provide service options that support the member’s priorities and outcomes.
D. Provide coordination across all facets of the service system in order to determine the efficient use of resources and minimize any negative impact on the member.
E. Provide necessary information to providers about any changes in the member’s functioning to assist the provider in planning, delivering, and monitoring services.
F. Review all professional evaluations.
G. Assume responsibility for completion of all components of the planning document in conjunction with the team.
H. Provide copies of the completed Planning Document (e.g., Annual Plan, Reassessment of the Planning Document, Changes in the ISP, cover sheet) to all team members and service providers within 15 working days of the date of the Planning Team meeting, or revision resulting in a change in the Planning Document, and ensuring that copies of the Planning Document are available in all settings where the individual receives services.

A critical component of the person-centered approach is the assessment process. This process involves the member and their family as appropriate in the identification of support needs and includes their participation in decision-making. In designing the plan, the Planning Team must consider the unique characteristics of the member as expressed by the member or documented by others who know the member. For the member, the planning process will:

A. Recognize and respect rights.
B. Encourage independence.
C. Recognize and value their competence and dignity.
D. Promote social inclusion.
E. Preserve integrity.
F. Support strengths.
G. Maintain the quality of life.
H. Enhance all areas of development.
I. Promote safety and economic security.

**Annual Plans**

An annual plan is required for all members. The member’s eligibility and placement determines the type of plan to be completed.

**Reassessment of the Planning Document**

Reassessments of the planning document are completed based on the member’s eligibility and placement. The reassessment is a review of the annual plan.

**Changes to the Planning Document**

Any team member may recommend changes in the Planning Document/Individual Support Plan (ISP) by forwarding the proposed change to the Support Coordinator using the *Changes in the ISP* form. Examples may include:

A. New or changes to outcomes
B. New action items
C. Changes in medications
D. Changes to the spending plan.

The Support Coordinator must sign the *Changes in the ISP* form signifying that the recommended change does not require a Planning Team meeting as outlined in this policy manual, obtain the member/responsible person's signature, file the original with the ISP/Planning Document in the member's file and forward a copy of the form to each team member. Any team member who disagrees with the change may request a special team meeting.

**Attendance Sheet**

The *Attendance Sheet* is required at every planning meeting to record who was present. Signatures are required from all team members. If a team member refuses to sign or is unable to sign, the Support Coordinator will print their name and indicate they were present. Signing the *Attendance Sheet* does not indicate agreement or disagreement with the planning document.

**Acknowledgement of Publications/Information**

*Acknowledgement of Publications/Information* highlights important information the Division is required to provide to members/responsible persons. Based on the member’s eligibility, the Support Coordinator must provide or offer the following publications annually:

A. Statement of Rights
B. Notice of Privacy Practices
C. Arizona Long Term Care Service (ALTCS) Member Handbook (for ALTCS members)

D. Decisions About Your Healthcare (for members age 18 and older)

E. Voter Registration (for members who do not have a legal guardian and who are or will be 18 by the next general election).

Additionally, there are acknowledgements the member/responsible person must make when reviewing this form. This form is reviewed at the initial planning meeting and annually thereafter and signed by the member/responsible person.

**Team Assessment Summary/Working with Me**

The *Team Assessment Summary* captures a complete picture of the member’s capacities, resources, challenges, and supports needed. The Support Coordinator obtains this information through a discussion with the team at the annual planning meeting.

**Support Information**

The *Support Information* page captures adaptive equipment, behavioral health information, and medications for members. Advance directive and burial plans information is captured on this page for members age 18 and older.

**Risk Assessment Plan**

Every member enrolled in the Division must be assessed for potential risks. The *Risk Assessment* identifies behaviors or conditions that may compromise the member’s health, safety, well-being, or quality of life. The Planning Team must develop steps to minimize or eliminate the potential risks. The emphasis on prevention must not result in disregard of rights, preferences, or lifestyle choices. Age appropriate developmental skills must be taken into consideration for infants and children when assessing potential risks. The *Risk Assessment* is reviewed at every planning and revised as needed.

**Managed Risk Agreement**

A document that the District Nurse/Support Coordinator must develop with the member or the member’s responsible person which outlines risks to the member’s safety and well-being as a result of choices or decisions made by the member or his/her responsible person. These risks which would require a managed risk agreement may be associated with the member or the member’s responsible person’s choices and decisions regarding services, placements, or caregivers.

This agreement should document:

A. The amount and type of service the Division can provide cost effectively

B. The placement, service and caregiver options offered to the member

C. The member’s choices regarding those options

D. The risks associated with the refusal of medically assessed services, placement, decrease in service amounts or potential gaps in services

E. Any plans the member/responsible person has to address those risks (e.g., paying
privately for services above 100%, using volunteer services).

The member or member’s responsible person acknowledge and agree to the service limitations and risks by signing the Managed Risk Agreement. If the member or member’s responsible person refuses to sign the Managed Risk Agreement, the agreement should be placed in the case file with documentation of the refusal.

**Vision and Priorities**

The member’s Vision and Priorities page provides direction for the plan. The Vision identifies the desired future for the member. The Priorities are what the member/responsible person would like to focus on in the upcoming year to help members reach their vision for the future.

**Service Considerations/Evaluation**

The Service Considerations page assists the team in evaluating the appropriate services a member may need. The Service Evaluation documents a member’s abilities, current needs, and future support needs. Outcomes identified for members assessed for Habilitation Hourly are also documented on this form. Services other than Habilitation Hourly are documented on the Additional Service Outcome page.

**Service Outcomes**

Based on the person’s Vision and Priorities, the Support Coordinator facilitates the development of attainable, observable, measurable, and time-limited outcomes. Members who receive Habilitation, Day Treatment and Training, employment-related programs, behavioral health supports, or therapy must have outcomes identified on the Planning Document. If progress on an outcome is not made within the designated timeframe, the team must consider changing the teaching strategy, developing a new outcome, offering a different service, or stopping the service.

The selected provider must develop a teaching strategy for each outcome, which describes the methodology to be used to support the member to achieve the outcome. The strategy must identify the time needed to implement the methodology described and define the data to be recorded regarding progress. Support Coordinators are responsible for ensuring continuity of teaching strategies related to outcomes that occur in more than one setting.

**Service Plan**

The Service Plan document assesses the services to be authorized, other services requested by team members, and/or indirect services. A Service Plan is completed at every meeting for all members eligible for the Division, excluding children who are Non-ALTCS Arizona Early Intervention Program (AzEIP) eligible.

**Contingency Plan (Back-up Plans)**

Development of the ISP - AHCCCS/ALTCS/DDD Member Contingency/Back -Up Plan (Contingency Plan) is required when any of the following critical services are authorized:

A. Attendant Care
B. Homemaker
C. Respite

D. Habilitation – Individually Designed Living Arrangement

E. Nursing.

Contingency Plans ensure continuous provision of services when the direct care worker is unable to work when scheduled. Family members should not be considered as a substitute for a Contingency Plan. The agency authorized must offer a substitute direct care worker.

The member/family may decline a substitute direct care worker and not receive the critical service from an agency direct care worker or may elect to provide the service informally. When only Independent Providers are authorized to provide services, the Planning Team must consider an agency as a backup. The Contingency Plan should include the back-up person identified and a reasonable option for alternative supports. Multiple back-ups must also be identified.

The Contingency Plan requires a member to select and document their preference level. The preference level is the time a critical service needs to be provided when the scheduled provider is unable to work a scheduled shift. The preference level may be changed by the responsible person at any time.

The Contingency Plan is completed annually and reviewed at each meeting.

Action Items

Each Planning Document includes action items to be completed, the person responsible for completing each action item, and the date by which the action item must be completed.

This form is completed annually and reviewed at each planning meeting.

Summary of Professional Evaluations

The Summary of Professional Evaluations captures medical appointments and medical issues. This form is required annually for members who live in licensed residential settings.

Rights, Health and Safeguards

The Rights, Health and Safeguards form documents exceptions to residential licensing. This form is required annually for all members residing in licensed residential settings.

Spending Plan

The Spending Plan determines how the member’s money will be spent in the upcoming year. The form is required annually for all members for whom the Division is the Representative Payee and for all members living in licensed residential settings.

Transfer Plan

Prior to transfer of a non-medically involved member from a residential setting operated or financially supported by the Division, the Planning Team must meet to plan the transfer.

The transfer plan will be documented on the Residential Transfer Checklist.
Cost Effectiveness Studies

Home and Community Based Services (HCBS) provided under the ALTCS Program must be cost-effective when compared to the cost of providing care to the member in an institutional setting. It is the responsibility of the Planning Team to identify if the member’s costs will exceed 100% of the institutional cost and develop a plan to reduce ALTCS costs. Written Cost Effectiveness Studies (CES) are also required by Arizona Health Care Cost Containment System (AHCCCS), for ALTCS eligible persons whose costs exceed 80% of their approved rate.

The CES is a three-month projection of costs. The Support Coordinator must complete a Cost Effectiveness Study Worksheet (CES Worksheet) if the member’s name appears on the quarterly report “Client_0060 – Members Exceeding 80% Cost Effectiveness.” This report identifies members whose costs exceeded 80% of their approved rate in previous quarters. When the Support Coordinator identifies the need for a CES, the CES Worksheet should be submitted to the Area Manager or District Designee within 30 days. A copy is maintained in the member’s file.

Collaboration should take place with identified District staff to obtain information.

Completion of a CES Worksheet must be done quarterly until costs are reduced below 80%. In addition, a CES is required within 30 calendar days for the following services:

A. Nursing services (including nursing respite) in excess of 200 hours monthly
B. Habilitation – Nursing Supported Group Home
C. Concurrent services of residential Habilitation (Individually Designed Living Arrangement or Group Home) when the staff ratio is 1:1 or 1:2 at either program
D. Habilitation, Community Protection.

The Division receives a monthly report from AHCCCS identifying members who had previously been above 80% of their approved rates. For these members who are now below 80%, a new CES Worksheet must be completed and entered on the CA160 screen in the AHCCCS computer system (PMMIS/CATS) within 60 days of the report. The CA160 screen will be printed and placed in the member file.

Each CES Worksheet must be signed by the Support Coordinator and their Supervisor (for members below 100%) and the District Program Manager/Lieutenant Program Manager (for members above 100%). This signature assures that all appropriate CES policies and procedures have been followed.

When a member is discharged from an institutional placement (e.g., an ICF/IID, the Arizona State Hospital or, a Skilled Nursing Facility) the Support Coordinator must complete a CES prior to the move. The costs used for the CES should be those proposed for the new placement, not from the institutional placement.

The completed CES Worksheet will be reviewed by District placement personnel. If the costs are below 100% of the appropriate institutional level and the move is approved, copies will be sent to Area Manager or District Designee and maintained in the member’s case record. The Area Manager or District Designee will ensure the CES is entered into the AHCCCS computer system at CA160.
In addition to the CES, a Discharge Plan consistent with Division policy must be in place prior to any move.

**Note:** It is advisable to complete an analysis of costs prior to any and all placement changes (e.g., Group Home, Developmental Home).

The completed CES Worksheet and the cost reduction plan must be maintained in the member’s case record. A copy of the CES Worksheet must be submitted to the Area Manager or District Designee. The Area Manager or District Designee will ensure that the CES is entered in the AHCCCS computer system.

Until the CES is brought below 80%, the Support Coordinator will be required to complete and submit a CES Worksheet quarterly. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

When the completed CES Worksheet generates a result over 100%, the following options should be pursued:

A. Request a higher medical rate.
B. Request a higher behavioral health rate.
C. Reconvene the Planning Team to review services.

**Request A Higher Medical Rate Through the Health Care Services Office**

Support Coordinators and ALTCS Specialists submit documentation for the Division’s Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinators and ALTCS Specialists must complete a justification packet that includes the following:

A. Narrative describing how the person meets the criteria
B. Current CES Worksheet
C. Plan To Reduce Costs.

**Request a Higher Behavioral Health Rate Through the Behavioral Health Unit**

The Support Coordinator submits documentation for the Behavioral Health Unit to review the appropriate use of a higher behavioral health institutional rate. The Support Coordinator must complete a justification packet that includes the following:

A. Narrative describing how the person meets the criteria
   - This narrative must contain the person’s psychiatric diagnosis, most recent psychiatric and psychological evaluations, description of how the person has difficulty adapting to community life, description of substance abuse issues (if applicable) and a description of criminal offenses (if applicable);
B. Current CES Worksheet
C. Plan To Reduce Costs
D. Current Behavior Plan
E. Any other information that will assist the Behavioral Health Unit in evaluating the request


The Division’s Health Care Services or the Behavioral Health Unit will inform the ALTCS Specialist of authorizations for higher institutional rates (medical and/or behavioral) with the approval time period. If costs continue at the higher level, a request should be resubmitted in advance of the approval expiration. Should the approval expire or be denied, the institutional rate will revert back to the regular institutional rate. The Support Coordinator must initiate review of the other remaining options listed above.

**Procedures for Reducing Cost Below 100% within 6 months**

The AHCCCS Medical Policy Manual provides that when the cost is expected to be below 100% within the next six months, justification must be added to the CES Worksheet and documented in the case file.

When/if services are reduced, the Support Coordinator must follow the Notice of Action (NOA) requirements in policy. If it is unlikely that costs can or will be reduced in the next six-month period, the Support Coordinator is responsible for initiating a review of other options.

Once the Support Coordinator completes the CES Worksheet and costs are found to exceed 100%, the Support Coordinator must submit the calculation to the District ALTCS Specialist so it can be entered in the AHCCCS computer system at CA160. In addition, the Support Coordinator should immediately consult with their supervisor, area manager, nurse, contract staff, etc. The Support Coordinator may need to call special team meetings to address the high costs. Planning Team members, including providers, should be notified that current costs exceed institutional levels and overall costs must be reduced by the end of the six-month period. The Planning Team may discuss the following:

A. Reducing service units (reducing staffing levels)

B. Alternative placements.

If, at the end of six months, costs have not been reduced below 100%, the Support Coordinator must notify the ALTCS Specialist, the District Program Manager (DPM)/Lieutenant Program Manager (LPM), and the ALTCS Program Administrator.

If the DPM/LPM approves home and community based services above 100% of the cost of serving the member in an institutional setting, these costs must be paid with State funds. The Support Coordinator will advise the CES Manager/Business Operations to adjust payments accordingly. The revised CES Worksheet (below 100%) is filed in the case record, and a copy is submitted to the ALTCS Specialist. The CES Worksheet calculation previously entered in the AHCCCS computer system at CA160 will be adjusted to reflect Medicaid approved costs up to, but not exceeding 100% of institutional cost.

State funds may be available for members residing in licensed residential settings such as Group Homes and Child or Adult Developmental Homes.

If District administration denies the use of State funds, the Support Coordinator should initiate termination of service costs in excess of 100%. The Support Coordinator must
advise the member/responsible person of the cost effectiveness limitations and discuss other options. The Support Coordinator must also follow the NOA requirements in policy.

If the member chooses to remain in his/her current placement, even though the Division cannot provide all of the services that have been assessed as medically necessary (including those ordered by the member’s Primary Care Provider), a Managed Risk Agreement is completed.

**Considerations for Possible Institutional Placement**

When considering institutional placement, the Support Coordinator must first document all other options considered and reasons why these options were not chosen, and submit for review by the DPM/LPM. The Planning Team must discuss the lack of appropriate, cost-effective alternatives for the member and discuss the potential placement.

The Support Coordinator will submit a completed CES Worksheet to the ALTCS Specialist. The ALTCS Specialist will ensure the CES is entered into the AHCCCS computer system.

District administration may continue current costs while any of the above options are being pursued. After six months, if costs continue beyond 100% without AHCCCS approval, the CES calculation in the AHCCCS system must be adjusted to reflect AHCCCS approved costs up to, but not exceeding, 100% of institutional cost.
2004 SERVICE AUTHORIZATION

REVISION DATE: 6/10/2016, 7/3/2015
EFFECTIVE DATE: July 31, 1993

All services funded by the Division require authorization prior to delivery. Support Coordinators may authorize services in certain circumstances. Some services may require authorization in addition to that of the Support Coordinator, such as physician prescribed services, which require prior authorization by Health Care Services (HCS). Other services may require authorization by the Assistant Director or designee.

Authorization by the Division Support Coordinator shall be documented by the Support Coordinator's signature on the service plan.

For members who are eligible for Arizona Long Term Care System (ALTCS), the Support Coordinator shall authorize long term care services only when the assessment and planning process outlined in this policy manual determines the services to be medically necessary, cost effective, and federally reimbursable. Services are cost effective when the total cost does not exceed 100% of the cost of an Intermediate Care Facility for Persons with an Intellectual Disability (ICF/IID). Non-covered services and services provided to members who are not ALTCS-Long Term Care shall be authorized only when the same processes determine them to be developmentally necessary and cost effective and state funding is available.

Prior to authorization, the Support Coordinator shall ensure that other potential resources for meeting the identified needs have been explored, and are either not available or not sufficient to meet the documented need for both ALTCS and non-Long Term Care services. The Support Coordinator shall also ensure that the service will be provided in accordance with the service definitions and parameters outlined for each service in this policy manual.

Support Coordinators shall follow the steps outlined below in authorizing services:

A. Members who are eligible for ALTCS receive identified services within thirty (30) days of eligibility. The Focus system will be updated within 5 days of the team meeting, unless a Utilization Review is required;

B. A Utilization Review is required for any new or increase in service including Attendant Care, Respite, Habilitation and Day Treatment and Training. This Utilization Review process must be completed within 10 days;

C. Entry of approvals in Focus shall be approved or denied following Support Coordinator authorization, other District management staff authorization if needed, and HCS authorization or other Division staff, if needed; and,

D. Within five days of approval by the appropriate authority, the Support Coordinator ensures authorization information for the needed service, the amount of units, the start/end dates, and the preferred provider are entered in Focus.
Other Authorizations

Therapies require prior authorization through the District Administration and the Central Office. Home Health Aide, Home Health Nurse, Hospice, and Respiratory Therapy services require prior authorization through Health Care Services. Home modifications require prior authorization through the Home Modification unit.
2005 REFERRAL AND PLACEMENT IN SERVICES

REVISION DATE: 7/15/2016, 10/1/2014
EFFECTIVE DATE: July 3, 1993

Following completion of all authorization procedures the Support Coordinator shall contact the identified provider and arrange to initiate the service.

Prior to a member starting a service, the Support Coordinator shall send a copy of the Planning Documents to the identified provider.

Preschool-age children shall not be placed in a Child Developmental Home without a stay-at-home parent, unless all other alternatives have been exhausted and the Assistant Director has given approval. There may be exceptions to this requirement for children whose cases have been transferred to the Division from Department of Child Safety (DCS). All other alternatives include currently available Child Developmental Homes.

The Division staff shall also make every attempt to develop an appropriate home if one is not available. The Assistant Director will consider the need for expansion of a Child Developmental Home after the family's situation and family dynamics have been thoroughly explored. Child Developmental Home expansion will not occur unless it is determined that the child can fully benefit from this placement, and that the quality of care and supervision of other members who reside in the home will not be adversely affected.

For members being placed in residential or day program service settings, the Support Coordinator shall also send to each provider the following information:

A. Demographic information that includes the member's name, address, telephone number, date of entry into the Division system, Focus identification number, legal competency status, language spoken and understood, name of parent/responsible person or next of kin (with address and telephone number), physician's name, address and telephone number, and Third-Party Liability (TPL) information (e.g., company, policy number). Printouts of the appropriate Focus documents and/or Planning Documents should contain most of this information, and will be acceptable documentation for referral purposes;

B. Current and appropriate consents and authorizations;

C. Description of special needs and how these should be met (e.g., medical or behavioral), if not thoroughly documented on the most recent Planning Documents;

D. A copy of most recent physical examination;

E. Medical history, including results of Hepatitis B, tuberculosis tests, and immunization records, if available;

F. Current medications and medication history, if not thoroughly recorded on the most recent Planning Documents; and,
G. Copies of other assessments necessary to provide effective services, such as vision and hearing screenings, dental records, therapy evaluations, or psychological evaluations.

In the event these records are not available, the Support Coordinator should assist the provider in scheduling appointments or obtaining the records needed to meet minimum residential licensing requirements.

For members being placed in a Nursing Facility (NF) or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), a physician's order, and the approval of the Assistant Director shall accompany the above information. The Assistant Director may delegate selective authority.

The Planning Team shall schedule a pre-placement meeting with the provider to introduce the member, review the Planning Documents and other records, and discuss any other information necessary to provide safe and effective services. The Support Coordinator shall coordinate and attend pre-placement meetings for residential and day program settings. The Support Coordinator shall determine the need to attend pre-placement meetings for other home and community based services on the circumstances of each case.
The Support Coordinator shall offer the member/responsible person the option to voluntarily withdraw from Arizona Long Term Care System (ALTCS) and seek services through an Arizona Health Care Cost Containment (AHCCCS) Acute Care Plan through other programs when there is no assessed service need, or no intent to pursue ALTCS services. If the individual voluntarily withdraws from ALTCS, the Support Coordinator shall inform the responsible person of the right to reapply for ALTCS at any time.

If the individual/responsible person chooses not to voluntarily withdraw from the ALTCS program, Acute Care status may be appropriate. The Division will notify the member/responsible person that a change from ALTCS to Acute Care status is being requested and AHCCCS may contact them to complete a financial redetermination.
2007 CASE CLOSURE

REVISION DATE: 3/25/2016, 7/3/2015
EFFECTIVE DATE: July 31, 1993

Causes for Division Case Closure

The following situations may require Division case closure. The member:

A. No longer meets the eligibility requirements defined in this policy manual;
B. Requests case closure verbally, in writing, or the responsible person requests such action;
C. Reaches the age of eighteen (unless an application for continuation of services has been filed);
D. Moved from previous residence and cannot be located via a certified letter, return receipt requested;
E. Moved out of state; or,
F. Has passed away.

All contact attempts must be documented in the case file. Prior to case closure, the Support Coordinator/Supervisor shall ensure due diligence to make contact and determine why attempts were unsuccessful. Additionally, the following must be considered:

A. Arizona Long Term Care Services (ALTCS) eligibility – These cases cannot be closed until the Division receives a roster disenrollment from Arizona Health Care Cost Containment System (AHCCCS); and,
B. Inactive Status – An option to consider if the person has a history of being unable to contact.

If the Support Coordinator/Supervisor determines case closure will be necessary, this should occur within 30 calendar days. Any Focus authorizations must be end dated when a case closure occurs.

Members who are eligible for the ALTCS cannot be placed in inactive status or discharged from the Division until the AHCCCS dis-enrolls them via a roster transmission. As long as the person remains ALTCS eligible, the Support Coordinator must continue attempts to schedule a meeting. AHCCCS will not dis-enroll the member if AHCCCS is able to contact with the member.

Notification of Case Closure

A Notice of Service System Discharge must be sent by certified mail, return receipt requested, to the member/responsible person informing him/her of the case closure at least
35 days prior to the date of the case closure. A copy shall also be sent to the local ALTCS office if the member is ALTCS eligible. The notice shall also discuss the opportunity for administrative review as described in this policy manual. If the member is ALTCS eligible, a case cannot be closed until AHCCCS dis-enrolls the member.

A Notice of Service System Discharge shall not be sent in instances where the member has passed away.

**Documentation of Case Closure**

The following steps shall be taken at the time a member's case is closed:

A. Include a copy of the applicable Notice of Service System Discharge in the case record;

B. Close the record in Focus including the appropriate reason code. If the member is ALTCS eligible, the case cannot be closed until AHCCCS dis-enrolls the member; and,

C. Store the record in accordance with this policy manual.
3001 FAMILY MEMBERS AS PAID PROVIDERS

REVISION DATE: 2/26/2016, 7/3/2015
EFFECTIVE DATE: June 30, 1994

In some situations, family members may be paid to provide certain services. Immediate relatives permitted to provide service include the following:

A. Natural Child;
B. Natural Sibling;
C. Adoptive Child;
D. Adoptive Sibling;
E. Stepchild or Stepsibling;
G. Grandparent or Grandchild; and, or,
H. Spouse of Grandparent or Grandchild.

Immediate relatives not permitted to provide services for children under age 18 include:

A. Natural Parent;
B. Adoptive Parent; and,
C. Step Parent.

Certain requirements are specific to family members who may be paid to provide supports to their family member with a developmental disability. They include:

A. Parent/Step Parents may only be paid for an adult child (over age 18). Other family members of an adult or minor who meet certification requirements may be paid to provide services;
B. A spouse of a person with a developmental disability may not be paid to provide services to their spouse (See Attendant Care section for exception);
C. The Planning Team must determine the type and amount of services the person needs within their home environment. This determination is based on assessed need as well as the availability of natural and community resources;
D. Family members cannot be paid for skilled care during the provision of services such as Attendant Care or Habilitation (skilled care includes, but is not limited to: G-tube insertion and feedings, catheter replacement, respiratory treatment such as Small Volume Nebulizers, or suctioning tracheostomy care) (See Appendix D – Skilled Nursing Matrix);

E. A single family member who is an individual independent provider may not be paid to provide more than 40 hours of any combination of service per week. This maximum of 40 hours per week does not limit another family member from providing services. For example, an adoptive sibling may provide 38 hours of services and the grandparent may provide another 12 hours of service;

F. Family members must comply with all requirements in their contract in addition to all policies, procedures, laws, and rules;

G. Primary caregivers/parents may not be paid to provide Respite;

H. Services shall not replace care provided by the person’s natural support system;

I. Family members shall participate in and cooperate with ongoing monitoring requirements by the Division;

J. Qualified family members may become certified home and community based service providers by meeting the certification requirements, as applicable; and,

K. When a family member requests to become the provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.
3002 HOME AND COMMUNITY BASED SERVICE DELIVERY

REVISION DATE:  2/26/2016, 7/3/2015
EFFECTIVE DATE:  June 30, 1994

Member directed service options allow members to have more control and flexibility over how some of their services are provided. The options are not a new service, but rather a way of providing services, which offers the member the ability to play a more active role in directing their own care. Member directed service options are available to Arizona Long Term Care System (ALTCS) members who live in their own home.

Traditional
Traditional is a way of providing Home and Community Based services which offers members the ability to select a Qualified Vendor.

Agency with Choice
Agency with Choice is a way of providing Attendant Care (ATC), Homemaker (HSK) or Habilitation (HAH/HAI) services which offers members the ability to play a more active role in directing their own care. The Agency with Choice service option allows ALTCS members living at home to enter into a partnership agreement with the provider agency. This gives the member more control over assigning duties and schedules for the caregiver but leaves the hiring, firing, and minimal training requirements as the responsibility of the provider agency.

If a member is unable to fulfill the partnership roles and responsibilities for the above listed services on their own, an Individual Representative may be appointed to assist them in directing their care. If a member has a legal guardian, that guardian automatically serves in the capacity of an Individual Representative. The role of an Individual Representative is to act on the member’s behalf in choosing and directing care, including representing the member during the service planning process and approving the service plan. Arizona Administrative Code Title 9, Chapter 28, Section 509 (A.A.C. R9-28-509) and Section 1915 (k) of the Social Security Act prohibit an Individual Representative from serving as a member’s paid Direct Care Worker.

Individual Independent Providers
Individual Independent Providers may provide Attendant Care (ATC), Homemaker (HSK), Respite (RSP) and Habilitation (HAH/HAI). This type of service delivery offers members and their families the ability to direct their care and gives the member control over assigning duties and schedules for the direct care worker including hiring, firing, and minimal training requirements. The member/responsible person must enroll with the Division’s Fiscal Intermediary agency as the employer of record. The member or responsible person can change Individual Independent Providers at any time. This method of service delivery mainly differs from Traditional and Agency with Choice in that the member does not have to choose a direct care worker employed by a Qualified Vendor to deliver these services.

An Individual Independent Provider is limited to 40 hours per week in combination of all services to all members.
3003 SELECTION OF PROVIDERS

REVISION DATE: 2/5/2018, 6/10/2016, 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: (A.A.C.) R6-6-2101 - R6-6-2115.

The Division of Developmental Disabilities (Division) does not discriminate against Qualified Vendors/Independent Providers who serve high-risk populations or who specialize in conditions that result in costly treatment because Division members select their providers. Support Coordinators and Division staff are not permitted to recommend any specific Qualified Vendor. If a Support Coordinator or Division staff is asked to make a recommendation regarding a Qualified Vendor, the staff must explain to the member/responsible person that he/she cannot make recommendations and then review the methods available for the member to select a provider. The Support Coordinator may contact the Qualified Vendors/Independent Providers to help determine availability. If Support Coordination is responsible/delegated to confirm availability of a provider, he/she must be unbiased in contacting providers. The Support Coordinator may assist the member/responsible person to identify criteria that help make a selection based on the needs of the member. The Support Coordinator may contact the Qualified Vendors/Independent Providers to help determine availability.

Selection of Qualified Vendors

A. Selection of a vendor is needed when:

1. A new service is authorized.
2. A change in a Qualified Vendor is requested by the member/responsible person at the time of the annual planning meeting and documented in the Planning Document. The Division accommodates the request, to the extent appropriate and practical.
3. The member/responsible person requests a change of a Qualified Vendor outside an annual planning meeting. The member/responsible person must state in writing or must report to the Support Coordinator for incorporation into the member record the following:
   a. The rationale for changing Qualified Vendors; and
   b. A description of the opportunities given to the current Qualified Vendor to address the member’s concerns.

B. When a service has been identified and added to the member’s Planning Document the Support Coordinator will assist the member/responsible person in selecting a Qualified Vendor or Independent Provider in one or more of the following ways:

1. Identification of Vendor by the Member
   a. A member/responsible person may identify a Qualified Vendor or contracted Independent Provider without assistance (i.e. “word of mouth”) and notify the Support Coordinator of their selection.
   b. A member/responsible person may use the Provider Search option available on the Division’s webpage “Help for Individuals or Families.”
2. Vendor Call

a. The Support Coordinator may provide an electronic or printed copy of the Qualified Vendor or Independent Provider directory. The Support Coordinator will also send out a vendor call.

b. Each time a member needs a new service, and does not have an identified vendor, the Division will issue a “vendor call.” The vendor call is a message sent to all vendors who might be able to provide the assessed services.

c. A vendor call is issued for up to five calendar days.

d. When a vendor call does not receive any qualified vendor responses, Direct Referrals are conducted by contacting one or more of the qualified vendors individually, until a Qualified Vendor is located.

e. The Division will contact Qualified Vendors that provide the service in the geographic area of the member and may extend the search to proximal areas or statewide solely at the discretion of the Division.

f. Special rate considerations and/or Out of Network providers may be utilized if no Qualified Vendors are identified using the vendor call/direct referral process.

**Selection through the Vendor Call Process**

When a vendor call response is received, the Division will provide the member/responsible person a list of vendors who responded that meet the criteria in the vendor call.

A. The member/responsible person must select from the vendor responses within three business days of receiving the responses or tell their Support Coordinator more time is needed to select. The member may be provided five additional business days to select.

B. If member/responsible person is unwilling, unable, or does not inform Support Coordination of their vendor selection from the responding vendors; or does not request an extension within three business days of receiving the responses, the Division may randomly auto-assign a Qualified Vendor from the vendor responses received that match the member’s needs as outlined in the vendor call. The Division will send a letter to the member/responsible person informing them of the vendor that was randomly auto-assigned.

C. The Qualified Vendor selected by the member/responsible person or Division is documented in the Planning Documents by the member’s Support Coordinator. For AzEIP eligible children the chosen provider is recorded directly on the Individualized Family Services Plan (IFSP), with the date and the responsible person’s signature.

D. If the Division is unable to identify a provider for a medically necessary service(s), Support Coordination will assess and document in the member’s Planning Document alternative services offered while a provider is being identified.
Selection of Independent Providers

The Division has a small number of Independent Providers who contract directly via an Independent Provider Agreement (IPA). The Division is not expanding the Independent Provider Program. Exceptions may be considered on a case by case basis and only if there is not network sufficiency to meet a specific member’s needs.

A. A member/responsible person may change Independent Providers at any time.

B. Independent Providers are paid a rate based on member assessment.

C. The Division requires the use of a fiscal agent to manage the tax responsibilities and other employer obligations related to Independent Provider selection.

D. The fiscal intermediary is responsible for:
   1. Paying claims submitted by Independent Providers, including tax obligations
   2. Tracking authorized service hours
   3. Working with member/responsible person, and the Division to resolve any financial concerns.

Requirements for Independent Providers

When a member/responsible person selects an existing Independent Provider(s) to provide the service(s) the member/responsible person must:

A. Hire, orient, and train each Independent Provider to deliver the support as authorized in the Planning Documents.

B. Review and sign each Independent Provider time sheet.

C. Track the hours of service used against the hours of service authorized by the Division.

D. Report any concerns to their Support Coordinator, and work with the fiscal intermediary and Division staff toward resolution.
3005 NOTIFICATION OF NETWORK CHANGES

REVISION DATE:  10/1/2014
EFFECTIVE DATE:  July 3, 1993

The Division will notify members/families who receive services of discontinued contracts for personal care providers, attendant care agencies, etc. The Division will send a letter to the member/family fifteen (15) days after receipt of the termination notice by the Division.
3006 SHORT TERM EMERGENCY SITUATIONS (RESIDENTIAL AND DAY PROGRAMS)

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: A.A.C. R6-6-2110

To protect the health and safety of a member, a Qualified Vendor (QV) must notify the Division within twenty-four (24) hours (including weekends) if an emergency situation exists in which the provider is unable to meet the health or safety needs of a member.

The QV shall explicitly specify the need for increased staffing due to the emergency. Emergency situations may include, but are not limited to: acute psychiatric episodes, suicide attempts, deaths in the immediate family, severe and repeated behavioral outbursts, acute and disabling medical conditions, evacuations, etc.

Notification of all emergency situations shall be made to the District Program Manager (DPM) or designee and the Central Office. The notification for increased emergency staffing must be honored if verification is present in any form that reasonably could be considered notification, including notification to after hour on-call, or e-mail.

The DPM/designee shall provide written approval/denial of emergency increased staffing to the QV. When approving an extension for emergency increased staffing (maximum is an additional fifteen ([15]) calendar days), the DPM/designee shall take into account the needs of the member receiving services and the capacity of the provider.

If a provider believes an inpatient placement is appropriate, the local Regional Behavioral Health Authority (RBHA) should be contacted for evaluation/placement.

Resolution of Emergency Situations

Upon notification from the QV, the DPM/designee will notify the Support Coordinator of the emergency situation. Within fifteen (15) working days of notification of an emergency situation, the support coordinator shall convene a Planning Team meeting to recommend any changes, including whether there is a need for additional temporary staffing to provide for the health and safety of the member.

If a need for additional temporary staffing is recommended beyond the initial emergency authorization for increased staffing, the Support Coordinator shall notify the DPM/designee of the continued need.

Within thirty (30) working days of initial notification of an emergency situation, the Planning Team, including a Division resource manager/designee, shall develop a written plan to resolve the situation.

The plan for resolution must include:

A. The change in behavior or condition that precipitated an emergency situation;

B. The actions being taken to assist member (e.g., medical or psychiatric appointment, arranging for positive behavioral support, grief counseling);
C. The projected date of completion for each step; and,

D. The criteria that would indicate the additional staffing levels are no longer needed

The support coordinator shall provide the written plan of resolution to the District Program Manager/designee for review and approval.

Qualified Vendor Request for Informal Review

After selection by the member/responsible person or the Division, or implementation of a plan to resolve an emergency, the QV discovers that it cannot meet the needs of a member; the vendor may request an informal review by the Division. The QV shall submit this written request for review to the DPM and provide notification to the Central Office.

The DPM shall review the facts and provide the final decision in writing to the QV within (21) calendar days of the request for a review. If the DPM rejects the vendor's request, the DPM shall provide the QV with the reason for the decision.

If the DPM approves the QV’s request to discontinue providing services to the member, the QV shall not discontinue service provision until an alternate provider is selected and the member is transitioned to the new provider.
3007  SERVICE PROVIDER INFORMATION, AUTHORITY, AND NOTIFICATION

REVISION DATE:  10/1/2014
EFFECTIVE DATE:  July 3, 1993

The Division shall disclose to a service provider in the Planning Document, and in all
meetings resulting from a response to a Vendor Call for Services, any historical and
behavioral information necessary for the provider to anticipate the member’s future
behaviors and needs. This includes summary information from the Program Review
Committee, Unusual Incident Reports reviewed by the Human Rights Committee, and
Behavioral Health Treatment Plans. The Division shall redact the member’s identification
from this information.

Service providers are authorized to engage in the following activities in accordance with the
member’s Planning Document:

A. Administer medications, including assisting the member’s self-administration of
medications;

B. Log, store, and dispose of medications; and,

C. Maintain medications and protocols for direct care.

The Division may establish procedures for items “A” through “C” listed above.
To protect the health and safety of a member, a provider must notify the Division within 24
hours if an emergency situation exists in which the provider is unable to meet the health or
safety needs of the member.

On notification of an emergency, the Department shall hold a Planning Meeting within 15
days after notification to recommend any changes, including whether there is a need for
temporary additional staffing to provide appropriate care for a member, and shall develop a
plan within 30 days after notification to resolve the situation.

Other Safety Considerations for Placements

Prior to any out-of-home respite or residential placement (including emergencies), the Pre-
Service Provider Information, Residential Transfer Checklist, and any other pertinent forms
shall be completed to gather general care information and identify potential safety concerns
to prevent risk to the member, other residents, staff, and the public.

The Planning Team shall complete the Case Transfer form as part of the pre-placement
meeting.

The Planning Team will identify in the Planning Document appropriate means to deal with
potential safety risks including, but not limited to training, inoculations, and staffing as
needed.

The Planning Team, in consultation with law enforcement, Behavioral Health, the
Department of Child Safety (DCS), or other members/agencies as appropriate, will identify
planned responses to known problems prior to placement, and document them on the Risk Assessment.
3001 THIRD PARTY LIABILITY
REVISION DATE: 4/24/2019, 9/1/2014
EFFECTIVE DATE: January 1, 1996

Third party liability (TPL) is any funding source other than the Division of Developmental Disabilities (the Division). It includes medical insurance, for example, Medicare, CHAMPUS, TriCARE, or Blue Cross/Blue Shield. It also includes any benefits or settlements a person has as the result of an accident. It may also include eligibility for other programs such as Children's Rehabilitative Services (CRS), Arizona Health Care Cost Containment System (AHCCCS), or county funded services.

Policy

The Division is required to bill any third party for all covered services for all individuals eligible for services through the Division. A member/responsible person is required to provide third party insurance information when requested.

Retroactive Recoveries Involving Commercial Insurance Payor Sources

For two years from the date of service, the Division engages in retroactive third-party recovery efforts for claims paid to determine if there are commercial insurance payor sources that were not known at the time of payment.

If a commercial insurance payor source is identified, the Division seeks recovery from the commercial insurance. The Division is prohibited from recouping related payments from providers, requiring providers to act, or requiring the involvement of providers in any way, unless the provider was paid in full from both the Division and the commercial insurance.

Other Third-Party Liability Recoveries

A. The Division will identify the existence of potentially liable parties using a variety of methods, including referrals, and data mining. The Division does not pursue recovery in the following circumstances, unless the case has been referred to the Division by AHCCCS or AHCCCS’ authorized representative:
   - Motor Vehicle Cases
   - Other Casualty Cases
   - Tortfeasors
   - Restitution Recoveries
   - Worker’s Compensation Cases.

B. Upon identification of a potentially liable third party for any of the above situations, the Division reports the potentially liable third party to AHCCCS’ TPL Contractor for determination of a mass tort, total plan case, or joint case within 10 business days.

The Division may refer mass tort or total plan cases to the Division’s authorized contractor. The Division will cooperate with AHCCCS’ authorized representative in all collection efforts.
**Total Plan Cases**

A. In total plan cases, the Division performs all research, investigation, the mandatory filing of initial liens on cases that exceed $250, lien amendments, lien releases, and payment of other related costs in accordance with A.R.S. §36-2915 and A.R.S. §36-2916 for cases pursued by the Division. The Division may retain up to 100% of its recovery collections if all of the following conditions exist:

1. Total collections received do not exceed the total amount of the Division’s financial liability for the member

2. There are no payments made by AHCCCS related to Fee-For-Service, reinsurance or administrative costs (e.g. lien filing).

3. Such recovery is not prohibited by state or federal law.

B. Prior to negotiating a settlement on a total plan case, the Division notifies AHCCCS or AHCCCS’ authorized TPL Contractor to ensure that there is no reinsurance or Fee-For-Service payment that has been made by AHCCCS. The Division must report settlement information to AHCCCS by the 10th day of each month on an AHCCCS-approved monthly file.

**Joint and Mass Tort Cases**

AHCCCS’ authorized representative performs all research, investigation, and payment of lien-related costs, subsequent to the referral of any and all relevant case information to AHCCCS’ authorized representative by the Division.

In joint and mass tort cases, AHCCCS’ authorized representative is also negotiating and acting in the best interest of all parties to obtain a reasonable settlement and may compromise a settlement in order to maximize overall reimbursement, net of legal and other costs. The Division will be responsible for their prorated share of the contingency fee. The Division’s share of the contingency fee will be deducted from the settlement proceeds prior to AHCCCS remitting the settlement to the Division.

**Other Reporting Requirements**

A. All TPL reporting requirements are subject to validation through periodic audits and/or Operational Reviews that may include the Division’s submission of an electronic extract of the casualty cases, including open and closed cases. Data elements may include but are not limited to:

- The member’s first and last name
- AHCCCS ID
- Date of incident
- Claimed amount
- Paid/recovered amount
- Case status.
4002 CLIENT BILLING

EFFECTIVE DATE: January 1, 1996
REFERENCES: A.A.C. R6-6-18, with appeal rights as described by A.A.C. R6-6-22.

Financial Contribution

Members receiving Home and Community Based Services (HCBS) may be required to make a financial contribution to the cost of their care.

Members receiving state-funded services who have a trust, annuity, estate, or assets exceeding $2,000 will be required to make a financial contribution for the actual cost of programs and services provided by the Division of Developmental Disabilities (Division). When billing a trust, the Division is not limited to trust income and can also bill the trust corpus.

Members who meet the financial eligibility requirements for federal Social Security Supplemental Income benefits or the financial eligibility requirements for Arizona Long Term Care Service (ALTCS) are not affected by this requirement.

Members and responsible parties affected by this financial contribution requirement may make applications to Arizona Health Care Cost Containment System (AHCCCS) for ALTCS eligibility determination. If eligible for ALTCS, the member will not receive a bill for the cost of programs and services, although a member may be billed for room and board.

Financial Contributions and Billing for Residential Services

A. The financial contribution for a member receiving residential services is based on the total amount of income and monthly benefits the member receives. For purposes of this policy, “residential services” means room and board.

1. The required financial contribution is a maximum of 70% of the member’s income and monthly benefits the member receives, but must not exceed the actual cost of room, and board.

2. When the member's personal savings exceeds the maximum limit allowed by the federal agency providing the monthly federal benefits, the billing amount is:

   a. For the ALTCS member, the actual cost of room and board services until the member’s personal savings drops below the maximum allowable limit

   b. For the non-ALTCS member, the actual cost of all services, including room and board, until the member’s personal savings drops below the maximum allowable limit.

B. The Office of Accounts Receivable and Collections (OARC) will notify the financially responsible person of the amount the member must pay each month for room and board costs.
C. The financially responsible person must pay the monthly bill or may contact the Division to request one or more of the following: a financial review, an Administrative Review, or a reduction in the amount billed based on hardship to the member.

D. The financially responsible person must report any lump sum payments from the benefit source to the Division. The Revenue Desk must bill a portion of those funds.

**Financial Review**

A. The financially responsible person may contest the figures or method used by the Division in calculating the amount, by requesting, verbally or in writing:

1. An informal business review. An informal business review is conducted by the Division’s Business Office and may be requested at any time 10 or more business days before the payment due date; the Division will make its best efforts to respond within 10 business days from receipt of the request. There is no right to appeal the response to an informal business review; only decisions resulting from an Administrative Review may be appealed as described below; or

2. An Administrative Review as prescribed by Arizona Administrative Code (A.A.C.) R6-6-18, with appeal rights as prescribed by A.A.C. R6-6-22. The financially responsible person may request an Administrative Review at any time within 30 days of the date payment is due by submitting a request to the Division’s Office of Administrative Review.

B. The financially responsible person may request an Administrative Review without requesting an informal business review.

C. Any request for consideration based on the member’s personal obligations or expenses must be resolved under a Hardship Reduction Request described below.

**Hardship Reduction Request**

A. Any person financially responsible for the cost of care of a member may submit a Hardship Reduction Request to the Assistant Director. The request must be accompanied by supporting documentation as described below.

B. Consideration for a hardship reduction will be given for any of the following expenses:

1. Medicare Part D prescription drug co-payments, when submitted with proof of out-of-pocket expenses

2. Amounts ordered by a court for restitution, child or spousal support, when documentation of the order is submitted

3. Amounts paid for services provided by and items prescribed by a licensed health care professional, when documentation of the expenses supporting the request and denial(s) from third party payers, or other potential sources of assistance are submitted
4. Expenses for an extraordinary circumstance that affects the member’s health and safety when documentation of the amount of the expense, and the effect on the member’s health and safety if the expense is not incurred is submitted.

5. Cost of a prepaid burial or cremation plan when supported by documentation of the cost and the length of the payment period.

C. The Division will review requests that include current documentation of the expenses supporting the request and will issue a written determination that:

1. Approves a temporary reduction of the billing amount for up to 12 months, or
2. Denies the request.

D. The financially responsible person who disagrees with the hardship determination may request an Administrative Review. This request must be received by the Division within 30 days after the date of the Division’s hardship determination.

E. The Division reserves the right to amend or rescind a reduction of costs if the member’s financial circumstances change or have been misrepresented.

F. Upon request by the Division, the financially responsible person must provide verification that the expense for which a hardship is granted has been paid.
A. The Division will issue a written decision within thirty (30) calendar days from receipt of the request for Administrative Review. Appeal of this decision is available as prescribed by A.A.C. Title 6, Chapter 6, Article 22 (R6-6-2201 et seq.).

B. If Administrative review is based on notice of an increase in the monthly billing amount, the billing amount shall not increase until the Department has issued its final decision.

C. If the Administrative Review decision or an appeal of an Administrative Review decision results in affirmation of the original order in whole or in part, the monthly billing liability shall be retroactively effective from the date of the original notice of the billing amount. The person liable for the cost of care shall pay all amounts as stated in the original notice, as adjusted (if any adjustment in the amount is made by Administrative Review or the appeal). The Department's final decision on the billing amount will be retroactively effective beginning with the month in which the request for Administrative Review was made. Failure to pay the amounts owed may result in termination of services.
4004 OVERVIEW

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

This chapter explains Department of Economic Security (DES) policies for safeguarding, using, and investing funds for members in the Division of Developmental Disabilities (DDD).
4004-A  DEFINITIONS

REVISION DATE:  8/30/2013
EFFECTIVE DATE:  January 15, 1996
REFERENCES:  A.A.C. R6-6-1204.

A. **Member Funds** - Funds entrusted to an individual or agency for safeguarding and investment. The requirements for this are found in the instrument establishing such funds, and by Division Policy and Internal Instruction Manuals. Funds include:

1. cash;
2. checks;
3. money orders;
4. petty cash funds;
5. change funds;
6. bank accounts; or
7. savings accounts and investments.

B. **Member Fund System** - The systems used by the Division to maintain and track member funds.

C. **Fiduciary Capacity** - A person who also handles member funds is acting in a fiduciary capacity. He/she is responsible to properly and faithfully account for all member funds received by him/her. They may include any employee of the State of Arizona or private provider under contract.

D. **Individual Spending Plan** - A plan designed for each member living in a community residential setting or for whom the Division is the representative payee. The Planning Team process creates the plan. This plan dictates the amounts and purposes for which each member’s money is spent.

E. **Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document)** - A document developed by a Planning Team identifying needed services. It also includes the goals and objectives to be attained. The Planning Document directs the provision of safe, secure, and dependable active treatment in areas necessary for individuals to achieve full social inclusion, independence, and personal and economic well-being.
F. **Personal Spending Money** - Discretionary funds and allowances provided to members.

G. **Railroad Retirement Annuities and Pensions** - A comprehensive benefit program for railroad employees that have retired and includes their families and survivors. It was created in the 1930's. For more information on this benefit, contact the Railroad Retirement Board and request form IB-2.

H. **Representative Payee** - A representative payee is an individual or organization that receives Social Security and/or Supplemental Security Income (SSI) payments or other benefits for someone who cannot manage or direct the management of his/her money.

1. When no one is willing or able to perform the duties of the representative payee, the Division shall request that the Social Security Administration appoint them to become the representative for the member. When the Division is the representative payee, the Support Coordinator is responsible for the management of the member funds as directed by the Planning Team (Individual Support Plan/Person Centered Plan).

I. **Residential Services** - Includes Room and Board and daily Habilitation. Examples include: Habilitation Services - with Room and Board; Habilitation, Child, or Adult Developmental Home; Habilitation; Nursing Group Home; Habilitation, Community Protection; Residential Room and Board, etc.

1. Because Residential Room and Board is not a reimbursable service under Title XIX, it is the only residential service that is billable under Administrative Rule R6-6-1204. (http://www.azsos.gov/public_services/Title_06/6-06.htm)

J. All other services that a member might receive in out-of-home care such as therapies, hourly support programs, day programs, etc. are not considered residential services.

K. **Social Security Benefits**: 

1. Social Security (SSA, Title II) is a social insurance program that protects workers and their families (dependents or survivors) from loss of earnings because of retirement, death, or disability of the wage earner. A worker’s spouse or children may become eligible for Social Security if the worker becomes disabled or dies. The amount someone receives depends upon the age of the wage earner, the length of time worked and the amount they earned from which Federal Insurance Contributions Act (FICA) taxes withheld.

   Benefits are based on the insured’s earnings. Persons receiving benefits cannot be disqualified because of income or resources. Persons become Medicare eligible after two years. Benefits are not affected by whom you live with or where you live.
2. SSI, Title XVI is a federal income maintenance program for the aged, blind, and disabled persons with few or no resources. The person must be blind, or disabled, or 65 or older, have limited income, and cannot have over $2,000 in allowable resources.

L. Veterans' Benefits - Benefits payable to surviving spouses and dependents of military personnel who die while in active military service and to survivors of veterans who die after active service.
4004-B MEMBER FUNDS SYSTEM

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

When members need assistance in handling their funds, but no other responsible party is available, the Division applies to be the representative payee for these members. The responsibility of being representative payee requires the Division to have policies and procedures that direct the Division on how to maintain these funds and how these funds are to be used.

The Member Fund System Manager acts in a fiduciary capacity and is responsible for the funds under his/her control. Black's Law Dictionary, sixth edition states:

"One is said to act in a fiduciary capacity or to receive money or contract a debt in a fiduciary capacity, when the business which he/she transacts, or the money or property which he/she handles, is not his/her own or for his/her own benefit, but for the benefit of another person, as to whom he/she stands in a relation implying and necessitating great confidence and trust on the one part and a high degree of good faith on the other part. The term is not restricted to technical or express trusts, but includes also such offices or relations as those of an attorney at law, a guardian, executor or broker, a director of a corporation and a public officer."

When the Division becomes the representative payee for the member funds, the Division sets up special accounts for these funds. These accounts are called the "Member Fund System" and are composed of:

A. Social Security Benefits (SSA);
B. Social Security Income (SSI);
C. Wages earned by the member;
D. Railroad Retirement (RR);
E. Veteran's benefits (VA);
F. Revenue from personal trust funds and estates;
G. Monetary gifts and other sources; or,
H. Earned interest.
This policy applies to all Division and contracted provider personnel involved with Division member funds if the Division is representative payee.

The Division will not be the representative payee when:

A. The Planning Team (Individual Support Team/Person Centered Plan team) determines that the member can learn to manage their own funds; or,

B. There is a guardian, family member, or other interested payee other than a paid provider, willing and able to serve in that capacity and who is approved by the Social Security Administration.

A paid provider shall not be representative payee for a member.

As an exception to this, Independent Providers who are also family members may be a representative payee for a member.

Service provider and Division contracts specify that providers develop internal policies regarding member funds. These provider policies must be consistent with Division policies and appropriate state and federal regulations. These provider policies are subject to Division approval during contract negotiations and subject to periodic review by Division staff.

This policy specifically prohibits a provider from establishing a bank account (other than the standard provider/member personal ledger) for a member.

The provider shall not establish or be included on a joint account for a member, nor establish any account where the provider or provider staff has access to the member's funds.

Money paid out of the member accounts administered by the Division is by specific direction of the Support Coordinator as developed by the Planning Team. Supervisory and management approval is required. Member Fund System disbursements require a Request for Funds form.

The Division should not maintain an account for the member's benefits while another person (relative, or friend, but not a provider) maintains an additional account for the member's wages. Separate accounts make it difficult to assure that the individual's financial eligibility level for benefits or Title XIX services is not exceeded.

If someone other than the Division is maintaining an additional account (i.e. wages) for the member, the Division shall recommend that this person should become the representative payee to keep all the member's funds in one account, unless there are reasons why this person cannot or should not be the representative payee.
4004-D RESPONSIBILITIES

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

A. District Program Administrators/Mangers are ultimately responsible for the proper use of the member funds.

B. The Division of Developmental Disabilities Business Operations will:

1. Ensure training, assistance, and technical guidance is provided to all employees responsible for member funds;

2. Exercise good judgment and due diligence in the administration of member funds; and,

3. Audit and provide administrative assistance to review activity related to member funds.

C. Confidentiality will be maintained in accordance with Chapter 1800 of the Policies and Procedures Manual.

D. No Division employee shall offer assistance or in any way help an individual complete income tax forms, unless they are the legal guardians for the member.
4004-E SAFEGUARDING MEMBER FUNDS

REVISION DATE: 8/30/2013
EFECTIVE DATE: January 15, 1996

A. Separate accounts:
   1. A separate accounting shall be maintained for each member. This will show all funds received, or disbursed, and remaining balances.
   2. Transactions posted to a member's account shall be traceable to an original source document, such as a Request for Funds form, a receipt, invoice/bill, etc.
   3. Electronic transfers in or out of member accounts are not allowed.

B. Fund Transactions:
   1. All funds received will be documented through the Member Fund System.
   2. When a member transfers from one district to another, accountability for inter-district fund transfers will be documented. Signed receipt forms shall be used. This shall be documented in the case record, See Chapter 900 for instructions.
      The District Member Fund Manager is to be notified in writing/e-mail of the transfer. The names of the sending and receiving responsible persons and the effective date of the transfer shall also be included.
   3. Checks and other negotiable instruments received must be immediately endorsed with the restrictive statement, as follows:
      
      AZ DEPARTMENT OF ECONOMIC SECURITY, DIVISION OF
      DEVELOPMENTAL DISABILITIES (insert District identifier here)
      ACCOUNT NUMBER (insert District Account Number here)
      FOR DEPOSIT ONLY

   4. Funds received are to be deposited in the designated bank account in a timely manner. Appropriate safeguards should be present while funds are being transported between the Division’s facility and the bank.

   5. The same person will not handle a transaction from beginning to end. If personnel and other cost considerations permit, cash and check handling and record keeping functions will be separated.

   6. The Member Fund System Manager acts in a fiduciary capacity, which includes responsibility to account for all funds in the Member Fund System.
7. Insurance purchased for members in the Member Fund System such as life or burial insurance shall not list as beneficiary:
   a. The Division;
   b. An employee of the Division;
   c. A paid contracted provider; and,
   d. An employee of a provider.

   However, a family member who is also an employee of the Division or a provider may be listed as a beneficiary.

8. All transactions and record keeping will be done confidentially. Only those with a need to know are allowed to review and to work with the member’s records.

C. The Support Coordinator shall submit a request to establish any new accounts. These requests are to be submitted to:
   1. The District Business Operations Manager or the District Program Manager for approval.
   2. The request shall include the member’s demographic data, effective dates, income sources, and any requests for funds.
   3. The District Member Fund Manager or designee will be notified once all the approvals are obtained.
4004-F MEMBER FUNDS SECURITY

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Member funds will be kept in a secure safe or locked location until deposited. When the Fund Manager leaves the work area, the safe or other location shall be locked.

Funds shall not be stored in desks, unlocked files, purses, or other places that are not secure.

Computer access to member information shall be restricted by secure passwords. No one other than the fund manager and/or designee shall have knowledge of the safe key/combination or the password to secure files.

The District Business Operations Manager or designee shall reconcile member accounts monthly. The administrator of business operations must approve any exceptions.
4004-G  DISBURSING MEMBER FUNDS

REVISION DATE:  8/30/2013
EFFECTIVE DATE:  January 15, 1996

A. All disbursements will be by pre-numbered checks.

B. All disbursements, except by authority of the District Program Manager/Lieutenant Program Manager (DPM/LPM), must be authorized in the Individual Spending Plan.

C. All disbursements require the following:

1. Disbursements shall be documented by written requests for funds; or,

2. Any request over $500 must be approved by the District Program Administrator/Manager or designee;

3. Documentation of the amount of each ongoing deduction for residential billings;

4. Excess funds are not to be used for non-approved purchases. If disbursed funds exceed the cost of the approved purchase, these excess funds shall be returned to the member's account with a reconciliation statement accounting for purchases. Anything under $5.00 may be returned to the member for personal use, unless the Support Coordinator requests otherwise; and,

   The person processing an expenditure shall not be the payee of the check. Nor will the person maintaining accounting records or preparing checks also sign the checks.

D. All pre-numbered checks will be accounted for monthly in the following categories to aid in the bank reconciliation process:

1. Paid by bank (cancelled);

2. Void;

3. Outstanding; and,

4. Suspense File: Cash or checks in the hands of third parties for the purchase of goods and services for members will be signed for and a suspense file established pending paid receipts. Suspense files will be cleared within thirty days after full payment for goods and services.

E. It is the policy of the Social Security Administration that individuals shall be provided at least $30 monthly for their personal needs.

1. Member personal spending money does not require receipts.
2. However, any personal spending money not paid directly to the member requires supporting documentation verifying the use of these funds. Those entities required to account for members' funds shall maintain a log of all expenditures for each member.

F. All non-personal spending money disbursed from the member's account for any good(s) or service(s) in excess of $50.00, shall be verified within 30 days, by an itemized receipt. The receipt must show:

1. The vendor name;
2. Date of purchase; and,
3. A written description of the individual item(s) or services. District Program administrators/Managers may establish a receipt limit of less than $50.00.

G. Until the properly supported receipt form is submitted, no further requests for that vendor or individual will be processed unless specifically approved by the District Program Administrator/Manager or designee.

H. It is permissible for a request to designate that several disbursements be made in the name of a member over a period of time. Examples include: monthly personal allowances, or rent subsidy. Such requests remain in effect until the Support Coordinator submits paperwork to change or cancel the request.

I. A disbursement request charging a member's account will not be honored unless that account has sufficient funds to pay the entire amount requested. The requesting party will be so notified and a modified request can be submitted.

J. All requests will be processed by the payment deadline set by the district business office or designated member fund system personnel.
A person or agency providing out-of-the-home services for members may receive and maintain funds on behalf of the member for personal spending. These funds shall be recorded in a ledger maintained in the member's residence or agency's business office.

The agency or caregiver shall be required to provide proof of how the funds designated for the member were expended, at the Division’s discretion.
4004-I LEDGERS MAINTAINED BY PROVIDERS

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. § 41-1345.

When the individual or service provider receives spending money from the Division, family, employment, or other sources on behalf of a member, they are to open and maintain a separate ledger for each member receiving these funds. The ledger is a financial record for each member, composed of a separate log and balance sheet with running totals. The balance is not to exceed $200. Funds in excess of $200 shall be returned to the District Member Fund Manager and deposited into the Member Funds System.

A. Funds can only be obligated and utilized for the member's personal needs; all funds received and expended must be accounted for in the ledger.

This ledger, maintained by the provider, will show:

1. All funds received: sources of those funds and the dates received;
2. All expenditures: what they were spent for, receipts, and dates funds were expended; and,
3. A running balance.

These records must be maintained for a minimum of seven years.

B. The ledger is to be sent to the member's Support Coordinator quarterly and provided for review at each Individual Spending Plan meeting or as frequently as requested by the Division and/or the guardian. Member funds are also subject to review by the assigned support coordinator and/or member's guardian.

The Support Coordinator shall adjust the spending plan to assure that the Member funds that are maintained by the individual or provider do not exceed $200. Any funds in excess of $200 shall be returned to the district Member Fund System Manager or designee for deposit into the member's account.

Member funds cannot be loaned, given, or provided in any way or manner to other members, provider staff, relatives, or friends. Member funds cannot be used to purchase anything that is ordinarily required to be supplied by the service provider or the Division.

Member funds cannot be used to purchase insurance, burial plans, pay medical expenses, etc. for other members, providers, staff, relatives, or friends.
The funds of several members may be pooled to make group purchases provided the Social Security Administration approval is obtained prior to the purchase (an example of a group purchase would be a large TV for a group home). The request for group purchases is to be submitted to the local Social Security Office for approval.

The provider must ensure that the member funds are used to meet the beneficiary’s acceptable day-to-day personal needs, including recreation and miscellaneous expenses as required by the Social Security Administration. The federal publication: Representative Payment Program, Guide for Organizational Representative Payees, Publication No. 17-013 is an excellent resource.

C. Member funds shall be kept in a secure locked location.

Any funds discovered stolen or missing from the member's ledger or personal cash shall be the responsibility of the Provider or Qualified Vendor to replace within 10 working days of the discovery of the theft or missing funds. It shall also be reported to the member's Support Coordinator within 10 working days of the discovery.

D. These member funds are subject to audit. Any audit exceptions are the responsibility of the service provider for resolution and/or repayment.

E. The Support Coordinator shall follow Division and Social Security Administration policy and is responsible for the use of these funds. The Member Fund Manager will provide technical assistance to the Support Coordinator when the member dies, moves to another setting, or returns home. Obligations to the Division shall be the first consideration. The final disbursement of these funds will be processed by the Member Funds System Manager or designee as directed by the Support Coordinator.

F. Service providers shall not be representative payees for a member's benefits.

G. The Member Funds System Manager, or designee, shall notify the chain of command of the Division of Developmental Disabilities (DDD) of any mismanagement, or suspected mismanagement, of member funds. The Administrator shall determine whether it is appropriate to refer issues to the Department of Economic Security (DES), Office of Special Investigations (OSI), and the Social Security Administration (SSA).
4004-J  BANK RECONCILIATION

REVISION DATE:  8/30/2013
EFFECTIVE DATE:  January 15, 1996

Bank and checkbook balances shall be reconciled monthly. The duties of reconciling the bank and Member Fund System balances and maintaining the accounting records will be separated. Bank, petty cash, and change fund balances shall be reconciled in member accounts monthly.

The Member Funds System Manager or designee shall send Monthly Member Fund reconciliation reports to the Division of Business and Finance, Accounting Office.

Summaries of these reports are to be sent to the Business Operations Administrator.

A report on the number of Title XIX eligible individuals shall be sent monthly to local Arizona Health Care Cost Containment System (AHCCCS) office:

A. Those with balances over $1,500; and,

B. Those with balances over $2,000.

A report including all accounts with balances over $2,000 shall be sent to the District Program Administrator/Manager. This report shall be reviewed by management staff to ensure that District staff are working towards a spend down plan.
4004-K USE OF MEMBER FUNDS

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.R. § 6-6-1204.

Member funds are administered in accordance with the intent of the individual or entity providing the funds.

A. For economy and efficiency of administration, member funds should be pooled into one bank account. Separate records shall be maintained that identify each Member funds.

B. Funds in the pooled bank account in excess of current requirements shall be invested in accordance with the provisions of Management of Consumer Funds of the Policy and Procedures Manual.

C. Member funds shall not be loaned to other members, state employees, or any other agency or person. Nor shall the member accept any loan from other members, state employees, or any other agency or person.

D. Member funds may be used to pay for the extraordinary expenses of an escort/attendant when the member is traveling, on vacation, or participating in community activities. These expenses may include the cost of transportation, admission fees, meals and/or lodging, but not souvenirs or other personal purchases for the escort/attendant.

Recommendations from the Individual Spending Plan, along with estimated expenses and availability of funds, shall be submitted to the Lieutenant Program Manager/Manager for approval.

Member funds that are advanced shall be reconciled against receipts for all expenditures. Any personal expenditure beyond the original funds that were advanced, which are over $5.00 must be evidenced by an original receipt to be eligible for reimbursement.

State employees cannot volunteer to be an escort/attendant when that activity is part of their job description.

Exceptions to part "d" require approval in the Planning Documents (Individual Support Plan/Person Centered Plan) and by the District Program Manager/Administrator.

E. The Individual Spending Plan (ISP) is developed as part of, and during, the member's Individual Support Plan/Person Centered Plan meeting. The spending plan is to include the fiscal planning for the member, what items are to be purchased, monthly expenditures, projected needs, current income, billing by the Division for residential services (room and board), etc., and is to be acknowledged and signed by those present.
During this fiscal planning the support coordinator shall inform the representative payee of his/her obligation to report to the Division the amount of benefits they receive and any changes in these benefits. They are also to be informed that the Division will bill up to 70% of the benefits to be used to offset a portion of the member's residential costs. It is especially important that the representative payee be informed that if he/she receives a large, lump sum payment from the benefit source, that they are to notify the Division, as the Division is required by Administrative Rule R6-6-1204 to bill a portion of those funds.

F. Unless allowed by law, member funds, including interest earnings, will not be used to defray the cost of administration, supplies, equipment, or services. However, bank and investment institution service charges for administering pooled checking and investment accounts may be offset against interest earnings.

G. Member funds can only be used for expenditures authorized in the ISP, except upon written approval of the Lieutenant Program Manager/Manager or designee.

If the ISP recommends that the member be issued a Debit Card, these recommendations from the ISP for the use of a Debit Card along with the plan on oversight and accounting of the use of the debit card shall be submitted for approval to the District Business Operations Manager and then to the Lieutenant Program Manager/District Program Manager for final approval.

The use of a credit card shall not be approved.

The purchase of gift cards shall not be approved. The use of gift cards does not allow for the level of accountability required by the Social Security Administration or the Division.

H. Unexpended member funds that have been advanced to a third party for purchases or allowances will be re-deposited in the bank and credited to the appropriate member's account. However, unexpended funds of less than $5.00 may be retained, provided they are expended for the member’s incidental needs.

I. Funds belonging to members no longer requiring financial management from the Division shall be disposed of as noted in this chapter.

J. If the member is a child receiving Foster Care Services (Child Developmental Home), the Office of Accounts Receivable and Collections maintains his or her account, including dedicated accounts as required by the Social Security Administration.

K. Individual accounts may be established in the Member Fund System to receive and distribute monthly personal spending allowances for members in Foster Care.
4004-L   REVIEWING MEMBER’S ACCOUNTS

REVISION DATE: 8/25/2017, 8/30/2013
EFFECTIVE DATE:  January 15, 1996

A. The District Member Funds Manager or designee must conduct random reviews of individual member accounts.

B. The service provider must make an up-to-date ledger sheet available for review quarterly, or upon request by the Support Coordinator, as required in this chapter.

C. A balance sheet must be sent to the assigned Support Coordinator monthly.

D. The Support Coordinator must be notified when the individual’s account exceeds $1,500 and when it exceeds $2,000. The Support Coordinator must make every effort to assure that eligibility for Social Security benefits and Title XIX are maintained.

E. When the state is not the representative payee, the Division of Developmental Disabilities (Division) does not have the authority to require the representative payee to inform the Division of the balance in the member's account.

The exception to this is when the member and/or representative payee is submitting a hardship request or applying for Client Services Trust Funds or other financial assistance, or eligibility for services.

When the Support Coordinator becomes aware that a member’s account exceeds the maximum amount to maintain eligibility for Arizona Health Care Cost Containment System (AHCCCS) and/or Social Security benefits, and the Division is not the representative payee, the Support Coordinator must ensure that this is noted at the time of the Planning Meeting (Individual Support Plan/Person Centered Plan meeting) and that it is documented in the Spending Plan.

The Support Coordinator must remind/notify the representative payee that anytime the member’s funds/resources meet or exceed $2,000, as described by the Social Security Administration (SSA) for eligibility determination, that the representative payee must notify the SSA and AHCCCS.

This notification by the representative payee is required to be made within 30 days of the member’s funds/resources meeting or exceeding the $2,000 limit. An immediate spend-down plan must then be developed with the representative payee in accordance with the SSA's definition of the proper use of these benefits.

The Support Coordinator must work with the representative payee to develop a spend-down plan, where the Division will bill the member's account at a higher rate until it goes below the eligibility limits for benefits and services. See part "F" below for 100% bill down procedures.
F. When the state is representative payee:

When a member account exceeds the maximum amount to maintain eligibility for (AHCCCS) and/or Social Security benefits, the Support Coordinator and the member team will develop a reasonable spend-down plan to bring the account below the current $2,000 limit.
4004-M       CHANGES IN A MEMBER’S STATUS

REVISION DATE:  8/30/2013  
EFFECTIVE DATE:  January 15, 1996

If the member experiences any change in status, the Division of Developmental Disabilities (DDD), District Member Funds Unit/staff must be notified. If the member is a social security beneficiary, the Social Security Administration must also be notified. This notification is to be done by the Support Coordinator or designee. These changes include the following:

A.  The member dies;
B.  The member moves;
C.  The member marries;
D.  The member starts or stops working, even if the earnings are small;
E.  A member's condition improves;
F.  The member starts receiving another government benefit or the amount of that benefit changes;
G.  The member plans to leave the United States for 30 days or more;
H.  The member is imprisoned for a crime that carries a sentence of over one month;
I.  The member is committed to an institution by court order for a crime committed because of mental impairment;
J.  Custody of a child changes or a child is adopted; and the parents’ divorce;
K.  You can no longer be payee; or,
L.  The member no longer needs a payee.

Additional events that you must report for Supplemental Security Income (SSI) beneficiaries:

A.  The member moves to or from a hospital, nursing home, or other institution;
B.  A married member separates from his or her spouse, or they begin living together after a separation;
C.  Somebody moves into or out of the member's household;
D.  The member has any change in income or resources (i.e., a child's SSI benefit check may change if there are any changes in the family income or resources); or,
E. The member has resources that exceed $2000.

The Support Coordinator will report any changes in the residential settings where room and board is paid to the provider, including both permanent or temporary placement changes. These reports are to be sent to Central Office, Site 791A Residential Billing, on the Division of Developmental Disabilities Billing and Benefit Information form.

These will then be forwarded to the Division of Business and Finance - Office of Accounts Receivable and Collections. A copy is to be placed in the member’s file and a copy sent to the Member Funds Manager. A DDD Billing and Benefit Information form is required on all new placements and changes to all out-of-home placements within five (5) working days of placement, and Benefit Information form, is also required for all the following:

A. Member leaves care;
B. Member moves out-of-state;
C. Member transfers to another District;
D. There is a change in billing information;
E. Member dies;
F. There is a change representative payee;
G. There is a request for a billing waiver;
H. There is change in income (earned or unearned);
I. Member has a change of address; or
J. Member enters/leaves acute care facility.
4004-N INVESTING MEMBER FUNDS

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Interest earnings, minus any bank charges on Member funds that are invested in the State Treasurer's Office, will be apportioned to member’s accounts quarterly based on account period ending balances.
4004-O TERMINATION OF A MEMBER’S ACCOUNT OR CHANGE IN REPRESENTATIVE PAYEE

REVISION DATE: 8/30/2013
EFFECTIVE DATE: January 15, 1996

Generally, a member’s account is made up of Social Security benefits, earned money, family gifts, and other payments. Social Security benefits make up the largest percentage of these accounts; therefore all applicable Social Security laws and rules are applied first to terminate a member account. These are outlined in the Social Security publication: “Understanding the Benefits”, Pub. No. 10024. (www.ssa.gov/pubs).

Fund balances will be returned to the member, Social Security Administration (SSA), guardian, or other authorized entity by check. But this will only be done after all outstanding debts are paid including residential billing in accordance with appropriate rule and law regarding terminated accounts statements. See Policy and Procedures Manual, Chapter 1100 – Case Closure.

A. When a member dies, and there is no entity to receive money from the member’s account, and there is no family, guardian, custodian, executor or beneficiary, the following Arizona Revised Statutes will apply in the disbursement of the account: A.R.S. §§ 44-312, 44-313, 44-317, 12-881, and 12-887 www.azleg.gov.

B. Funds not attributed to Social Security benefits as identified on parts 3 and 4 of this section and not able to be assigned to a family member, estate, guardian, custodian, executor, or beneficiary will be paid to the Arizona Department of Revenue, Unclaimed Property Unit. (See their publication #601 for details www.azunclaimed.gov).

1. Funds of deceased individuals may be used to pay for funeral expenses and shall be used for other outstanding debts, including residential room and board costs, before closing the account.

2. Accounts having been determined to be inactive (having no transactions for a year or more) will be terminated after reasonable efforts to dispense funds have failed. The account will be closed and funds sent to the Arizona State Treasurer after five (5) years. (Unclaimed Property – Arizona Department of Revenue, Unclaimed Property Unit.)

3. Social Security (SSA, Title II) is paid after the month of eligibility. Any funds received from the SSA the month after the death of a member receiving SSA, shall not be spent, but shall be returned to the SSA.

For example, – If the member dies on May 30th, the last day of the month, and the SSA check received the first of May was for April the check is due and payable as the member was alive and eligible for the entire month of April.
However, if a check is received the first of June for May, The Support Coordinator or designee shall return the check as the member was not eligible for SSA for the entire month of May, the month the member died.

4. Supplemental Security Income (SSI) is paid in anticipation of eligibility. Any funds received from the SSA during the month of the member’s death remain the property of the member’s estate. Funds received the month after a member’s death shall not be spent, but shall be returned to the Social Security Administration.

For example, if a SSI check comes May 1, and the member was alive during some portion of May, the check is due and payable. If a Check comes in June, the Support Coordinator or designee shall return it as the member was not alive or eligible in June.

For additional information regarding SSI resources, refer to – Pub No. 05-10029 - Disability Benefits and 05-11011 – “What You Need to Know When You Get SSI Benefits” (www.ssa.gov/pubs).

To report changes to the SSA, call or visit your local Social Security office. The Support Coordinator or designee shall document the phone call in the case record including information on who they talked with, the date and the outcome.

To report changes to the Division, contact your local District Member funds Unit/staff.

C. When a change in representative payee is made from the Division to another entity, after all debts incurred while the Division was Representative Payee are paid, all of the Member Funds that can be identified as Social Security Benefits are to be returned to the SSA. The new representative payee is then to request these funds from the SSA. They are not to be transferred directly from the Division to the new representative payee. Providers shall not be representative payees for members. Additionally, agency board members are prohibited from being representative payees except for members of their own families who are members.

D. If the new representative payee is not the Division, any funds remaining in the “Member's Personal Allowance Fund” that were generated as a foster child shall be sent back to the Social Security Administration. The Social Security Administration may then transfer these funds to the new representative payee.

If the Division becomes the new representative payee, these funds are transferred to the new account that is set up in the local District Business Office for the member’s personal use.

E. A person willing to become the representative payee must file a SSA form (www.ssa.gov/about.htm) requesting a change in payee.
If no one else is available, the Division may request to become the representative payee. Or, Social Security may request/require the Division to become the representative payee. A Member Fund System account is set up in the local district Business Office.

The Social Security Administration is to be notified of the change of address to the local Business Office for the District.
6001-A CONFIDENTIALITY

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-568(01), 36-551(07), 41-1346, 41-1959, 36-568(01), and, 36-551(01); A.A.C. R6-6-102, et seq., and, R6-6-102.

Confidential Information

Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) adheres to statutory, administrative rule, and Departmental requirements that all personally identifiable information obtained, and records prepared during the course of application and provision of services concerning any applicant, claimant, recipient, employer or member is to be considered confidential and privileged, unless otherwise provided by law.

This confidentiality includes members or persons involved in dependency actions, case closure of parental right actions or in any protective services action.

Confidentiality Officer

Each District Program Manager (DPM) must designate, in writing, a person as confidentiality officer and provide the name of the designee to the Assistant Director and District staff. The confidentiality officer shall completely administer and supervise the use of all personally identifiable information including storage, disclosure, retention, and destruction of this information in accordance with departmental procedures of the DES and the Department of Library, Archives and Public Records.

Confidentiality officers or their designee(s) must ensure that members/responsible persons are notified of their rights of confidentiality regarding the disclosure of personally identifiable information such as name, Social Security Number (SSN), ASSISTS or Arizona Health Care Costs Containment System (AHCCCS) I.D. This notification must occur at the time of eligibility closure and during subsequent Individual Support Plans (ISPs). Rights of confidentiality include:

A. The right to inspect/review their own records without unnecessary delay (within 45 days) with the understanding that they may not be denied access to such records;

B. The right to be informed of the procedures for inspecting, reviewing, and obtaining copies of their records;

C. The right to receive one copy of their medical record free of charge annually;

D. The right to be informed of a description of circumstances whereby, for legitimate cause, the agency may deny a request for copies of a case record, even though the record may be reviewed;

E. The right to a listing of types and locations of records maintained and the titles/addresses of the officials responsible for such records;
F. The right to a policy regarding written consent for release of information shall insure that personally identifiable information shall not be released outside the DES/DDD without the written and dated consent of the responsible person except as required by federal law, State statute, court order, or in the event that the health or safety of the member is in jeopardy;

G. **Subpoenas are not court orders.** Notify the Office of Compliance and Review (OCR) immediately upon receipt of a subpoena for records and forward the subpoena to that office via interoffice mail to Site Code 016F;

H. The right to file complaints;

I. The right to seek correction of records; and

J. Should the agency refuse to amend the records, the member or the responsible person shall have the right to a hearing. Should the hearing find favor with the agency, the member or the responsible person shall have the right to insert in the record a statement or explanation.

Consent forms must be time limited and maintained in the central case record. Those consent forms taken during intake expire in 90 days. Subsequent releases are valid for only up to six months. The person signing the consent must have the capacity to understand the nature of the consent. The consent must be voluntary and signed without coercion.
6001-B  RELEASE OF INFORMATION

REVISION DATE:  9/1/2014
EFFECTIVE DATE:  July 31, 1993
REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-104; 42 CFR 483.410(c) (3).

An authorized list of persons or titles, who may have access to personally identifiable information, shall be maintained and available for public inspection. Consents for the release of personally identifiable information, must be:

A. Obtained from the member or responsible person in writing and dated); and,

B. Maintained in the case file.

Consents for the release of information, obtained during intake, expire within ninety (90) days. Subsequent consents should be obtained on an as-needed basis, and are valid for no more than six (6) months.
6001-C ACCESS TO PERSONALLY IDENTIFIABLE INFORMATION

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R6-6-103.

A Record of Access documents all requests for receipt and review of confidential information. The confidentiality officer is responsible for assuring that a Record of Access is maintained for each member in service. Requests for information by other State agencies, local or State officials, organizations conducting approved studies, advocacy groups or accrediting organizations will be honored, with ALL personally identifying information deleted.

While Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) do not require a standardized Record of Access, all Record of Access documents shall include:

A. Requestor's name;
B. Date information copied/sent;
C. Purpose for request;
D. Specific information released;
E. Where information was sent; and
F. Verification of consent.

A Record of Access is not required for the following:

A. Member/responsible person or their written designee;
B. Federally authorized members including AHCCCS and DHS staff; or
C. Direct care staff, Qualified Intellectual Disabilities Professional (QIDP)s or Support Coordinators in the performance of their job duties.

The confidentiality officer must maintain a Log Book which documents the names of persons, other than Support Coordinators, or supervisors reviewing the case record and date/time of the review is maintained. The Record of Access is typically maintained in the central case record, but may be kept in a location other than the member's master file. In such instances, the Support Coordinator shall document in the master file the required information recorded on the Record of Access (See Master Folder Access Log).
6001-D  LAWFUL DISCLOSURE OF CONFIDENTIAL INFORMATION

REVISION DATE:  9/1/2014
EFFECTIVE DATE:  July 31, 1993

Confidential information shall not be released by any Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) or contract provider staff except as defined below:

A. When the responsible person designates in writing to whom records/information may be disclosed;

B. Pursuant to court order;

C. To the extent necessary to make claims on behalf of a member for public/private assistance, insurance, or health or medical assistance to which the member may be entitled;

D. In oral/written communications between professional persons in the provision of services or the referral to services;

E. When disclosure of otherwise confidential information is necessary to protect against a clear and substantial risk of imminent or serious injury to a member;

F. To the superior court when a petition to establish guardianship for the person is filed;

G. To other State agencies or bodies for official purposes. All information shall be released without the designation of the name of the member, unless such name is required by the requestor for official purposes. The State agency or body receiving such information shall regard the information as confidential and shall not release it unless a consent to release information has been obtained from the member/responsibility person;

H. To foster parents and/or persons certified to adopt if necessary to assist in the placement with or care of a child(ren) by such persons;

I. To an officer of the superior court, the Department, or any agency required to perform an investigation, if the information is pertinent to the investigation. All information received by the officer, the department or agency pursuant to this paragraph may be disclosed to the court but shall otherwise be maintained as confidential; and,

J. A standing committee of the legislature, a committee appointed by the President of the Senate, or the Speaker of the House of Representatives may obtain the information upon written notification to the director.
Any receiver of confidential information is prohibited from using/releasing the information except in the performance of his/her duties, as defined by statute. Any questions should be referred to the Office of Compliance and Review (OCR).
6001-E VIOLATIONS AND PENALTIES

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-568(01); A.A.C. R6-6-204

ANY EMPLOYEE WHO UNLAWFULLY DISCLOSES PERSONALLY IDENTIFIABLE INFORMATION IS SUBJECT TO DISCIPLINARY ACTION OR DISMISSAL. KNOWN VIOLATIONS MUST BE REPORTED TO THE EMPLOYEE’S IMMEDIATE SUPERVISOR AND THE CONFIDENTIALITY OFFICER. VIOLATIONS ARE SUBJECT TO PENALTIES APPLIED BY STATUTE.
Central Case Records

The Division of Developmental Disabilities (Division) maintains a central case record for each member to whom services are provided. This record contains all pertinent information concerning services provided to a member and is kept in a location designated by the local Confidentiality Officer/designee, but it is usually in the Support Coordinator/Qualified Intellectual Disabilities Professional’s (QIDP’s) office.

Central case records are available to the member or responsible person upon written request to:

**Office of Administrative Review**
4000 North Central Avenue
3rd Floor, Suite 301301
Mail Drop 2HE5
Phoenix, Arizona 85012
Fax: 602-277-0026

The Support Coordinator makes sure that all information generated regarding services to the member is documented in the central case record.

A. Central case records must contain the following:

1. Birth Certificate
2. Guardianship records, if applicable
3. Adoption records, if applicable
4. Divorce Decree, and/or Custody Orders, if applicable
5. Court Orders [including Orders of Protection], if applicable
6. Arizona Confidentiality Program (ACP) records, if applicable
7. A copy of the member's Planning Documents/Individualized Education Program (IEP)
8. Program data and progress notes
9. The member's identifying information and a brief social history
10. Pertinent health/medical information
11. Current evaluative data/assessments
12. Authorization for emergency care, if appropriate
13. Visitation records, if appropriate
14. Record of financial disbursements, if appropriate
15. Active treatment schedule (ICF/IID)
16. Resident fact sheet, if appropriate
17. Periodic dental records, if appropriate
18. ICAP, if appropriate
19. Documentation regarding the protection of member rights, including records authorizing the release of educational and protected health information.
20. An accepted diagnosis/diagnostic scheme
21. Documentation of an evaluation that identifies the member's specific needs
22. Reviews/modifications to the Planning Documents and IEP
23. Communication among persons involved with the member and his/her program, including emails
24. Documentation of protection of the legal rights of each person served including records of all actions that may significantly affect these rights
25. Documentation to furnish a basis of review, study and evaluation of overall programs provided by the Division
26. Member primary data from FOCUS
27. For members residing in a Nursing Facility (NF) placed on termination status:
   a. A Primary Care Physician (PCP) statement that the NF does or does not continue to meet the member's needs
   b. Documentation of the member's choice of placement
   c. The reason for non-placement in a NF placed on termination status for a new placement.

B. Case records, where applicable, must contain the following additional documentation:

1. Arizona Long Term Care System (ALTCS) eligibility
2. Utilization review report
3. Current photograph of the member, if needed
4. Physician statements of medical necessity
5. Pre-Admission Screening
6. Psychological evaluations/social history
7. Medication history
8. Immunization record
9. Incident, injury, illness, and treatment reports including hospital stays
10. Seizure reports
11. Records of contacts/referrals
12. An accounting ledger
13. Authorization for emergency care
14. Behavioral health records as described in this Policy Manual
15. Other pertinent information.

Program/Service Records
Occasionally, the delivery of services or a centralized recordkeeping system requires maintenance of separate program/service records; this includes overflow files. The Confidentiality Officer, Support Coordinator, or QIDP assures:

- Files are available at each site where the member receives services, as appropriate
- The Support Coordinator/QIDP has access to such files
- A summary of information contained in such records is entered into the member’s Central record.

These files must contain:

A. The name, address and phone number of the physician or health facility providing medical care
B. Reports of accidents, illness, and treatments
C. Reports of significant behavioral incidents, if applicable
D. Current medication treatment plan, if applicable
E. A description of the member's specialized needs
F. A copy of the Planning Documents/IEP
G. Program data/progress notes
H. Identifying information/social summary
I. Pertinent health/medical information
J. Current evaluative data/assessments
K. Authorization for emergency care
L. Visitation records
M. Records of financial disbursements
N. Active treatment schedule (ICF/IID)
O. Resident fact sheet; and where applicable
P. Periodic dental reports.
6001-G DOCUMENTATION REQUIREMENTS

REVISION DATE: 9/1/2014
EFFECTIVE DATE: July 31, 1993

All documentation entered into a case record must be in ink or typed, legibly written in non-technical terminology if possible, and dated, and signed by the person making the entry. In case of an error in documentation, cross out the error with a single line and initial it. Do not erase or use "White Out". If room remains on a Progress Note page, draw a line through the remaining spaces after your signature. Each case record shall include a legend for explaining symbols, and abbreviations.

The Support Coordinator has primary responsibility for assuring that case records contain all of the required documentation, and that such documentation meets the criteria set forth in this Chapter by being complete, accurate, timely, and reflective of the member's programmatic, social, medical, developmental, educational, or vocational status.
6001-H RECORDS STORAGE AND SECURITY

REVISION DATE: 2/17/2017, 12/11/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 12-2297, Records Reference Request (J-240)

Internal Storage (Active Case Records)

The Division of Developmental Disabilities (Division) considers case records for members currently eligible for services to be active records. Active files may contain too much information to be confined to one case record. The Division may establish and use overflow files to store non-essential, outdated information.

Once established, overflow records can contain progress notes, educational records, Planning Documents, correspondence, status reports, guardianship records, medical records, etc. The Support Coordinator, Qualified Intellectual Disabilities Professional (QIDP) notes in the most current active record that there is an overflow(s) file and indicate where it is stored.

The overflow record is maintained within the Division in a place designated by the District for an unspecified period of time.

External Storage (Closed/Terminated Case Records)

The Records Center is the Department of Economic Security (DES) official depository for closed/terminated case records. The Records Center provides storage, retrieval, and re-file services for DES.

To transfer closed/terminated files for storage/retention, Division staff:

A. Review the records retention schedule to determine that the records are appropriate for retention at this time.

B. Pack records into standard boxes 15” L X 12” W X 10” H, leaving a minimum of two inches of space to permit retrieval.

C. Electronically complete a DES Records Storage Request (J-239) through the Records Center Management System (RCMS).

D. Assign a temporary box number to each box and place that number on the small side of the box, but not directly below the handles. The temporary numbers must be consecutive and continue in consecutive order for future pick-up.

E. Upon receipt of a Records Center box number, place that number directly below the handle.

Records Retrieval

To retrieve stored records, Division staff electronically complete a Records Reference Request (J-240) through RCMS.
**Destruction of Records**
Records are destroyed in accordance with the records retention schedule, in compliance with A.R.S. § 12-2297.
6001-I  MANAGEMENT AND MAINTENANCE OF RECORDS RELATED TO THE MEDICAID LINE OF BUSINESS

REVISION DATE:  9/1/2014
EFFECTIVE DATE:  July 31, 1993

The Division will maintain all records for a period of five years from the date of final payment under contract with Arizona Health Care Cost Containment System (AHCCCS) unless a longer period of time is required by law.

For retention of the member’s medical records, the Division will ensure compliance with A.R.S. § 12-2297, which provides, in part, that a health care provider shall retain the member’s medical records according to the following:

A. If the member is an adult, the Division will retain the member’s medical records for at least six years after the last date the adult member received medical or health care services from the Division.

B. If the member is under 18 years of age, the Division will maintain the member’s medical records either for at least three years after the child’s 18th birthday or for at least six years after the last date the child received medical or health care services from the Division, whichever date occurs later.

The Division will comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j)(2).

If the Division’s contract with AHCCCS is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any such termination. Records which relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the Division’s contract with AHCCCS, or costs and expenses of the Division’s contract with AHCCCS to which exception has been taken by AHCCCS, shall be retained by the Division for a period of five years after the date of final disposition or resolution thereof.
6002-A DEFINITIONS OF INCIDENTS AND SERIOUS INCIDENTS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993

An Incident is defined as an occurrence, which could potentially affect the health and well-being of a member enrolled with the Division or poses a risk to the community. If the incident is determined to be “serious” as defined in this policy, the “Serious Incident” section of this policy shall be followed.

Incidents

Incidents include, but are not limited to:

A. Death of member;
B. Potentially dangerous situations due to neglect of the member;
C. Allegations of sexual, physical, programmatic, verbal/emotional abuse;
D. Suicide threats and attempts;
E. Member missing;
F. Accidental injuries which may or may not result in medical intervention;
G. Violation of a member’s rights as stated in this policy manual;
H. Provider and/or member fraud;
I. Complaints about a community residential setting, resident or the qualified vendor;
J. Allegations of inappropriate sexual behavior;
K. Theft or loss of member’s money or property;
L. Use of emergency measures;
M. Medication errors such as:
   1. Wastage of a Class II substance;
   2. Giving medication to the wrong member;
   3. Wrong method of medication administration;
   4. Wrong dosage administered; or,
   5. Missed medications;
N. Community disturbances in which the member or the public may have been placed at risk;

O. Serious work related illnesses or injuries (Division employees). (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee] ;)

P. Threats to Division employees or state property (See DES Policy # DES 1-07-02.A, Unusual Incident Reporting [Employee]); and accidents on state property involving non-member/non-employees. (See DES Policy # DES 1-07-02B, Unusual Incident Reporting [Client] ;)

Q. Environmental circumstances which pose a threat to health, safety or welfare of members such as loss of air conditioning, loss of water or loss of electricity;

R. Unplanned hospitalization or emergency room visit in response to an illness, injury, medication error;

S. Unusual weather conditions or other disasters resulting in an emergency change of operations; or,

T. Provider drug use.

**Serious Incidents**

A Serious Incident is an extraordinary event involving a member, facility, or employed/contracted worker. A serious incident poses the threat of immediate death or severe injury to a person, substantial damage to individual or state property, and/or widespread interest in the news media.

Serious incidents include, but are not limited to the following:

A. All deaths;

B. A circumstance that poses a serious and immediate threat to the physical or emotional well-being of a member or staff member;

C. Severe physical injury that:
   1. Creates a reasonable risk of death;
   2. Causes serious or permanent disfigurement: or,
   3. Causes serious impairment of a member’s or worker’s health;

D. Property damage estimated in excess of $10,000;

E. Theft or loss of a member’s money or property of more than $1,000;

F. Reporting to law enforcement officials because a Division enrolled member is missing and presumed to be in imminent danger;
G. Reporting to law enforcement officials due to possession and/or use of illegal substances by members or staff/providers;

H. A 9-1-1 call due to a suicide attempt by a member; or,

I. An incident or complaint from the community that could be or is reported by the media.
6002-B INCIDENT MANAGEMENT SYSTEM (IMS) DEFINITIONS

EFFECTIVE DATE: July 31, 1993

The following definitions are used when entering incidents into the Incident Management System (IMS) database. Incidents are entered by the type (the main reason for the incident) and by the category (the main classification for the incident).

A. **Accidental Injury** - a non-intentional or unexpected injury.

B. **Member Missing** - an incident in which a member without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in his/her Planning Document is missing longer than the plan provides.

C. **Community Complaint** - a complaint from the community that puts a member or the community at risk of harm.

D. **Death** - “expected” (natural), “unexpected” (unnatural), or “no provider present”.
   1. *Expected deaths*: may include deaths from long-standing, progressive medical conditions, or age-related conditions, e.g. end-stage cancers, end-stage kidney or liver disease, HIV/AIDS, end-stage Alzheimer’s/Parkinson’s disease, severe congenital malformations that have never been stabilized.
   2. *Unexpected deaths*: include motor vehicle accidents, suicides, accidental drug overdoses, homicides, acute myocardial infarction or strokes, trauma/abuse, sudden deaths from undiagnosed conditions, or generic medical conditions (e.g., seizures, pneumonia, falls) that progress to rapid deterioration.
   3. *No provider present*: refers to deaths of members living independently or with family and no provider is being paid for service provision at the time of the death. The “expected” or “unexpected” categories must be used if a paid provider is present at the time of death.

E. **Emergency Measure** - the use of physical management techniques (Prevention and Support Intervention Techniques) or behavior modifying medications in an emergency to manage a sudden, intense, or out of control behavior.

F. **Fact-finding** - a detailed and systematic collection and verification of facts for the purpose of describing and explaining an incident. The process could include:
   - Interviews with the member; Provider and/or Division staff
   - Collection and/or review of member and provider documentation
   - Coordination with investigatory agencies.
G. **Health Care Acquired Condition (HCAC) inclusive of the Hospital Acquired Condition (HAC)** - as described under the Medicare program, a condition that, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, occurs in any inpatient hospital setting and that is not present on admission; examples include:

1. Foreign object retained after surgery
2. Air embolism
3. Blood incompatibility
4. Pressure ulcers stage III and IV
5. Falls and trauma (fractures, dislocations, intracranial injuries, crushing injuries, burn, electric shock)
6. Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, and secondary diabetes with hyperosmolarity)
7. Catheter associated urinary tract infections (UTI)
8. Vascular catheter-associated infection
9. Surgical site infection following:
   - Coronary artery bypass surgery (CABG)
   - Bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, and laparoscopic gastric restrictive surgery)
   - Orthopedic procedures (spine, neck, shoulder and elbow)
10. Deep venous thrombosis or pulmonary embolism (DVT/PE) after total knee or hip replacement (does not include pediatric and obstetric patients)
11. **Other Provider Preventable Conditions (OPPC)**
    An OPPC is a condition, occurring in an inpatient and outpatient health care setting that Arizona Health Care Cost Containment (AHCCCS) has limited to the following:
    a. Surgery on the wrong member
    b. Wrong surgery on a member
    c. Wrong site surgery.
H. **Human Rights Violation** - a violation of a member’s rights, benefits, and privileges guaranteed in the constitution and laws of the United States and the State of Arizona. Human rights are defined in A.R.S § 36.551.01 as a violation of a member’s dignity or personal choice, violations of privacy, the right to open mail, send and receive phone calls, access to one’s own money, choosing what to eat, etc.

I. **Member** - a person enrolled with the Division of Developmental Disabilities.

J. **Investigation** - collection of facts/information for the purpose of describing and explaining an incident. An investigation may be completed by law enforcement, Child Protective Services, Adult Protective Services, or other state agencies.

K. **Legal** - an incident of alleged provider fraud/inappropriate billing, member exploitation through using a member to gain monetary or personal rewards, the possession or use of illegal drugs by provider or state staff.

L. **Medication Error** - the administration of medication in an incorrect manner. This includes: giving medication to the wrong member, administering medication in the wrong method, giving the wrong dosage, or not administering the medication.

M. **Neglect** - the deprivation of food, water, medication, medical services, shelter, supervision, cooling, heating or other services necessary to maintain a vulnerable adult’s minimum physical or mental health. Neglect is an intentional health and safety violation against a member, such as lack of attention to physical needs failure to report health problems or changes in health condition, sleeping on duty, abandoning the work station, or failure to carry out a prescribed treatment plan.

For example: In the case of children, the definition includes the substantial risk of harm due to inability or unwillingness of a parent, guardian, or custodian, to care for the child. This includes; supervision, food, clothing, shelter or medical care if that inability or unwillingness causes substantial risk of harm to the child’s health or welfare, unless the inability of a parent or guardian to provide services to meet the child with a disability is solely the result of unavailability of reasonable services.

N. **Other** - incidents which involve behavioral episodes without the use of physical restraints, hospitalizations, or treatment at an emergency medical facility/urgent care facility due to medical conditions or illness.

Other Abuse: programmatic abuse, verbal/emotional abuse and sexual abuse.

1. **Programmatic Abuse**: aversive stimuli techniques not approved as part of a person’s plan. This can include isolation, restraints, or not following an approved plan and/or treatment strategy.

2. **Verbal/Emotional Abuse**: remarks or actions directed at a member enrolled in the Division that are ridiculing, demeaning, threatening, derogatory, or profane.
3. **Sexual Abuse:** any inappropriate interactions of a sexual nature toward or solicited from a member with developmental disabilities.

O. **Physical Abuse** - intentional infliction of pain or injury to a member.

P. **Property Damage/Theft** - damage or theft of state property in a member-related incident, or the theft or damage of a member’s property.

Q. **Provider** - any person, entity or person hired by the entity, who is paid, through contract or agreement to deliver services to any member.

R. **Suicide** -
   1. Attempted suicide with medical and/or police involvement.
   2. Threatened suicide with a statement from a member that he/she wants to commit suicide.
6002-C REPORTING REQUIREMENTS

REVISION DATE: 11/29/2017, 3/2/2015
EFFECTIVE DATE: July 31, 1993

When an incident occurs, take whatever actions are necessary to resolve the emergency and implement protective measures immediately for the person’s safety, which may include calling 9-1-1 or taking other emergency action.

A. As designated by law, medical professionals, psychologists, social workers, Support Coordinators, peace officers, and other people who have the responsibility for the care of a child or a vulnerable adult are mandatory reporters.

Mandatory reporters who have a reasonable basis to suspect that abuse or neglect or exploitation of the member has occurred must report such information immediately to a peace officer or protection services worker, (i.e., Adult/Department of Child Safety, Tribal Social Services). Refer to Support Coordination and Operations Policy 6002-E Incident Reports, for additional information regarding mandated reporting.

B. Serious Incidents, as described in Operations Manual Policy 6002-A Definitions of Incidents and Serious Incidents, must be reported and written as soon as possible, but no later than 24 hours after the incident.

Within 24 hours of a serious incident:

1. The provider must notify the District of the serious incident to include the submission of a detailed incident report.

2. District personnel must enter the incident into the Incident Management System (IMS) database within 24 hours or the next business day if the incident occurs over a weekend or holiday.

3. Notification to Responsible Person, i.e., guardian or family member - The responsible person must be notified, unless otherwise specified in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan).

The procedures for notification of the responsible person must be coordinated between the service provider and the Support Coordinator. The Support Coordinator or designated District staff member must ensure notification of the responsible person of an incident within 24 hours after the incident. The responsible person must also be notified of any follow up actions that occurs.

C. All other incidents listed in Policy 6002-A must be reported to the District by close of the next business day following the incident, and be entered by designated District personnel into the IMS database within 48 hours of notification (if applicable).

D. Incidents occurring after normal business hours must meet the above reporting requirements.
6002-D MEMBERS AT-RISK IF MISSING

EFFECTIVE DATE: July 31, 1993

The actions in this section are required when a vulnerable member leaves a Division-funded setting without planned alone time, is missing, and is at risk of harm; or when a member with alone time as defined in his/her Planning Document is missing longer than the Planning Document provides.

A vulnerable member is defined as a person who is at potential risk of harm while unsupervised in the community. He or she may:

- Be a danger to self or others
- Require medication to control a condition such as diabetes, seizure disorder
- Lack essential survival skills (such as the ability to communicate or move safely about the community).

The Individual Support Plan team must assess the potential risk of a member who may leave his or her service site without supervision and must note the results of that assessment in the Individual Support Plan. If the member has prescribed medication, the Team must contact the primary care physician and/or psychiatrist to determine whether a potential medical risk may arise if the member goes without prescribed medication for any length of time; this must be noted in the plan.

Provider Responsibilities:

A. When a vulnerable member leaves a Division-funded setting without planned alone time is missing and is at-risk of harm, or when a member with alone time as defined in his/her Planning Document is missing longer than the plan provides, the provider staff must:

1. Conduct a search of the immediate area.
2. If the member is not located within 15 minutes, notify the program supervisor/other staff to assist with the search.
3. If the member is not found within thirty minutes, notify law enforcement agencies (e.g., police, Sheriff’s Office) in both the immediate and surrounding communities and the parent/guardian.
4. To assist in locating the member, contact the following entities during the search: hospitals, shelters, jails and bus stations.
5. If the member is not located within one hour:
   a. Notify the Division by speaking directly to Support Coordination staff during regular business hours or by calling the District after hours reporting system on evenings and weekends.
b. Notify the Division immediately, when the missing member is located.

c. Report the following information to the Division and submit a written incident report to the Division within 24 hours:

i. Age of member

ii. General description of the person

iii. Time and location of disappearance

iv. Efforts to locate member

v. Vulnerability

vi. Means of communication

vii. Medical or special needs

viii. Precursors to disappearance

ix. Time police and parents/guardian notified

x. Other entities contacted

xi. Legal status (e.g., foster care, probation).

B. If the member is located within one hour, the provider must notify the parent/guardian immediately and provide notification to the Division within 24 hours.

**Media Involvement**

The decision to contact the media for assistance in locating a member must be a collaborative agreement between the Division, law enforcement officials, the parent/guardian, and the provider.

A. Prior to contact with the media, the provider must obtain verbal or written authorization from the parent/guardian. The approval must be documented in the provider and the Division records.

B. As authorized, the provider must work directly with law enforcement officials by providing essential information about the member to be released to the media. Law enforcement will make the request for release of the vulnerable member’s information to the media.

C. Support Coordination must immediately notify the District’s Program Manager or designee when a media release is requested, complete the *Incident Call Report (Form DDD-1746A FORFF)*, and submit DDD-1746A FORFF to the District Quality Unit Incident Report mailbox within 24 hours.

D. District Program Manager/designee must notify the Division on-call Batphone for notification to the Department’s Director and Public Information Officer.
**Planning Team Responsibilities**

The member's Planning Team will meet to discuss the incident within 30 days or as designated in the Behavior Plan to review the appropriateness of the current plan and Risk Assessment Tool.
6002-E INCIDENT REPORTS

REVISION DATE: 11/29/2017, 3/2/2015
EFFECTIVE DATE: July 31, 1993

The Incident Management System (IMS) is the computerized database for incidents and reports.

A. All incidents meeting the criteria of the IMS including serious incidents must be entered into the IMS as defined in this policy.

B. Reporting an Incident

Providers may use either of the following to record/report incidents:

- Division’s Incident Report (DD-191-FF) form
- A provider’s own internal incident report form, as defined in this policy.

C. Incident Reports must:

1. Be written clearly, objectively, and in order of occurrence without reference to the writer’s opinion (incident reports may be available to family/guardians and are considered legal documentation)

2. Include demographic information (i.e., full name, address, date of birth and Focus ID number) about the member

3. Include the names and job titles of staff that witnessed or were involved in the alleged incident

4. Include a description of the incident including all known facts, location, and the date and time the incident occurred

5. Include causes of injury (if applicable)

6. State whether the responsible person was notified and, if not, why

7. Include whether or not law enforcement, Adult Protective Services, Department of Child Safety or Tribal Social Services were contacted

8. Include signatures and names of the person completing the report and his/her supervisor and any additional comments

Note: If electronic incident reports are completed/submitted from a hand-written document, those documents must be maintained and provided to the Division, upon request.

9. Be completed for each individual involved in the incident and reference other individuals by initials only

10. Be included in the member’s primary record maintained by the Support Coordinator and by the provider completing the report.
6002-F FACT FINDING

REVISION DATE: 10/1/2014
EFFECTIVE DATE: July 31, 1993

The Division may initiate a fact-find of any incident. Except when such action would compromise the legal investigation by law enforcement, Protective Services, or another State Agency (i.e., DES Office of Licensure, Certification, and Regulation, an Office of the Inspector General (OIG)) the Division should notify the service provider of the onset of a fact find.

Service providers shall ensure that any service provider worker alleged to have endangered the health or safety of an individual shall not have direct contact with any individual served by the Division, pending the outcome of the Division's fact finding activities.

Division staff is responsible for notifying and assigning appropriate personnel to initiate fact-finding.

The District Program Manager is responsible to assign only qualified Division personnel to complete a fact-finding. Division personnel assigned to conduct a fact finding will meet the following qualifications:

A. Have demonstrated ability to be objective;
B. Can maintain confidentiality;
C. Can complete the task within the assigned period;
D. Have expertise regarding the particular situation; and,
E. Have no conflict of interest involving the situation.

The staff assigned to complete fact finding of any incident must have successfully completed fact-finding training offered by the Division.

When a fact-finding of an incident occurs, the following apply:

A. Protective measures must be taken immediately for the person’s safety.
B. Initiation of the fact-finding occurs within 24 hours of notification or the next business day for the following incidents:
   1. Allegations of physical abuse which results in medical treatment or police involvement;
   2. Allegations of sexual abuse;
   3. High risk incidents of member missing;
4. Attempted suicide;
5. Unexpected deaths;
6. Allegations of neglect that involve imminent danger; or,
7. Accidental injuries involving hospitalization.

C. Fact-Findings are initiated within 10 days of notification for:

1. Allegations of physical abuse which do not result in medical/police intervention;
2. Allegations of verbal/emotional or programmatic abuse;
3. Community complaints;
4. State property damage or theft above $100;
5. Member property damage or theft over $25;
6. Expected deaths;
7. Allegations of human rights violations;
8. Allegations of neglect that involve potential danger;
9. Accidental injuries that resulted in medical intervention; or,
10. Legal issues involving allegations of fraud, member exploitation, or provider drug use.

The fact-finding may involve a review of the provider’s incident reports, as well as a review of other records maintained in the provision of services. A fact-finding will typically include interviewing the person reporting the incident, the service provider, and/or members who might have additional information or insight regarding the incident.

If an external investigation is initiated, the Division may delay its fact-finding until Office of Special Investigations, Department of Child Safety (DCS), Adult Protective Services, Tribal Social Services, law enforcement personnel, or other State Agencies (e.g., DES Office of Licensing Certification and Regulation [OLCR], OIG) have completed their investigation, to avoid potential conflicts. If another state agency is involved, the assigned Division employee must coordinate efforts with that agency.

Conclusion of the Division’s fact-finding shall be within 30 days from notification date of the incident. A fact-finding can be extended an additional 30 days twice for a total of 90 days if more time is needed to allow DCS, Adult Protective Services, Tribal Social Services, law enforcement or, other state agencies to complete their investigation and provide the results to the Division.
6002-G ABUSE AND NEGLECT

EFFECTIVE DATE: July 31, 1993

Definitions

A. **Abuse** (any of the following) -
   1. Intentional infliction of physical harm
   2. Injury caused by negligent acts or omissions
   3. Unreasonable confinement or unlawful imprisonment
   4. Sexual abuse or sexual assault.

B. **Abusive treatment** (any of the following) -
   1. Physical abuse by inflicting pain or injury to a member. This includes hitting, kicking, pinching, slapping, pulling hair, or any sexual abuses
   2. Emotional abuse which includes ridiculing or demeaning a member, making derogatory remarks to an member or cursing directed towards an member
   3. Programmatic abuse which is the use of an aversive stimuli technique that has not been approved as part of such person's Individual Support Plan (ISP) and which is not contained in the rules and regulations adopted pursuant to A.R.S. § 36-561(B). This includes isolation or restraint of a member.

C. **Child, youth or juvenile** - a member who is under the age of eighteen years.

D. **Exploitation**: - the illegal or improper use of an incapacitated or vulnerable adult or his/her resources for another's profit or advantage.

E. **Incapacity**: - an impairment by reason of mental illness, mental deficiency, mental disorder, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that the person lacks sufficient understanding or capacity to make or communicate informed decisions concerning his/her person.

F. **Neglect**: - the deprivation of food, water, medication, medical services, shelter, cooling, heating, or other services necessary to maintain minimum physical or mental health. Neglect also means any of the following:
   1. Intentional lack of attention to physical needs of members such as toileting, bathing, meals, and safety.
   2. Intentional failure to report health problems or changes in health condition to immediate supervisor or nurse.
   3. Sleeping on duty or abandoning work station.
   4. Intentional failure to carry out a prescribed treatment plan for a member.
G. **Physical injury** - the impairment of physical condition, including, but not limited to any of the following: skin bruising, pressure sores, bleeding, failure to thrive, malnutrition, dehydration, burns, fracture of any bone, subdural hematoma, soft tissue swelling, injury to any internal organ, or any physical condition which imperils health or welfare.

H. **Serious physical injury** - physical injury which creates a reasonable risk of death or which causes serious or permanent disfigurement, serious impairment of health or loss, or protracted impairment of the function of any bodily organ or limb.

I. **Vulnerable adult** - a member who is eighteen years of age or older who is unable to protect himself/herself from abuse, neglect, or exploitation by others because of a mental or physical impairment.

**Department of Child Safety**

When a Support Coordinator suspects abuse or neglect, as a mandated reporter, the Support Coordinator must immediately report to Department of Child Safety (DCS). Additionally, any allegation of abuse or neglect must be reported in accordance with A.R.S. §13-3620 as outlined below. Upon reporting, the Support Coordinator should provide sufficient information regarding the alleged abuse and/or neglect to allow the DCS worker to set the appropriate priority to the case. The Support Coordinator must cooperate during investigations, and follow-up as required.

Reports made regarding American Indians will be in accordance with tribal procedures. Reports made to DCS must contain all of the following:

A. The names and addresses of the minor and his/her parents or person or persons having custody of such minor.

B. The minor's age, and the nature, and extent of his/her injuries or physical neglect, including any evidence of previous injuries or physical neglect.

C. Any other information that such person believes might be helpful in establishing the cause of the injury or physical neglect.

Reports must be made to DCS, within 24 hours, per instructions provided on the DCS website.

**Incident Report**

When the Support Coordinator reports alleged abuse or neglect to DCS, the Support Coordinator must complete an *Incident Call Report (DDD-1746A-FORFF)* and submit to the District Incident Report mailbox. The District will ensure the DCS Program Manager receives an information copy of all IRs on DCS referrals from Division staff.

The list of persons with a duty to report a reasonable belief that a minor has been the victim of abuse or neglect is expanded to include any person who is employed as the immediate or next higher level supervisor to or administrator of a person who has a duty to report (other than the child's parent or guardian) and who develops the reasonable belief in the course of the supervisor's or administrator's employment. If the supervisor or administrator reasonably believes that the report has been made by the person with a duty to report, the supervisor or administrator is not required to report.

When DCS staff reports alleged abuse or neglect made by someone other than Division staff, the Support Coordinator will complete and forward an Incident Call Report.
Investigative Procedures

It is the responsibility of DCS to determine whether an investigation of the allegation is necessary and to proceed with the investigation. The Support Coordinator must receive the results of the investigative decision by DCS. If, subsequent to an investigation, DCS opens a case, the Support Coordinator must participate in a team staffing to develop a collaborative plan.

Working with Department of Child Safety

The Support Coordinator must work as expeditiously as possible with the DCS worker to resolve any concerns regarding a report or investigation made to DCS.

Whenever possible, the Support Coordinator must meet in person with the DCS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator must notify his/her immediate supervisor whenever issues cannot be quickly and satisfactorily resolved at the Support Coordination level. Supervisory and/or management staff must immediately pursue the steps necessary to resolve the issues.

Adult Protective Services

In accordance with A.R.S. §46-454, as a mandated reporter, the Support Coordinator or other Division staff must immediately report any suspicions/allegations of abuse, neglect or exploitation of an adult to Adult Protective Services (APS). APS responds to allegations of abuse, neglect, or exploitation according to the following requirements the person:

A. Is 18 years of age or older

Reports

Reports made to APS must contain:

A. The names and addresses of the adult and any persons having control or custody of the adult, if known
B. The adult's age, and the nature, and extent of his/her incapacity or vulnerability
C. The nature, and extent of the adult's injuries or physical neglect or of the exploitation of the adult's property
D. Any other information that the person reporting believes might be helpful in establishing the cause of the adult's injuries or physical neglect or of the exploitation of the adult's property.

When the member resides in his/her own home, a family residence, or an agency not funded by the Division, APS will take the lead for the investigation. APS will work together with the District QA Incident Specialist, Support Coordinator or other Division staff as appropriate. Specific responsibilities are decided on a case-by-case basis. The APS worker will remain involved until the abuse or problem situation has been resolved.

When the adult resides in a DES/DDD operated or funded program, APS will investigate the complaint. DES/DDD is responsible for coordination with APS and notification of the fact finding.
process. DES/DDD staff, as appropriate, will conduct a fact-find to determine programmatic and contract compliance issues.

**Incident Report**

When a report is made to APS, the Support Coordinator must complete an *Incident Call Report (DDD-1746A FORFF)*, following procedures established in this policy manual.

**Working with APS**

The assigned DDD QA Incident Specialist and Support Coordinator must work as expeditiously as possible with the APS worker to resolve any concerns regarding a report or investigation made to APS.

Whenever possible, the Support Coordinator must meet in person with the APS worker to review all aspects of the report including any information the Support Coordinator could provide regarding important historical information.

The Support Coordinator must notify his/her immediate supervisor whenever issues cannot be quickly, and satisfactorily resolved at the Support Coordination level. The Support Coordinator must cooperate during investigations, and follow-up as required. District Quality Assurance Supervisory and/or management staff must immediately pursue the steps necessary to resolve programmatic or contractual issues identified during the investigation.
6002-H REFERRAL TO OTHER INVESTIGATIVE AGENCIES

REVISION DATE: 11/29/2017, 3/2/2015
EFFECTIVE DATE: July 31, 1993

The Assistant Director, Chief Quality Officer, Corporate Compliance Unit, or Office of Compliance and Review may refer incidents for investigation to the Department of Economic Security (DES) Office of Special Investigations. An external investigation request may be made for incidents involving any of the following:

A. Potential criminal activity
B. Possible misconduct by a Division or service provider's employee
C. Fraud (this type of incident must also be referred to Arizona Health Care Cost Containment System (AHCCCS), as appropriate).
6002-I INCIDENT CLOSURE AND CORRECTIVE ACTIONS

REVISION DATE: 11/29/2017, 3/2/2015
EFFECTIVE DATE: July 31, 1993

A. An incident is complete when:
   1. The fact finding if needed is reviewed and approved by the Division;
   2. Recommendations for corrective action are identified and provided to appropriate Division and provider personnel;
   3. Corrective action plans, if needed, are requested, and received from the provider and approved by the Division; or,
   4. Designated District personnel have verified the information entered into the Incident Management System (IMS) database and have verified that all corrective actions have been completed no later than 60 days from the acceptance of for a plan.

B. Corrective actions may be member-specific or systemic.
   An example of a member-specific corrective action would be requiring the person’s Planning Team to reconvene to discuss the incident and review the need for any changes in the Planning Document (Individual Support Plan/Individualized Family Service Plan/Person Centered Plan) or Risk Assessment to ensure the health and safety of the member.

   Systemic corrective actions may require the provider to rewrite or clarify agency policy, procedure, recommend specialized training of staff, or require other quality improvement actions to increase the ability of the provider to improve the health and well-being of members served.

C. The member’s Planning Team must review all incidents for the effectiveness of services and assess risk as part of the Planning Document and update the process.

D. The Division’s Program Monitoring staff (at the Central Office and District Level) must review all incidents for residential placements and Day Treatment & Training programs to be monitored prior to the visit to identify any areas that may warrant extra monitoring.
6002-J TRENDS FOR QUALITY IMPROVEMENT

REVISION DATE: 11/29/2017, 3/2/2015
EFFECTIVE DATE: July 31, 1993

Trending is an essential component of the Incident Management System (IMS).

District Quality Management lead must compile District-specific quarterly data analysis reports and submit to the Quality Management unit. The content must include at a minimum:

A. Total incidents by type and category, provider, and member

B. Trends by provider and member, including:
   1. Total allegations of abuse, neglect, and exploitation
   2. Information of whether or not the allegation was substantiated

C. A narrative analysis of findings, patterns, areas of concern, and recommended actions for quality improvement.

The Division’s Central Office designee must prepare a Statewide Incident Summary Report monthly, quarterly and/or annually, that includes at a minimum:

A. Total incidents by type and category by District

B. Trends by provider and member, including:
   1. Total allegations of abuse, neglect, and exploitation
   2. Information of whether or not the allegation was substantiated.

C. A narrative analysis of findings, patterns, areas of concern, and recommended actions for quality improvement.

Incident Summary Reports must be provided to the Quality Administrator, the Assistant Director, and designated personnel.

The Division Management Team and Statewide Quality Management Committee must formally review the summary reports on a quarterly basis.

If the District or Statewide Incident Summary Reports indicate any areas of concerns or patterns, the Central Office designee, District Quality Management leads or designee must complete focus studies. If the focus study confirms any areas of concerns or patterns, corrective actions will be recommended for quality improvement.
6002-K  INFORMATION SHARING

REVISION DATE:  3/2/2015
EFFECTIVE DATE:  July 31, 1993

Incident reports may be made available to:

A.        The Human Rights Committees as prescribed in this policy manual;

B.        The member/responsible person(s);

C.        Others who are bound by confidentiality on a need to know basis; and, or,

D.        All requests should be directed to the Office of Compliance and Review.

Fact finding reports and action plans are confidential. Fact-finding and corrective action plans are summarized in the Incident Management System (IMS) Fact Finding screens.
6002-L  MORTALITY REVIEW AUDITS

REVISION DATE:  3/2/2015  
EFFECTIVE DATE:  July 31, 1993  

Computer and desk audits will be conducted to determine the timeliness and accuracy of reports, investigations, and implementation of corrective actions involving the death of a member. Quality reports of the system will also be used to identify patterns of user concerns, i.e., entering an incident into the incorrect type or category, common data entry errors, that indicate the need for additional training, technical assistance, or management information system change.
6002-M MORTALITY REVIEW PROCESS

REVISION DATE: 11/29/2017, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 11-597

The purpose of this policy section is to improve quality of care for members by a systematic examination of deaths.

Notification Procedure

When a death is reported to a Support Coordinator, the Support Coordinator will complete the Incident Call Report (DDD-1746A FORFF) and submit to the District Quality Unit’s Incident Report mailbox for entry into the Incident Management System (IMS) database within 48 hours of notification of a death.

Once the Support Coordinator is alerted to an incident, he/she must notify the responsible person or next of kin, if they have not already been notified. The Quality Assurance Manager or designee must immediately notify the appropriate District Manager or designee within 24 hours of the Division’s notification of a member’s death. All service authorizations must be closed in Focus with the date of death as the effective date by the Support Coordinator. Support Coordination (Department of Child Safety) and Bereavement Counseling offered to the family may remain authorized after the Division was notified of the death. If staff becomes aware of any service utilization after the date of the member’s death, staff should report the service utilization into the IMS.

If Health Care Services (HCS) staff is notified of a death, HCS staff must notify the Central Office on-call person within 24 hours.

The District Manager or designee must notify:

- The Assistant Director/designee or the Division’s on-call line within 24 hours of being notified of a death
- The Adult Protective Services or Department of Child Safety agency as required by statute.
- The Human Rights Committee District liaison.

Central Office designees will notify the Department of Administration (DOA) Risk Management, if the death may give rise to a liability claim against the state.

Review Procedure

A. District Review

1. The Support Coordinator and his/her supervisor must jointly review all deaths within 30 days, to identify apparent issues relating to care or cause of death.
2. The Support Coordinator or designee must enter the following information and answer the following questions, as applicable relating to the death, into the IMS database:

   a. Member’s underlying primary medical conditions

   b. Detailed circumstances of the death: Date of Death. What happened? Where did it happen? Was a provider present? Did providers follow policy such as calling 911 and performing CPR? Had the member been ill? Was the member recently seen by PCP? What symptoms of illness did the member have? What is the suspected cause of death (if known)?

   c. Was hospice involved?

   d. Did the member have an Advance Directive in place?

   e. Had Department of Child Safety/Adult Protective Services (DCS/APS) been involved within the last year?

   f. Is there litigation pending?

   g. Is there further fact-finding pending?

   h. Was the family/guardian notified?

   i. Did the Division offer support/grief counseling for the family?

3. The District must send the primary case file to Central Office Health care Services within 60 days after being notified of the death.

B. Health Care Services Quality Assurance Investigative Nurse (HCS QA Nurse) Review

   1. The Health Care Services Quality Assurance (QA) Nurse reviews the mortality information documented in the IMS database and requests further information, as necessary.

   2. The Chief Medical Officer assigns the death into one of the following categories:

      Level A These include deaths that are expected and/or anticipated, due to natural causes, such as terminal illness or congenital anomalies. Level A deaths typically would also include members who lived with family or independently and were not receiving any services from the Division at the time of death.

      Level B These include deaths that are not expected and/or are sudden, such as trauma or pneumonia that progresses to respiratory failure. These deaths require a closer inspection into the circumstances surrounding the death and assessment of any systemic issues which should be addressed. Other situations where Level B is indicated include: aspiration, coroner cases, law enforcement/9-1-1 calls, decubitis, methicillin-resistant staphylococcus aureus (MRSA), unexpected circumstances, unusual or suspicious circumstances, and
problems with emergency or other medical care.

C. The HCS QA Nurse must:
   1. Request death certificates and when indicated, autopsy reports.
   2. Gather additional medical records for review when indicated.
   3. Track mortality information in a database specifically designed to collect information related to member deaths.

D. The Chief Medical Officer must:
   1. Communicate via IMS the status of the mortality review and when the case is considered closed.
   2. Share any recommendations in the summary.

E. Based on the information reviewed by the Chief Medical Officer, cases will be selected from the Level B deaths to present to the Mortality Review Committee at their next quarterly meeting; the selected cases warrant additional review by the Committee and demonstrate situations where systemic improvement may be made.

**Mortality Committee Review**

A. The Mortality Review Committee must:
   1. Discuss each case selected and identify changes to practice, training, or processes that may positively affect care and treatment.
   2. Report in writing their recommendations to the Management Team.

B. The Management Team must, within 30 days of receiving a recommendation from the Mortality Review Committee, report their disposition and intended steps to respond to recommendation(s).

C. Following the Mortality Review Committee review, the case must be closed unless it is referred for Level C review.

**Review Level C – Root Cause Analysis Review**

A. The Chief Medical Officer must arrange the Root Cause Analysis, which must follow the general protocols recommended by the Joint Commission on Accreditation of Health Care Organizations, and must be conducted on cases recommended to the Assistant Director by the Mortality Review Committee or as requested by the Assistant Director.

B. No more than three Root Cause Analyses must be conducted in a fiscal year.

C. The HCS QA Nurse must monitor the implementation of recommendations from a Root Cause Analysis.
Process

A. The Mortality Review Committee must meet at least quarterly.

B. The Chief Medical Officer must issue annually a Mortality Review and Analysis that will aggregate, analyze, and summarize mortality data and actions taken for system improvements.

C. The HCS QA Nurse is responsible for monitoring the mortality review process and conducting integrity checks, including protecting any privacy rights of the deceased.

D. Autopsies must always be requested for children in foster care. For all other deaths, requests must be made whenever it is possible that something can be learned about the death. Consent for an autopsy rests with the responsible person or next of kin, unless the county attorney or coroner is involved.

The HCS QA Nurse requests:

1. An autopsy from the county medical examiner
   Arizona Revised Statute 11-597 provides for county medical examiners to complete an autopsy and outlines when this is required.

2. Authorization for an autopsy from the family (when the medical examiner does not identify a need for an autopsy)
   The Division can request the family to authorize an autopsy, at the expense of the Division, when the Division’s Chief Medical Officer believes there are unanswered questions surrounding the death.

E. Death Certificates will be requested by the HCS QA Nurse.

F. Reviewers and all others involved with these processes must in all cases exhibit compassion and sensitivity to next of kin, caregivers, and others who cared about the member.
6002-N FRAUD AND FALSE CLAIMS

EFFECTIVE DATE: July 31, 1993

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 procedures for prevention, detection, and reporting of fraud, false claims, and abuse within the Division.

Policy Objectives

The objectives of this policy are to:

A. Prevent or detect fraud and abuse.
B. Delineate reporting requirements.
C. Define procedures.
D. Explain Corporate Compliance.
E. Describe training requirements.
F. Specify policy requirements for providers.

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 and regulations published in the Federal Register by the departments and agencies of the Federal Government.
C. Claim – Under the 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 –The Deficit Reduction Act of 2005 (DRA), is a United States Act of Congress concerning the budget (Public Law No: 109-171 (02/08/2006)). 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** - 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 (31 U.S.C. § 3729-3733). 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

1. 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. **Preliminary Fact-Finding Investigation** - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practice, it may conduct a preliminary fact-finding to determine whether there is a sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

I. **Prevention** - Keep something from happening.

J. **Primary Contact** - The central person within the Division who is charged with the responsibility to report potential incidents of fraud and abuse to the AHCCCS in the manner prescribed in this policy.

K. **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 Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.
L. **Remit Advice** - A document detailing the status of each line item in a provider claim, by member specificity. It reports the resolution for each line as paid, denied, or pended. Reason codes are attached and summarized for those lines denied.

M. **Waste** - As defined by the Arizona Health Care Cost Containment System (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.

**Prevention and Detection**

The Division is committed to fostering a culture of compliance and an environment conducive to preventing and detecting fraud, waste, and abuse. The Division provides training to its employees about their role in reporting concerns and problems in relation to compliance and ethics. All Division employees 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 aspect of organizational compliance. Any employee who fails to report properly either through internal lines of communication 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, will be subject to discipline, up to and including termination.

As part of the Division’s Compliance Program objectives, all employees, contractors, agents, subcontractors, in particular those involved in the provision or arrangement of provision of services, under government programs including members and providers, must report 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.

A. The Division establishes internal controls on the member payment system including claim edits and prior authorization requirements. The Claims System is used to prevent and/or detect payments to providers when services were not performed, not authorized, or otherwise inappropriate. The original claims process is tested for the validity of its ability to detect fraud and misuse by reporting high utilization by members (CLT_0060), underutilization by members (CLT_0150), inappropriate service costs, and analyzing units by service title, month by month over the fiscal year. referral to AHCCCS OIG for suspicion of fraud, waste, or abuse. The Business Operations Unit conducts a post-payment review process, as outlined below:

B. **Claims Edits**

Claims are edited through a computerized system. During the initial processing of a claim, the claim is reviewed for items such as member eligibility, covered services, excessive or unusual services, duplication of services, prior authorization, invalid rate codes, and duplicate claims. Claims over a certain amount are automatically referred for review if the provider has exhausted all authorized units.

The Division segregates the functions of service authorization and claims processing.

C. **Post Processing Review of Claims**

Once claims are paid, the Division conducts a retrospective review of a sample of claims to ensure that the processing of the claim was specific to the processing instructions for the specific review. The Division conducts audits of claims payments to attain reasonable
assurance that payments are being prepared correctly for the claims submitted by authorized providers for eligible AHCCCS members. The Division reviews detailed remittance advice. The Auditor General performs an annual audit of the ALTCS program including claims processing and payment.

D. Prior Authorization


E. Utilization/Quality Management

The Division complies with the requirements set forth in the AHCCCS Medical Policy Manual.

F. Contract Provisions

All providers must comply with the "Uniform General Terms and Conditions" and the "Special Terms and Conditions" of the Qualified Vendor Agreement or the terms of the Independent Provider's "Individual Service Agreement."

G. Reporting

The Division enters all reports of suspected fraud or false claims into the Incident Management System (IMS). The incidents are reviewed, trended, and reported as required.

The IMS is the tracking system for any suspected fraud or false claims reported by providers, members, or staff.

Report suspected fraud, waste, or abuse via one of the following:

1. Call the toll free DES/DDD Hotline at 877-822-5799.
3. Mail to:
   DES/DDD
   Attention: Corporate Compliance Unit
   1789 W. Jefferson Street
   Phoenix, AZ 85007
4. Email: DDDFWA@azdes.gov
5. Contact AHCCCS through their website: https://www.azahcccs.gov/Fraud/AboutOIG/
False Claims Act

The False Claims Act (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. 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 will be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the Division 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.

Corporate Compliance

The Corporate Compliance Officer implements, oversees, and administers the Division’s compliance program including fraud and abuse control. The Corporate Compliance Officer must be an on-site management official, available to all employees, with designated and recognized authority to access and provide records and make independent referrals to the AHCCCS Office of Inspector General.

The Division reviews, analyzes, and trends fraud and false claims through the Compliance Committee meeting held at least once quarterly. The committee is a body comprised of the Chief Compliance Officer and Executive Leadership. Executive Leadership is limited to the following positions/designees:

- Assistant Director/Chief Executive Officer
- Office of Person Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Medical Chief Officers
- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer
The Corporate Compliance Committee meeting includes information that has been forwarded for review through more frequent standing committees such as the bi-weekly Contract Compliance Committee. Information that may be included at a Corporate Compliance Committee meeting includes but is not limited to:

- Incident Management System data (including suspected fraud)
- Consumer Resolution System data
- Program Monitoring reviews; claim disputes, appeals and state fair hearings
- Monthly meetings between the Attorney General’s Office, Office of Administrative Review, Assistant Director and Executive Leadership to review any pending litigation
- Compliance Risk Management data analysis and remediation
- Development of strategies to promote compliance and detect any potential violations
- Development, implementation and monitoring of Corrective Action Plan (CAP)
- Training and Education
- Review of Compliance policies and procedures
- Approval of Standards of Conduct
- Identify staffing needs and resources of the Compliance Unit
- Communications to all colleagues regarding compliance issues (e.g., HIPAA, Codes of Conduct violations, Whistleblower Protections, False Claims)

The committee makes recommendations for improvement of the compliance program as identified through the analysis and review of reports. This committee is authorized to implement or require implementation of all necessary actions to ensure that the Division achieves the goals of an effective compliance program.

**Training**

The Division has available training through both the continuous core curriculum as well as
Computer Based Training regarding fraud, waste and abuse. The Corporate Compliance Unit provides standalone in-services to each District regarding compliance issues including the FCA. The Division has contract language requiring Qualified Vendors to comply with the Deficit Reduction Act including providing training to their employees.
6002-O  HEALTH CARE ACQUIRED CONDITIONS

REVISION DATE:  3/2/2015
EFFECTIVE DATE:  July 31, 1993

Identification and Reporting

Any Health Care Acquired Conditions (HCAC) occurrence that has been identified and verified will be entered into the Division’s Information Management System (IMS) by the Health Care Services (HCS) Quality Assurance Registered Nurse/designee who has the final determination of confirmed HCAC occurrence and will enter each confirmed HCAC as an Incident Report (IR) within twenty-four (24) hours of confirmation. These IR’s will be reviewed on a daily basis for reporting to Arizona Health Care Cost Containment System (AHCCCS), by the Division’s HCS Quality Assurance Registered Nurse. In addition, a report could be made to the appropriate regulatory boards and agencies (Arizona Department of Health Services, Arizona Medical Board, and Arizona State Board of Nursing).
**6003-A DEFINITIONS**

**REVISION DATE:** 3/2/2015  
**EFFECTIVE DATE:** July 31, 1993

*Action*: a written decision made by the Division not agreed upon by the member/responsible person, when Arizona Long Term Care System (ALTCS) actions include:

A. Service denial or a limited authorization (an authorization in an amount, duration or scope less than what is ordered or requested) of a requested service, including the type or level of service, is granted; or

B. A previously authorized service is reduced, suspended, or terminated;

C. Payment for a service, in whole or in part, is denied in accordance with the Arizona Administrative Codes;

D. Authorization of services not initiated in a timely manner; or,

E. A request by a member, who resides in a rural area with only one health plan, is denied his/her right to obtain services outside the network.

*ALTCS Notice of Action*: the written notice to the affected member regarding an action by the Division.

*Appeal*: formal process under ALTCS to request a review of an action taken by the Division.

*Administrative Decision*: the formal decision made by the Office of Compliance and Review (OCR) related to a state funded service, including eligibility.

*Administrative Review*: formal review and investigation of the stated issues conducted by the OCR or assigned designee.

*Grievance*: a member/responsible person's expression of dissatisfaction with any aspect of a member's care not involving an action.

*Notice of Intended Action*: a letter from the Division related to a state funded service informing the member/responsible person of the decision and the member/responsible person's due process rights.

*Notice of Appeal Resolution*: the formal written decision made by the OCR regarding an ALTCS covered service.
6003-B INFORMAL RESOLUTION/GRIEVANCE PROCESS NON-ARIZONA LONG TERM CARE SERVICES

REVISION DATE: 8/14/2019, 4/10/2019, 7/22/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

A member or the member’s responsible person may have a grievance or expression of dissatisfaction with any aspect of the member’s care such as a quality of care issue or problems related to communication or courtesy. A member or the member’s responsible person, including members with Serious Mental Illness (SMI) and or with a Children’s Rehabilitative Services (CRS) eligible condition, will be encouraged to discuss any problems with the Support Coordinator as soon as they arise to seek resolution. The Support Coordinator is responsible for reviewing the grievance(s) and attempting to resolve it informally before the grievance is elevated to the Division of Developmental Disabilities Customer Service Center.

If necessary, the Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution. At any time, the member or the member’s responsible person may contact the Support Coordinator's Supervisor or Program Manager.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or the member’s responsible person of the process for filing a grievance by contacting the DDD Customer Service Center directly at 1-844-770-9500 or DDDCustomerServiceCenter@azdes.gov.

The Support Coordinator must document the member's grievance, the Support Coordinator's attempts to resolve the grievance, and that the member or the member’s responsible person was advised of the right to file a grievance and the process for doing so. This documentation should be included in the progress notes.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division of Developmental Disabilities Customer Service Center will advise the member or the member’s responsible person in writing of the resolution of the grievance within 10 business days, or no later than ninety (90) calendar days from the receipt of the grievance and will record all results in the Resolution System.
6003-C APPEAL PROCESS FOR MEMBERS WHO RECEIVE STATE FUNDED SERVICES

EFFECTIVE DATE: July 31, 1993

When a decision is rendered by the Assistant Director (AD) with which the member or his/her responsible person does not agree, he/she may file a request for a hearing by the Department of Economic Security (DES) Office of Appeals. The appeal request must be made in writing and received by Office of Administrative Review (OAR) no later than 30 calendar days after the postmark date of the decision letter. The request should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3 3rd Floor, Suite 301p 2HE5
Phoenix, Arizona 85012

Once the hearing request is made, OAR staff will prepare a duplicate file for submission to DES along with the hearing request. This file will include copies of the Notice of Intended Action, request for administrative review, investigative materials, and the decision letter.

DES representatives will schedule the hearing and the member/responsible person will be notified of the date and time of the hearing in writing. DES will also notify OAR of the hearing schedule.

At the hearing, the member or his/her responsible person, including any legal representative and a Division representative will meet with a DES Hearing Officer. This hearing is informal and the rules of evidence do not apply.

Based on the information gathered by the Hearing Officer through testimony, presentation of evidence, and the record supplied by OAR, the Hearing Officer will prepare written findings of fact and conclusions of law, and render a decision in writing. Any member adversely affected by the decision will be notified by the Hearing Officer of the right to appeal the decision.

An appeal of the Hearing Officer's decision, if requested, must be made to the DES Office of Appeals no later than 15 calendar days after the date of the decision. The request must completely explain the grounds on which the appeal is being made.

Appeal requests should be sent to:

DES Office of Appeals
1951 West Camelback Road, Suite 360
Phoenix, Arizona 85015

The DES Office of Appeals/Appeals Board (the Board) will decide the appeal. The Board will issue a final written decision on the matter within a reasonable time period.
If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the DES decision through the court system. All administrative remedies must be exhausted before the court will consider the case.
6003-D NOTICE OF INTENDED ACTION (STATE ONLY)

REVISION DATE: 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1802

A Support Coordinator or District representative must issue a written Notice of Intended Action to any member/responsible person who receives services from Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) that is not eligible to receive Arizona Long Term Care System (ALTCS) services, or the service is not an ALTCS covered service.

State only actions include:

A. Service denial, change, reduction, termination; or,
B. Eligibility is denied or terminated.

The notice must be issued on the Division form, Notice of Intended Action or Service System Discharge, and include the following information:

A. The name and address of the responsible person;
B. The date that the notice is mailed;
C. The name of the member affected by this action;
D. The action that is being taken;
E. The effective date of the action;
F. The reason for the action;
G. What the member/responsible person can do if he/she does not agree with the action being taken; and,
H. The signature of the person authorized to make the decision regarding the determinations noted previously.

Every effort must be made to explain the action using vocabulary the member/responsible person will understand. The notice will be written in English and when appropriate and reasonably possible to do so, in the primary language of the recipient. If the recipient cannot understand the notice, the recipient may call the Support Coordinator for assistance with interpretation.
6003-E ADMINISTRATIVE REVIEW PROCESS (STATE ONLY)

REVISION DATE: 8/28/2019, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-563; A.A.C. R6-6-1803

If the member or his/her responsible person does not wish to pursue informal resolution of his/her complaint, or the informal resolution process was not successful, a request for administrative review can be made. This request must be made within 35 calendar days of the attempted informal resolution or written notice of intended action. If there was no informal resolution process or written notice, the member or his/her responsible person has 35 calendar days from the date of the initial problem to request an administrative review.

The request should be made either in writing or by telephone to the Office of Administrative Review (OAR). Verbal requests will not be accepted.

Whatever manner of request for a review is used, the following information must be given:

A. Member's name, date of incident, address, identification number, birth date and health plan, if appropriate.
B. Responsible person's name, relationship, and telephone number.
C. Support Coordinator's name and telephone number.
D. Physician's name, if applicable.
E. Statement of the nature of the complaint and the action requested.

All written requests for Administrative review should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3rd Floor, Suite 301p 2HE5
Phoenix, Arizona 85012

OAR will complete a review and investigation of the stated issues. OAR staff will submit a request for facts to the District office. Any documentation of the administrative review must be returned to OAR within 5 calendar days. OAR staff will then contact the member or his/her responsible person, medical providers, service providers and/or District staff to obtain additional information. Relevant policies will be reviewed and Central Office staff will be consulted as necessary. Once the fact finding is complete, a written decision will be rendered to the member or his/her responsible person within thirty (30) calendar days of receipt of the member's administrative review request.
There will be no change in the member’s status or the services he/she receives while the administrative review is occurring. An exception may be allowed under certain circumstances (i.e., a member may need additional services and/or care if necessitated by a change in health status).
Further appeal options depend on whether the member is Arizona Long Term Care Service (ALTCS) eligible or whether he/she receives state funded services. There are common components to the two appeal processes, which include:

A. The hearing must be held at the established hearing location that is most convenient for the member or responsible person. The member and his/her responsible person must be informed of the date, time, and location of the hearing no less than 20 calendar days in advance for standard requests. At the discretion of the hearing officer, the hearing can be conducted by telephone.

B. The hearing notice must state that the member or responsible person has the right to:
   1. Present his/her case in person or by telephone;
   2. Receive a copy of all case file documents, and any material that the Division will use in the hearing at a reasonable time before the hearing;
   3. Obtain assistance from the Division local office in preparing his/her case;
   4. Make inquiry at the Division local office concerning the availability of free legal resources; and
   5. Request a change of the hearing officer.

C. Hearings must be conducted in an orderly manner by the hearing officer. The hearing officer can rule on the admissibility of evidence, and include or exclude witnesses. Parties may present evidence, cross examine witnesses, and present arguments.

D. A complete record is made of all hearings. The member and his/her responsible person may inspect the record at a location that is accessible to them.

E. The hearing decision must be based solely on the evidence and testimony presented at the hearing, appropriate state and federal law, and applicable Department of Economic Security (DES) rules.
6003-G ARIZONA LONG TERM CARE SERVICE GRIEVANCE PROCESS

REVISION DATE: 8/14/2019, 4/10/2019, 6/10/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

State Only

A member or the member’s responsible person, including members with Serious Mental Illness (SMI) condition, may have a grievance regarding an issue unrelated to a Notice of Intended Action, such as a quality of care issue or problems related to communication or courtesy. Members and their responsible persons will be encouraged to discuss any problems or grievances with the Support Coordinator as soon as they arise.

The Support Coordinator is responsible for reviewing and investigating grievances and attempting to resolve them informally before they reach the grievance stage. The Support Coordinator should contact the District Program Manager (DPM) or designee to inform them of the informal resolution. If needed, the DPM or designee may assist in the informal resolution.

If no informal resolution to the problem is possible, the Support Coordinator will advise the member or the member’s responsible person of the process for filing a grievance by contacting the DDD Customer Service Center directly at 1-844-770-9500 or DDDCustomerServiceCenter@azdes.gov.

Arizona Long Term Care Service Members

The Support Coordinator must document the member's grievance, the Support Coordinator’s attempts to resolve the grievance, and the fact that the member or the member’s responsible person was advised of the right to file a grievance and the process for doing so. Grievances can be filed for a member with a Serious Mental Illness (SMI) and or with a Children's Rehabilitative Services (CRS) eligible condition. This documentation should be included in the case notes.

To initiate the grievance process, contact the DDD Customer Service Center directly at 1-844-770-9500 or DDDCustomerServiceCenter@azdes.gov.

The Division will acknowledge receipt of a grievance electronically, orally, or in writing. Receipt of grievances will be recorded in the Resolution Tracking System.

The Division will ensure that the person who makes a decision on a grievance was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will provide written notice of the grievance decision within 10 business days, or no later 90 calendar days after the Division receives the grievance and will record all results in the Resolution Tracking System.
6003-H ARIZONA LONG TERM CARE SERVICE NOTICE OF ADVERSE BENEFIT DETERMINATION

REVISION DATE: 7/10/2019, 3/2/2015
EFFECTIVE DATE: July 31, 1993
REFERENCE: CHAPTER 400 AMPM

Intended Use

The purpose of a Notice of Adverse Benefit Determination (NOA) is to notify members of adverse decisions and provide them with the factual basis or reason for that decision. The NOA must contain and explain, in easily understood language, the information necessary to understand the adverse benefit determination. It is unacceptable to cite lack of medical necessity as a reason for denial, unless the NOA also provides a complete explanation of why the service is not medically necessary. Failure to provide the reasons and explanation supporting the lack of medical necessity in the adverse benefit determination will result in regulatory action by AHCCCS.

Standard Request

For termination, suspension, or reduction of a previously authorized service, the NOA must be mailed at least ten (10) calendar days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice.

For service authorization decisions that deny or limit services, the contractor must provide an NOA no later than 24 hours from the receipt of a request for authorization of a medication regardless of whether the due date falls on a weekend or legal holiday as defined by the State of Arizona. When the prior authorization request for a medication lacks enough information to render a decision, the contractor must request additional information from the prescriber no later than 24 hours from receipt of request. A final decision and an NOA must be rendered no later than seven (7) working days from the initial date of request.

For a non-medication request for authorization, as expeditiously as the member’s health condition requires but no later than 14 calendar days from receipt of request regardless of whether the due date falls on a weekend or legal holiday as defined by the State of Arizona, unless there is a Notice of Extension (NOE).

Notice of Extension

The written notice to a member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.

Expedited Request

The Division will expedite a request if it is determined that taking the time for a standard request could seriously jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function. In these circumstances, the decision must be made within three working days from the date of receipt of a service request, with a possible extension of up to an additional 14 calendar days if the criteria for an extension are met.
A Notice of Adverse Benefit Determination will be issued within three working days for denial of a service request in which an expedited decision was requested. If a service requested is denied after a Notice of Extension was issued, a Notice of Adverse Benefit Determination will be issued.

If a service request does not seriously jeopardize the member’s life, health, or ability to attain, maintain, or regain maximum function, the expedited request may be downgraded to a standard request. When an expedited request is denied, the Division will promptly contact the member/responsible person to advise him/her of the denial to expedite the request. The Division will follow the oral notification with written notice of denial no later than two calendar days to the member/responsible person. If the member/responsible person disagrees, he/she can submit additional documentation to support the expedited request.

**Procedure**

The notice must be issued on Division or health plan letterhead, clearly explained and written in an easily understood manner, and available in alternate formats:

A. The requested service
B. The reason/purpose of the requested service
C. Reasons for the Adverse Benefit Determination the contractor has made or intends to make (i.e. denial, limited authorization, reduction, suspension or termination) with respect to the requested service consistent with 42 CFR 438.404(b)(1)
D. The effective date of a service denial, limited authorization, reduction, suspension, or termination
E. The right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits as required in 42 CFR 438.404(b)(2)
F. The legal basis for the Adverse Benefit Determination
G. Where members can find copies of the legal basis (e.g. the public library and web page with links to legal authorities). When a legal authority or an internal reference to the contractor’s policy manual is available online, the contractor must provide the URL site to enable the member to find it
H. A listing of legal aid resources
I. The member’s right to request an appeal and the procedures for filing an appeal of the Contractor Adverse Benefit Determination, including information on exhausting the contractor’s appeals process described in 42 CFR 438.402(b) and the right to request a state fair hearing consistent with 42 CFR 438.402(c)
J. The procedures for exercising the member’s rights as described in 42 CFR 438.404(b)(4)
K. The circumstances under which an appeal process can be expedited and how to request
L. Explanation of the member’s right to have benefits continue pending the resolution of the appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services if the appeal is denied (42 CFR 438.420, how to request benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services if the appeal is denied (42 CFR 438.420(d))
Division of Developmental Disabilities  
Operations Manual  
Chapter 6000  
Administration Operations  
Grievance and Appeals

6003-I ARIZONA LONG TERM CARE SERVICES APPEAL PROCESS

EFFECTIVE DATE: July 31, 1993  
REFERENCES: A.A.C. R9-34-209, R9-34-216

Definitions

AHCCCS means the Arizona Health Care Cost Containment System (AHCCCS) Administration as defined in A.R.S. § 36-2901.

Appeal means a request for review of an adverse benefit determination.

Administrator Service Subdivision or AdSS (AdSS) means an organization or entity that has a capitated contract with the Division to provide goods and services to its members either directly or through subcontracts with providers, in conformance with contractual requirements, state statutes and Rules, and Federal law and regulations.

Adverse Benefit Determination means any of the following:

A. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

B. The reduction, suspension, or termination of a previously authorized service;

C. The denial, in whole or in part, of payment for a service;

D. The failure to provide services in a timely manner, as defined by the State;

E. The failure to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;

F. For a resident of a rural area with only one MCO, the denial of a member’s request to exercise the right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

G. The denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities.

Arizona Revised Statutes (A.R.S.) means the statutory laws in the state of Arizona.

Arizona Administrative Code (A.A.C.) means the official publication of Arizona’s codified rules.

Department means the Arizona Department of Economic Security.

Division means the Division of Developmental Disabilities within the Department.

Days means calendar day unless otherwise specified.

Enrollee means a person eligible for AHCCCS under A.R.S. Title 36, Chapter 29 and who is enrolled.
with an AHCCCS AdSS.

Filed means the date the AdSS or the Division, whichever is applicable, receives the request as established by a date stamp on the request or other record of receipt.

Limited Authorization means a service authorization that falls short of the original request with respect to the duration, frequency, or type of service requested.

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR Part 438 and that is [42 CFR 438.2]:

A. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR Part 489, or

B. Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
   1. Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

Member means an individual enrolled with the Division.

Notice of Appeal Resolution means a written notice that includes the results of the resolution process per A.A.C. R9-34-216.

Notice of Adverse Benefit Determination means a notice that, per A.A.C. R9-34-205, explains:

A. The benefit determination the Division or AdSS has taken or intends to take;

B. The reasons for the benefit determination;

C. The enrollee's right to file an appeal with the Division or the AdSS;

D. The procedures for exercising the rights specified in Article 2 of A.A.C., Title 9, Chapter 34;

E. The circumstances under which an expedited resolution is available and how to request it; and

F. The circumstances under which an enrollee has a right to have services continue pending resolution of the appeal, how to request that services be continued, and the circumstances under which the enrollee is liable for the costs of services.

OAR means the Office of Administrative Review, which is the business unit within the Division of Developmental Disabilities responsible for processing member’s appeals.

Prior authorization means a process used to determine in advance of provision whether a prescribed procedure, service, or medication will be covered.

Qualified Clinician means a behavioral health professional who is licensed or certified under A.R.S. Title 32 or a behavioral health technician who is supervised by a licensed or certified professional.
Recovering Costs means when the state fair hearing decision upholds the decision of the Division or the AdSS, the entities may initiate cost recovery for the service or services provided pending the outcome of the hearing decision. 42 CFR 431.230(b).

Representative means an individual authorized in writing by the responsible person to represent the member during the appeal process.

Responsible Person means the same as in A.R.S. § 36-551.

Rural means the same as in A.R.S. § 36-2171.

Seriously mentally Ill (SMI) means persons who, as a result of a mental disorder as defined in section 36-501, exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, the mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation as in A.R.S. § 36-550.

Suspension of Service means a decision to temporarily stop providing a service that was previously authorized or approved.

Termination of Service means a decision to stop providing a covered service that was previously authorized or approved.

Working day means Monday, Tuesday, Wednesday, Thursday, or Friday from the hours of 8:00 a.m. to 5:00 p.m., unless:

A. A legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday; or
B. A legal holiday falls on Saturday or Sunday and a Division or AdSS is closed for business the prior Friday or following Monday.

Applicability

This policy applies to a decision made by the Division or its Administrator Service Subdivision (AdSS) regarding:

A. Timely provision, approval, or authorization of a requested service or continuation of a covered service, benefit, or associated copayments including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

B. For members with SMI only, this also includes:
   1. SMI Eligibility determination decisions
   2. A PASRR determination related to a preadmission screening or an annual resident review which adversely affects member
   3. Clinical Team findings regarding member’s competency, capacity to make decisions, need for guardianship/other protective services or need for special assistance
Planning Document or Inpatient Treatment and Discharge Plan (ITDP) service goals, objectives, or timelines and long-term views

Recommended services identified in assessment reports, Planning Documents, or ITDPs

Application of procedures and timeframes for developing a Planning Document or ITDP

Sufficiency or Appropriateness of an Assessment

Access to or prompt provision of services identified in the Planning Documents or ITDPs

Denial of request to review outcome of, modification to, or failure to modify or termination of a Planning Document, ITDP or portion thereof

Decision to provide service planning including provision of an assessment or case management to a person who is refusing such services or a decision not to provide such services to the member

Decision regarding a person’s fee assessment or the denial of a request to waive fees

Denial of payment of claims

Failure of the Division, AdSS, or AHCCCS to act within established Appeal timeframes

**Non-Applicability**

For members with SMI this procedure does not apply to:

A. Determinations of categorical eligibility/ineligibility for Title XIX or Title XXI services

B. Title XIX Appeals of an adverse determination affecting services that are subject to Prior Authorization for individuals eligible for Title XIX/XXI covered services, (See RHBA Contract Exhibit-14)

C. Adverse Determinations that are a result of changes in state or federal law requiring an automatic change or in order to avoid exceeding the legislatively appropriated state funding for program services and benefits

D. Allegations of rights violations made by members with SMI (See ACOM Policy 446)

E. Decisions involving a request for a service that requires a physician’s order and the physician’s refusal to order the service

**Responsible Entity for Appeals Process**

The division has delegated appeals to the AdSS for the following services:

A. Physical Health Care (i.e., prescription medications, DME, dental services, etc.)
B. Behavioral Health Services

C. Seriously Mentally Ill (SMI) Services

D. Nursing Facility (NF) Services

E. Habilitative Physical Therapy for Members 21 Years of Age or Older

F. Emergency Alert System (EAS)

**Filing an Appeal (Non-SMI)**

When a Notice of Adverse Benefit Determination is given by the Division or the Administrator Services Subdivision or AdSS (AdSS) with whom the member/responsible person/representative does not agree, he/she may file an appeal. An authorized representative, including a service provider, may file an appeal on the member's behalf, with written consent from the member/responsible person/representative.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

**Filing an Appeal (SMI)**

A member with SMI or the member’s authorized representative may also appeal in writing or orally without prior receipt of a Notice of Adverse Benefit Determination when he/she is appealing any denial, decision, finding or recommendations outlined in the **Applicability** section of this procedure pertaining to members with SMI only.

An authorized representative includes a legal guardian, guardian ad litem, designated representative or attorney, parent with legal custody, a court-appointed guardian ad litem or attorney of a member under 18 years, or a state or government agency that has executed an Intergovernmental/Interagency Service Agreement (IGA/ISA) with the Division for the provision of behavioral health services but which does not have legal custody or control of the member.

Neither the Division nor the AdSS will take punitive action against a member/authorized representative or service provider who exercises the right to appeal or supports a member's request for a resolution of the appeal.

**Appeal Filing Timeframes**

Any member/responsible person/representative must file an appeal within **60 calendar days** after the date of the Notice of Adverse Benefit Determination either orally or in writing.

For members with SMI, an appeal may also be filed at any time even when there is no Notice of Adverse Benefit Determination when a member contests/disagrees with any denial, decision, finding or recommendation outlined in the **Applicability** section of this procedure as referenced above.

For appeals from American Indian Health Plan members or appeals related to Long Term Services and Supports (LTSS) delivered by the Division to its members the appeal must be filed with the Division’s Office of Administrative Review (OAR) at:
For appeals from members who are enrolled with an AdSS, member appeals must be filed to the AdSS address specified in each Notice of Adverse Benefit Administration delivered to the member by the AdSS when it made its decision to deny, reduce, suspend or terminate a service. For appeals from members with SMI who are enrolled with an AdSS, appeal must be filed to the AdSS address or phone number listed in the Member’s Handbook or communicated through the Health Plan Customer Services who will transmit this appeal request to the appropriate Appeals unit of the respective AdSS.

Each appeal receipt will be acknowledged in writing within five calendar days. At the time the appeal is filed, the member/responsible person/authorized representative may request an expedited appeal.

Late appeals will be accepted from an SMI member or his/her authorized representative only upon showing of good cause. If the Division or AdSS refuses to accept a late appeal or determines that a service may not be appealed, the Division or AdSS will inform the member/authorized representative, in writing that he/she may request an Administrative Review of the decision with AHCCCS within 10 business days. AHCCCS will issue a final decision on a timely request for Administrative Review within 15 calendar days of the request.

If the final day of any timeframe falls on a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a holiday.

The Division will assist the member/responsible person/representative with the completion of forms and other procedural steps, upon request. The member/responsible person/representative may present information to the Division in person or in writing at any time during the appeal process. The member/responsible person/representative may review the member’s records and other documents considered before and during the appeal process, not protected from disclosure by law. The Division ensures the member/responsible person/representative is included as a party to the appeal process.

**Appeal Notifications and Documents (SMI)**

Notices and written documents will be available in each prevalent non-English language spoken within geographic service area. These will be made available in alternative formats such as Braille, large font, enhanced audio and other special communication devices and methods necessary to understand information. When needed, Oral interpretation services will be made available to members to explain written content contained in notices and written documents. Member/authorized representative will not be made financially liable for all types of communication assistance provided.
All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work or as specified in member/authorized representative’s oral or written appeal.

Copies of notices will be maintained in the Division’s official files using a unique docket number for each appeal filed which will be referenced in all appeal correspondence generated. All records will be maintained in a secure and locked place in compliance with HIPAA standards and requirements. The member/authorized representative will have the right to examine those documents and records maintained in member’s docket file that will be used in informal conferences or Administrative Hearings upon request. The Division or AHCCCS may DENY access to Appeal case docket records when permitted by State and Federal law.

Continuation of SMI Services

If an appeal relates to the modification or termination of a behavioral health service, the service under Appeal will continue pending the resolution of the appeal through the Division’s decision unless:

A. A Qualified Clinician (see definition) determines that the modification or termination is necessary to avoid a serious or immediate threat to the health or safety of the person or another individual or

B. The member or guardian, if applicable, agrees in writing to the modification or termination.

Appeal Resolution Process for Members with SMI

When the appealing member with SMI is enrolled with AIHP the appeals process will be followed by the Division’s OAR Appeals Unit. When the appealing member with SMI is enrolled with an AdSS, the Appeals Unit within each respective AdSS will follow the same appeal resolution process outlined below.

A. Division Informal Conference

1. Within seven days of receipt of an oral or written appeal, the Division or AdSS will hold an informal conference with the member/authorized representative. If member has been identified as needing special assistance and does not have an assigned Advocate, the Division or AdSS will contact AHCCCS Office of Human Rights to request for an advocate to be present during the informal conference or any part of the appeal process.

2. The Division or AdSS will schedule the informal conference at a convenient time and place and notify all participants in writing, at least two days prior to the scheduled conference listing date, time, location, and the option to participate by telephone or teleconference when preferred and the member’s right to be represented by a designated representative of his/her choice.

3. The Informal Conference will be chaired by the designated representative of the Division or AdSS with authority to resolve the issues under appeal and who will seek to mediate and resolve the issues in dispute. The Division may designate a staff from its Behavioral Health Unit, Quality Management Unit, or Support Coordination to represent OAR during an informal conference.
4. During the informal conference the Division’s designated representative will record a statement of the nature of the appeal, the issue presented, any resolution(s) agreed upon and the date(s) of implementation. Any unresolved issues will be identified for further appeal.

5. Upon a satisfactory resolution of member’s appeal, the Division or AdSS will issue a dated written notice to all parties which contains the statement of the nature of the appeal, the issue addressed, the resolution(s) achieved, and the resolution implementation dates agreed upon.

6. If member’s appeal is not resolved to member’s satisfaction and the appeal issue does NOT relate to the member’s eligibility for behavioral health services/SMI services, the member and other representative present during the Informal conference (member’s designated representative/authorized representative, Advocate) will be informed that the appeal will be forwarded to AHCCCS for a second informal conference. The procedure for requesting a waiver of the AHCCCS informal conference will be communicated to member/designated representative at this time.

7. If member’s appeal is not resolved to member’s satisfaction and the appeal issue relates to the member’s eligibility for behavioral health services/SMI services, or the member has requested a waiver from the AHCCCS informal conference in writing, the Division or AdSS will:
   a. Provide a written notice to the member/authorized representative of the process to request an Administrative Hearing.
   b. Determine during the informal conference if the member/authorized representative or Advocate is requesting an Administrative Hearing. If so, the Division will file a request with AHCCCS within three business days of the informal conference.
   c. The Division will send a copy of the Appeal, informal conference results and written notice of the process to request an administrative hearing and notice of an Administrative hearing to the AHCCCS Office of Human rights for members in need of Special Assistance whether the member has an assigned Advocate who attended the informal conference or not.

8. For all appeals that are unresolved after an informal conference, the Division will forward the Appeal case record to AHCCCS within three days from the conclusion of the informal conference.

9. If the member fails to attend the scheduled informal conference and fails to notify the Division or AdSS, another informal conference will be rescheduled following written notification requirements followed previously.

10. If the member fails to attend the rescheduled informal conference and fails to notify the Division or AdSS prior to conference, the Division or AdSS will close the Appeal docket and send written notice of the closure to the member/authorized representative.
11. If the member requests the appeal to be re-opened due to failure to receive the informal conference notification and/or due to other good cause, the Division of AdSS may re-open the appeal and proceed with another informal conference.

B. Expedited Appeals Requests (SMI)

1. At the time an Appeal is initiated, the member may request an expedited Appeal in writing. The Division or AdSS will accept requests to expedite an Appeal for good cause, and for the following:
   a. A Denial of admission to or the termination of a continuation of inpatient services, or
   b. A Denial or termination of crisis or emergency services.

2. Within one day of receipt of a request for an expedited Appeal, the Division or AdSS will:
   a. Inform the member in writing that the Appeal has been received and of the time, date, and location of the expedited informal conference; or
   b. Issue a written decision stating that the Appeal does not meet criteria as an expedited Appeal; and
   c. Inform the member that he/she may, within three days of the Division or AdSS’s decision, request an Administrative Review of the Division or AdSS’s decision from AHCCCS.

3. Within two days of receipt of a written request for an expedited Appeal, the Division or AdSS will hold an informal conference to mediate and resolve the issues in dispute.

4. If the member requests an Administrative Review on a timely basis, AHCCCS will complete the review and issue a written decision within one day from the date of receipt. The decision of AHCCCS will be final.

C. AHCCCS Informal Conference

1. AHCCCS will hold another informal conference within 15 days of the notification from the Division that the Appeal was unresolved unless the member/authorized representative waives an informal conference with AHCCCS, or the appeal relates to eligibility for SMI services.

2. At least five days prior to the date of the AHCCCS-scheduled informal conference, AHCCCS will notify the participants in writing of the date, time, and location of the conference.

3. The informal conference will be chaired by a representative of AHCCCS who will seek to mediate and resolve the issues in dispute.
4. The AHCCCS representative will record a statement of the nature of the Appeal, the issues involved, any resolution(s) achieved, the date by which the resolution(s) will be implemented and identify any unresolved issues for further Appeal.

5. If the issues in dispute are resolved to the satisfaction of the member, AHCCCS will issue a dated written notice to all parties, which will include a statement of the nature of the Appeal, the issues involved, the resolution achieved and the date by which the resolution will be implemented.

6. For a person in need of Special Assistance, AHCCCS will send a copy of the informal conference report to AHCCCS Office of Human Rights.

7. If the issues in dispute are not resolved to the satisfaction of the member, AHCCCS will:
   a. Provide written notice to the member of the process to request an administrative hearing;
   b. Determine at the informal conference whether the member is requesting AHCCCS to request an administrative hearing on behalf of the member and, if so, file the request within three days of the informal conference;
   c. For a person in need of Special Assistance, AHCCCS will send a copy of the notice to AHCCCS Office of Human Rights.

8. If the member requests an expedited AHCCCS Informal Conference, AHCCCS will hold an informal conference to mediate and resolve the issue in dispute, within two days of notification from the Division or AdSS, unless the member/authorized representative waives the informal conference, in which case the Appeal will be forwarded within one day to AHCCCS to schedule an administrative hearing.

9. If the AHCCCS informal conference is not waived, and AHCCCS fails to resolve the Appeal, the Appeal will be forwarded to AHCCCS to schedule an administrative hearing, within one day of the informal conference.

10. If the member/authorized representative fails to attend the AHCCCS informal conference and fails to notify AHCCCS of this, AHCCCS may issue a written notice, within three working days of the scheduled conference, which contains a description of the decision on the issue under appeal and advises the member/authorized representative of his/her right to request an Administrative hearing.

11. In the event the member requests the Appeal be re-opened due to not receiving the informal conference notification and/or due to other good cause, AHCCCS may re-open the Appeal and proceed with the informal AHCCCS conference.

D. Requests for Administrative Hearing

1. In the event a request for administrative hearing is filed with the Division or AdSS, the Division or AdSS will ensure that the written request for hearing, Appeal case record, and all supporting documentation is received by AHCCCS within three days from such date.
2. A written request for hearing filed by the Division or AdSS with AHCCCS will contain the following information:
   a. Name of the member and person receiving services (if different),
   b. Member’s case docket number,
   c. The decision being Appealed,
   d. The date of the decision being Appealed, and
   e. The reason for the Appeal.

3. Administrative Hearings will be conducted and decided pursuant to A.R.S. § 41-1092 et seq.

**Standard Appeal Resolution Timeframe**

The Division will respond to the standard appeal filed as a result of receipt of a Notice of Adverse Benefit Determination and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 30 calendar days after the date the Division receives the appeal. The Division will extend the 30-day timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division may request a 14-calendar day extension of the 30-day time frame if additional information is needed and the extension is in the best interest of the member. The OAR will provide the member/responsible person/representative written notice of the reason for the decision to extend the 30-day timeframe.

**Appeal Notification Requirements**

All notices and appeal decisions will be personally delivered or mailed by certified mail to the required party at their last known residence or place of work. In the event that it may be unsafe to contact the member/authorized representative at his/her home address, or the person indicated that he/she does not want to receive mail at home, the alternate communication methods specified by the member/authorized representative will be used.

Notices and written documents generated through the Appeals process will be available in alternative format such as Braille, large font, or enhanced audio and take into consideration the special communication needs of members.

** Expedited Appeal**

The member/responsible person/representative may request an expedited resolution of the appeal when the appeal is filed as a result of a Notice of Adverse Benefit Determination. The Division or AdSS will conduct an expedited appeal if it is determined that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function. The Division will conduct an expedited appeal if a request is received directly from a health care provider, with written authorization from the member/responsible person/representative, and the health care provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

If the request for an expedited appeal is denied, the Division’s OAR or AdSS will promptly contact...
the member/responsible person/representative orally to advise him/her of the denial. It will send a written notice of the denial no later than two calendar days to the member/responsible person/representative. If a request for an expedited appeal is denied, the Division will follow the standard appeal resolution timeframe and the appeal will be resolved no later than 30 calendar days after the day the Division received the appeal.

If the request for an expedited appeal is granted, the Division’s OAR or AdSS will promptly contact the member/responsible person/representative orally to advise him/her of the approval. The Division will adjudicate the appeal and mail the written Notice of Appeal Resolution to the member/responsible person/representative within 72 hours from the day the Division or AdSS receives the request for an expedited appeal. The Division or AdSS will extend the 72-hour timeframe up to an additional 14 calendar days upon request by the member/responsible person/representative. The Division or AdSS may request a 14-calendar day extension of the 72-hour timeframe if additional information is needed and the extension is in the best interest of the member. The Division or AdSS will provide the member/responsible person/representative written notice of the reason for the decision to extend the 72-hour timeframe.

**Appeal Decisions and Timeframes**

For standard and expedited appeals filed as a result of a Notice of Adverse Benefit Determination, the Division will ensure the person who makes a decision on an appeal was not involved in any previous level of review or decision-making. The Division will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or 72 hours for an expedited appeal, the member may consider the appeal denied. The Notice of Appeal Resolution is issued to the member/responsible person/representative. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;
B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;
C. The factual and legal basis of the decision; and
D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the Department of Economic Security (DES)/Division of Developmental Disabilities (DDD or Division) decision.

If the Notice of Appeal Resolution is reversed, the Division or AdSS will notify Support Coordination and the other entity (Division or AdSS), as appropriate. Upon notification services will be provided expeditiously as the member’s health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division may recover the cost of services from the member.

The Division or AdSS will ensure the person who makes a decision on an appeal was not involved
in any previous level of review or decision-making. The AdSS will ensure that healthcare professionals who make decisions have the appropriate clinical expertise to make the decision.

The Division or AdSS will render a written Notice of Appeal Resolution to the member/responsible person/representative no later than 30 calendar days from the date the appeal was received. The Notice of Appeal Resolution will include the results of the resolution process and the date it was completed. If a Notice of Appeal Resolution is not rendered in 30 calendar days for a standard appeal or within 72 hours for an expedited appeal, the member may consider the appeal denied. The Notice of Appeal Resolution is issued to the member/responsible person/representative and the Division through the Office of Administrative Review. If the appeal is not wholly resolved in favor of the member, the Notice of Appeal Resolution will include:

A. The member's right to request a fair hearing and how to do so;

B. In cases where the member requests the services continue, the member's right to receive services while the fair hearing is pending;

C. The factual and legal basis of the decision; and

D. The member/responsible person/representative's liability for the cost of the continued services if Arizona Health Care Cost Containment System (AHCCCS) upholds the AdSS decision.

If the Notice of Appeal Resolution is reversed, the AdSS or the Division of Developmental Disabilities, Office of Administrative Review by the other. Upon notification services will be provided expeditiously as the member’s health condition requires. If the Notice of Appeal Resolution is upheld, and services were requested to continue pending resolution of the appeal, the Division or AdSS may recover the cost of services from the member.
6003-J ARIZONA LONG TERM CARE SERVICES STATE FAIR HEARING PROCESS

EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 41-1092.07

When a Notice of Appeal Resolution is rendered by the Division with which the member or his/her responsible person does not agree, he/she may file a request for a fair hearing by the Office of Administrative Hearings. The fair hearing request must be filed in writing and received by Office of Administrative Review (OAR) no later than 120 calendar days from the date of the Notice of Appeal Resolution. The request should be sent to:

DES/DDD
Office of Administrative Review
4000 North Central Avenue
3rd Floor, Suite 301
Mail Drop 2HE5
Phoenix, Arizona 85012

Once the hearing request is filed, OAR staff will prepare a duplicate file for submission to the Arizona Health Care Cost Containment System (AHCCCS) along with the hearing request. The OAR staff will submit the file to AHCCCS within five (5) business days. This file will include the completed AHCCCS Submission of Request for Hearing form, a cover letter, copy of the entire file, copies of the Notice of Adverse Benefit Determination, request for fair hearing, investigative materials, and the decision letter.

The hearing will be scheduled by AHCCCS and the member or his/her responsible person will be notified of the date and time of the hearing in writing. The member and/or responsible person including any legal representative, an Assistant Attorney General, and a Division representative will meet with an Administrative Law Judge (ALJ). This hearing is informal, and the rules of evidence may not apply.

Based on the information gathered by the ALJ through testimony, presentation of evidence, and the record supplied by OAR and the appellant, the ALJ will prepare written findings of fact and conclusions of law and render a recommended decision to the AHCCCS Director. The AHCCCS Director will then issue his/her decision in writing and notify any party adversely affected of the right to request a rehearing or review. If it is decided that a review will not be petitioned, the OAR will arrange with the appropriate Division staff and/or contracted health plan staff to authorize and provide the service as expeditiously as possible.

A petition for rehearing or review, if requested, must be made to the AHCCCS Office of Administrative Legal Services no later than 30 calendar days after the date of the AHCCCS Director's decision. The petition must completely explain the grounds on which the rehearing is being made. Petitions for rehearing/review are to be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034
The rehearing will be decided by the AHCCCS Director or designee and a final written decision of the matter will be issued.

If the member or his/her responsible person is still not satisfied with the decision, he/she may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.
6003-K CLAIM DISPUTES

EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-2903.01(B)(4) and 41-1092.01; A.A.C. R9-34-402 and R9-34-405

Definitions

A. Administrator Service Subcontractors (AdSS) - means an organization or entity that has a capitated contract with the Division of Developmental Disabilities (the Division) to provide goods and services to its members either directly or through subcontracts with providers, in conformance with contractual requirements, Arizona statutes, Arizona rules, federal law, and federal regulations.

B. AHCCCS Administration - means the Arizona Health Care Cost Containment System (AHCCCS) Administration as defined in A.R.S. § 36-2901(1).

C. Clean Claim - means the same as in A.R.S. § 20-3101(2).

D. Claim Dispute - means a dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

E. Contractor - means the following:
   1. A contractor or program contractor as defined in A.R.S. § 36-2901(1);
   2. The Comprehensive Medical Dental Program in the Department of Economic Security; and
   3. The Children’s Rehabilitation Services and Behavioral Health Services in the Arizona Department of Health Services.

F. Day - means calendar day unless otherwise specified.

G. Director - means the Director of the AHCCCS Administration or the AHCCCS Administration designee.

H. Director's Decision - means the final administrative decision under A.R.S. § 41-1092(5).

I. FFS Member - means a Fee For Service Member eligible for AHCCCS coverage under Arizona Revised Statutes Title 36, Chapter 29, who is enrolled with AHCCCS on an FFS basis, and who is not enrolled with an AHCCCS contractor.

J. Filed - means the date AHCCCS receives a request established by a date stamp on the request or other record of receipt.

K. State Fair Hearing - means an administrative hearing under Arizona Revised Statutes, Title 41, Chapter 6, Article 10.
Applicability

This policy is applicable to:

A. Fee for Service Providers who are filing claims and claim disputes to the Division for services rendered to the Division’s AIHP members

B. Providers who are affiliated with an AdSS which processes claims and claim disputes from its providers for services rendered to its enrolled members

Claim Dispute Process

A Division representative will provide written notice advising the service provider of a denial of claim payment and the reason for denial. The notice may be included in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the Division.

If the Division gives the service provider a notice that the service provider disagrees with, the service provider may file a claim dispute. The Division will accept a claim dispute only when the dispute involves a payment of a claim, a denial of a claim, an imposition of a sanction, or reinsurance.

The service provider must adhere to both of the following requirements when filing a claim dispute:

A. Submit the claim dispute to the Division in writing; and

B. Submit the claim dispute within the time period that will occur last out of the following, in accordance with A.R.S. § 36-2903.01(B)(4):

1. Within the 12 consecutive months immediately following the date(s) of service; or

2. Within the 12 consecutive months immediately following the date that the member's eligibility is posted; or

3. Within the 60 consecutive days immediately following the date of denial for a timely claim submission.

The Division will date all claim disputes upon the Division’s receipt. The Division will send the service provider a written notice acknowledging receipt of the claim dispute within the five consecutive working days immediately following the Division’s date of receipt. If the service provider wishes to submit any additional information to the Division for consideration, the service provider must submit the additional information within the 10 consecutive days immediately following the Division’s date of receipt. The Division will advise the service provider about the 10-day deadline for the service provider to submit any additional information.

Division Business Operation staff may contact the service provider to obtain additional information. The Division will consider and review, relevant Arizona Revised Statutes, Arizona Administrative Code, AHCCCS policies, and Division policies. The Division staff will be consulted as necessary.
The Division will investigate every claim dispute using applicable authorities and facts obtained from all parties. Both the Division and the service provider must mutually agree to any deadline extension(s). If both parties mutually agree to extend the decision deadline either to allow additional time for the Division to make a decision or the service provider to submit supporting documentation, the Division will issue a letter to the service provider. When the Division completes the fact-finding, the Division will render a written Notice of Decision to the service provider. The Division will send the Notice of Decision within the 30 consecutive days immediately following the Division’s date of receipt unless the parties mutually agree to a deadline extension.

The Notice of Decision must both comply with relevant regulatory and contractual requirements, as well as include all of the following:

A. The date of the decision,
B. The factual and legal basis for the decision,
C. The service provider’s right to request a fair hearing, and
D. The instructions for requesting a fair hearing.

**State Fair Hearings for Claim Disputes**

If a service provider disagrees with the Division’s Notice of Decision on the service provider’s claim dispute, then the service provider may file a request for a fair hearing by the Department of Economic Security (DES) Appellate Services Administration/Arizona Long Term Care System (ALTCS). The service provider must make the fair hearing request in writing to the Office of Administrative Review (OAR) within the 30 consecutive days immediately following the Division’s dated receipt of the Notice of Decision. The service provider must send the fair hearing request to:

**DES/DDD**

Office of Administrative Review

4000 N. Central Ave, 3rd Floor Suite 301

Phoenix, Arizona 85012

Once the fair hearing request is made, OAR staff will prepare a duplicate file and submit the duplicate file with the hearing request to both the DES Appellate Services Administration/ALTCS and the Attorney General's Office. The OAR staff will prepare the duplicate file to include all of the following:

A. Copies of the claim dispute,
B. Investigative materials, and
C. The Notice of Decision.

OAR staff will submit the documents to the DES Appellate Services Administration/ALTCS within the five consecutive working days immediately following the Division’s dated receipt.
of the request for hearing.

A DES Appellate Services Administration/ALTCS representative will schedule the fair hearing. The service provider will receive written notification of the fair hearing's scheduled date and time. The DES Appellate Services Administration/ALTCS representative will notify both the Attorney General's Office and the OAR about the scheduled hearing.

At the fair hearing, the service provider, a DES/Division of Developmental Disabilities (DDD) representative, and an Assistant Attorney General will meet with a DES Appellate Services Administration/ALTCS Hearing Officer. The rules of evidence will not apply to the fair hearing.

The Hearing Officer will prepare written findings of fact, written conclusions of law, and render a decision. The Hearing Officer will render the decision based on the following:

A. Information the Hearing Officer gathers through testimony,
B. Any presentation of evidence, and
C. Any other records supplied by OAR.

A DES Appellate Services Administration/ALTCS representative will forward a copy of the decision to all of the following:

A. The AHCCCS Office of Administrative Legal Services,
B. The service provider,
C. DES/DDD, and
D. The Attorney General's Office.

If the service provider wants to petition for rehearing or review, then the service provider must submit the request to the AHCCCS Office of Administrative Legal Services within the 30 consecutive days immediately following the date of the DES Appellate Services Administration/ALTCS Administrative Law Judge’s decision. The petition must completely explain the grounds for a rehearing or review. Petitions for rehearing or review must be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the Division’s decision, the Division will confer with the Attorney General's Office to determine if a request for review will be petitioned to the AHCCCS Director. If the Division and the Attorney General's Office decide a review will not be petitioned, the OAR will arrange with the appropriate Division staff to both authorize payment and pay for the services as reasonably expeditious as possible.
If the Division or the service provider is still dissatisfied with the AHCCCS decision, the Division or service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.

**Overtuned or Reversed Claim Disputes**

The Division shall reprocess and pay both overturned and reversed claim disputes within the 15 consecutive business days immediately following the date of the decision. The Division will make payments in a manner consistent with the decision.

**IMPORTANT TO NOTE: The Division will adhere to the same claim dispute process described herein for FFS claims on behalf of AIHP members.**

**THE DIVISION HAS DELEGATED ACUTE CARE CLAIM DISPUTES TO THE ADSS FOR ADJUDICATION FOR ALL THE FOLLOWING SERVICES:**

- Physical Health Care (i.e., hospitalizations, prescription medications, DME, dental services, etc.)
- Behavioral Health Services
- Seriously Mentally Ill (SMI) Services
- Nursing Facility (NF) Services
- Habilitative Physical Therapy for Members 21 Years of Age or Older
- Emergency Alert System (EAS)

**Claim Dispute Process**

The AdSS representative will provide written notice advising the service provider of both a denial of claim payment and the reason for denial. The AdSS representative may include the notice either in a remittance advice or other form of written communication that includes the service provider's right to file a claim dispute with the AdSS.

If the service provider disagrees with a notice given by the AdSS, the service provider may file a claim dispute. The AdSS will accept a claim dispute only if the dispute involves one of the following:

A. A payment of a claim,
B. A denial of a claim,
C. An imposition of a sanction, or
D. Reinsurance.

The service provider must file the claim dispute in writing with the AdSS. In accordance with A.R.S. § 36-2903.01(B)(4), the service provider must submit the claim dispute within the time period that will occur last out of the following:
A. Within the 12 consecutive months immediately following the date(s) of service,

B. Within the 12 consecutive months immediately following the date that the member’s eligibility is posted, or

C. Within the 60 consecutive days immediately following the denial date of a timely claim submission.

The AdSS will date all claim disputes upon AdSS’s receipt. The AdSS will send the service provider a written notice acknowledging receipt of the claim dispute within the five consecutive business days following the date the claim dispute is received. The AdSS will advise the service provider that any additional information the service provider wishes to submit to the AdSS for consideration must be done so in 10 calendar days.

The AdSS staff may contact the service provider to obtain additional information. Relevant Arizona Revised Statutes, Arizona Administrative Codes, and AHCCCS and Division policies will be reviewed, and the AdSS staff will be consulted as necessary.

AdSS will investigate all claim disputes using applicable authorities and facts obtained from all parties. Both parties must mutually agree on any deadline extensions. If there is a mutual agreement to extend the decision due date either to allow the AdSS to make a decision or allow the service provider additional time to submit supporting documentation, the AdSS will issue a letter to the service provider. Once the fact-finding is complete, a written Notice of Decision will be rendered to the service provider within 30 calendar days of receipt of the service provider's claim dispute unless the provider and the AdSS agree to a longer period.

The Notice of Decision must comply with regulatory and contractual requirements. The Notice of Decision must include all of the following:

A. The date of the decision,

B. The factual basis for the decision,

C. The legal basis for the decision,

D. The service provider’s right to request a fair hearing, and

E. The instructions for requesting a fair hearing.

**State Fair Hearings for Claim Disputes**

If a service provider disagrees with the AdSS’s Notice of Decision on a claim dispute, the service provider may file a request for a fair hearing by the Office of Administrative Hearings (OAH). The service provider must make the request for fair hearing in writing to the AdSS within the 30 consecutive days immediately following AdSS’s receipt of the Notice of Decision.

In accordance with DDD Operations Manual Policy 445, the AdSS will forward the service provider’s fair hearing request file to the Division’s Office of Administrative Review (OAR) to be submitted to the AHCCCS Office of Administrative Legal Services (OALS). The AdSS staff will prepare a duplicate file along with the hearing request, copies of the claim dispute,
investigative materials, and the Notice of Decision for submission to the DDD Office of Administrative Review (OAR). The AdSS will submit the duplicate file to the DDD Office of Administrative Review (OAR) within the three consecutive business days immediately following AdSS’s receipt of the request for fair hearing. OAR staff will submit the documents to the AHCCCS Office of Administrative Legal Services (OALS) within the two consecutive business days immediately following OAR’s receipt of the file from the AdSS.

The fair hearing will be scheduled by the AHCCCS Office of Administrative Legal Services (OALS). The service provider will receive written notification of the date and time. The AHCCCS Office of Administrative Legal Services (OALS) will notify both the AdSS and the Division of the scheduled hearing.

At the hearing, the service provider, an AdSS representative, and the AdSS General Counsel, if appropriate, will meet with an Office of Administrative Hearings (OAH) Hearing Officer. The rules of evidence will not apply to the fair hearing.

The Hearing Officer will prepare written findings of fact, conclusions of law, and render a decision. The Hearing Officer will render a decision based on the following:

A. Information gathered through testimony,
B. Any presentations of evidence, and
C. Any other records from the AdSS or service provider.

An Office of Administrative Hearings (OAH) representative will forward a copy of the decision to the Arizona Health Care Cost Containment Service (AHCCCS) Director.

The AHCCCS Director will issue a final written decision on the matter. If the AHCCCS Director overturns the AdSS decision, the AdSS will determine if a request for review will be petitioned to the AHCCCS Director. If the AdSS decides that a review will not be petitioned, the AdSS will arrange with the appropriate AdSS staff to both authorize and pay for the services as expeditiously as reasonably possible.

Parties may file a petition for rehearing or review with the AHCCCS Office of Administrative Legal Services (OALS) by the AdSS or service provider. The petition must be submitted within the 30 consecutive days immediately following the date of the AHCCCS Director’s decision. The petition must completely explain the grounds for rehearing or review. Petitions for rehearing or review must be sent to:

AHCCCS
Office of Administrative Legal Services
701 East Jefferson Street
Phoenix, Arizona 85034

If the AdSS or the service provider is still dissatisfied with the decision, the AdSS or service provider may seek judicial review of the AHCCCS decision through the court system. All administrative remedies must be exhausted before the court will consider the case.
Overtipped or Reversed Claim Disputes

The AdSS shall reprocess and pay overturned or reversed claim disputes within the 15 consecutive business days immediately following the date of the decision. The AdSS will make payments in a manner consistent with the decision.
6003-L ATTORNEYS AT PLANNING MEETINGS

REVISION DATE: 5/20/2016, 3/2/2015
EFFECTIVE DATE: July 31, 1993

The member/responsible person may invite anyone to participate at planning meetings, including his/her attorney. It is recommended that the member/responsible person notify the Support Coordinator, at least two business days before the meeting is scheduled to occur, that legal counsel will participate with the responsible person at the planning meeting.

If prior notice is not given, the planning meeting may be postponed. If the Division’s legal counsel is not present at the meeting and Division staff determines that legal counsel is needed, Division staff may temporarily stop the meeting in an effort to obtain legal counsel. In addition to Division staff, the Division may have an Assistant Attorney General at a meeting. Any meeting may be audio recorded.
6003-M  CONDUCTING ALL MEETINGS

REVISION DATE:  2/26/2016, 1/15/16, 3/2/2015
EFFECTIVE DATE:  July 31, 1993

To provide defined objectives and to allow for adequate meeting facilities complete the following:

A. Clarify the purpose of the meeting;

B. Check with the member/responsible person as to how many people they will have in attendance so adequate space will be provided and clarify with the family the names and titles of those attending from the Division; and,

C. Schedule space appropriate for the number of people in attendance.

Tape Recording Meetings

Unless there are either pending grievances or legal actions, there is no prohibition for members/responsible persons to tape record Individual Support Plan (ISP) meetings. Canceling a meeting for this reason is not acceptable.

Requests for Member Information

In order to ensure uniformity and conformity, all requests for member information must be cleared through the Office of Compliance and Review (OCR). Situations include, but are not limited to:

A. Any circumstance where staff may deem it necessary to initiate contact with an attorney or his/her staff; or,

B. Any request for member records or communication regarding a member's services unless prior authorized by the OCR.
6004-A   QUALITY MANAGEMENT

REVISION DATE: 8/30/2013
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. §§ 36-550, 36-595 et seq.; A.A.C. R6-6, R9-28, R9-33, R6-18; 42 CFR 438.66

The purpose of Quality Management is to monitor and assure the quality of all care and services provided to individuals through a coordinated, comprehensive, and continuous effort. The goals of Quality Management include:

A. Ensuring services are available, accessible, timely, safe, supportive, and appropriate.
B. Providing ongoing, objective, and systematic measurement, analysis, and trending to facilitate performance improvement efforts.
C. Oversight for determining quality, efficiency, and effectiveness of service delivery.

Division employees are responsible for internal oversight of the following Quality Management activities: ensuring providers are compliant with requirements of external entities; providing oversight of Support Coordination; providing oversight of the Division’s contracted Health Plans; and oversight of a variety of services; and settings such as:

A. Assisted living facilities;
B. Individual’s home (not contracted with the Division);
C. Day programs (Day Treatment and Training (child and adult));
D. Employment programs;
E. Nursing facilities;
F. Provider’s home; or,
G. Residential settings (group homes, Intermediate Care Facility for Persons with an Intellectual Disability (ICF/ID), developmental homes).
6004-B  INTERNAL OVERSIGHT

REVISION DATE:  8/30/2013
EFFECTIVE DATE:  July 31, 1993

Monitoring

The Division’s program and contract monitoring activities provide oversight of services around a set of minimum expectations as documented in statute, rule, and contract. The Division’s Program Monitors review all residential settings as required for programmatic and contractual compliance as well as compliance with licensing and certification requirements. Additional monitoring of services may occur depending on Division requirements.

Continued Stay Reviews

Continued Stay Reviews ensure the appropriateness and necessity of an ICF/ID level of care through reviews of health and programmatic records. The review also assesses the quality of care and assists in discharge planning.

Quality Management staff must review each individual within six (6) months of admission and at least every six (6) months thereafter. Reviewers evaluate the physician’s certificate of need for care, medical evaluations, the plan of care, and the facility’s Utilization Control Plan in relation to the individual’s community integration and placement in the least restrictive environment.

Program Operations and Business Operations

Prior to receiving a contract, Division staff will ensure applicants have completed all the necessary steps, and qualify as a provider for the Division. Division employees at the District and Central Office are required to provide oversight of contracted providers to ensure contract compliance.

Support Coordination

Support Coordination serves as the first level of oversight to ensure Division funded settings and services are meeting the individual’s needs. This oversight can take place during a review and/or annual planning meeting and includes an assessment of the placement and/or provider’s ability to meet the individual’s needs. On-site reviews shall be conducted while the individual is present.

Support Coordination is responsible for reporting any concerns regarding the setting or the provider’s ability to meet individual’s needs using the incident reporting system. See Chapter 2100 for further details.
Support Coordination is also responsible for ensuring the implementation of the Arizona Long Term Care System (ALTCS) program as described in the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual. This includes oversight of all services in all settings.
Health Care Services

Health Care Services serves as the first level of oversight to ensure contracted health plans comply with their contract.

In addition to the reviews completed by the Support Coordinator, Health Care Services nurses complete utilization/concurrent reviews to ensure individuals are receiving the appropriate level of nursing care. This oversight can be provided in all settings.

Arizona Long Term Care System Administrator/Specialists

The ALTCS Administrator oversees the entire ALTCS program including oversight of the ALTCS Specialists/designees who audit case files to monitor support coordination compliance with the ALTCS program.

The Division monitors implementation of the ALTCS and Targeted Support Coordination (TSC) programs through the use of specific audit tools. Data gathered is analyzed to identify Support Coordination system issues and corrective action plans are developed as appropriate.

Arizona Long Term Care System

A. An ALTCS audit monitors completion of timely planning meetings by a review of case files. Documentation in the case file must establish the following:

1. The member’s presence and participation with support as needed in the development of the planning document.

2. The meeting occurred at the member’s home unless documentation indicates the member/responsible person has chosen an alternate location. At least one ISP/review must occur in the individual’s home every twelve months.

3. An acceptable reason when the planning meeting occurs after the due date.

B. The ALTCS On-Site and Timeliness Audit are used to monitor timeliness of planning meetings. To achieve timeliness, a planning meeting must have occurred:

1. Within the required interval based on a comparison of the date of the most current and the previous review (prior timeliness); and,

2. On the date of the audit, all planning meetings must be current. (Current timeliness).

The Division completes this audit on 100% of the ALTCS cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.
C. The Support Coordinator ALTCS Audit is used to monitor the Division’s compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM.) Quarterly, the District must complete a minimum of two Support Coordinator ALTCS audits for every Support Coordinator position allocated, including vacant positions. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.

Targeted Support Coordination

A. The TSC audits monitor completion of a timely planning meeting through a review of documentation contained in a member’s file. Documentation must establish the following:

1. The planning meeting was held at the frequency requested by the member/responsible person using the contact type requested; and,

2. An acceptable reason if the planning meeting occurred after the due date.

B. The Targeted Timeliness Audit is used to monitor completion of a timely planning meeting through a review of documentation contained in a member's file. Documentation must establish the following:

1. At least annually, the type and frequency of contact chosen;

2. When the member receives a service that has a “mandated minimum review cycle” requirement, the chosen contact type and frequency do not exceed the “mandated minimum review cycle.”

3. The planning meeting is within requested/required intervals based on a comparison of the date of the most current and the previous review (prior timeliness).

4. The most current planning meeting is within the required interval when compared to the date of the audit (current timeliness).

The Division completes audits on 100% of the Targeted cases for 10% of Support Coordinators per District, each quarter. Of the cases audited, 90% must demonstrate timely planning meetings for both current and prior timeliness. In addition, each District must meet the 90% requirement for cases audited in that District each quarter.

C. The Targeted Support Coordination Audit is used to monitor the Division’s compliance with its policies and procedures and the AHCCCS Medical Policy Manual (AMPM). Quarterly, each District completes audits on 10% of their Targeted Support Coordination cases. For each audit question, 90% of the responses must demonstrate compliance. In addition, each District must meet the 90% compliance requirement for each audit question.
Other

Additional Division employees are responsible for oversight activities such as tracking, trending, and reporting issues related to Quality Management.

Additional oversight of Support Coordination occurs at the District and Central Office level.
**6004-C  EXTERNAL OVERSIGHT**

REVISION DATE:  8/30/2013  
EFFECTIVE DATE:  July 31, 1993

**Licensing/Certification**

For settings that require licensing and/or certification, the entities that provide the license and/or certification also have oversight responsibilities. Entities responsible for oversight include:

A.  U.S. Department of Labor;  
B.  Arizona Department of Health Services (DHS);  
C.  Arizona DHS, Division of Behavioral Health Services (DBHS);  
D.  Arizona DHS, Division of Licensing Services, Office of Long-Term Care Licensing; and,  

**Arizona Health Care Cost Containment System**

Arizona Health Care Cost Containment System (AHCCCS), as the Single State Medicaid agency, has the authority to inspect Arizona Long Term Care System (ALTCS) funded settings at any time. The purpose of AHCCCS oversight is to ensure compliance with the standards set forth in the AHCCCS Medical Policy Manual (AMPM). The Division, as an ALTCS program contractor, is required to ensure that all ALTCS eligible individuals are receiving services as medically needed. This process typically involves review of support coordination functions as they relate to the Planning Document. AHCCCS may or may not actually visit the site during the review.

**Advocacy**

Advocacy agencies have the authority to review residential settings in the community at reasonable times. This authority was granted because of the Arizona Training Program Coolidge lawsuit (Griswold vs. Riley) and is noted in Arizona Revised Statutes. This includes the Developmental Disabilities Advisory Council.

**Financial Audit**

All agencies with a contract are subject to the programmatic and fiscal monitoring requirements of the Department to ensure accountability of the delivery of all goods and services. Specific requirements are delineated in the provider's contract.
6004-D  DIVISION OVERSIGHT FINDINGS

REVISION DATE:  8/30/2013
EFFECTIVE DATE:  July 31, 1993

When deficiencies are identified, the scope and severity of the deficiencies as well as the oversight activity, will determine the next steps. At a minimum, the Division may request a Corrective Action Plan from the Provider.
6004-E OPERATIONAL REVIEWS

EFFECTIVE DATE: May 20, 2016
REFERENCES: 42 CFR Part 438, AHCCCS 1115 Waiver

Purpose of Operational Reviews

The purpose of the Division performing an Operational Review (OR) is to:

A. Know the Contractor’s system and operation.
B. Support Contractor compliance with Division requirements.
C. Improve Contractor’s compliance with Division requirements.
D. Recognize Contractor accomplishments.
E. Perform Contractor oversight as required by the Centers for Medicare and Medicaid Services (CMS), in accordance with the Arizona Health Care Cost Control System (AHCCCS) 1115 Waiver.
F. Determine whether the Contractor satisfactorily meets:
   1. Division contract requirements
   2. Division policies
   3. Arizona Revised Statute
   4. Arizona Administrative Code
   5. 42 CFR Part 438, Managed Care.
G. Determine progress made in implementing recommendations made during prior reviews.
H. Determine Contractor compliance with its own policies and procedures.
I. Evaluate the effectiveness of Contractor policies and procedures.

Types of Operational Reviews

The following are types of Operational Reviews:

A. Full Review, which includes a review of all standards
B. Focused Review, which includes review of specific:
   1. Areas across all Contractors, e.g., implementation of value based purchasing
   2. Standards related to individual Contractor performance.
Prior to Onsite Review Timeline

The timeline for performing Operational Reviews is as follows:

A. Three (3) weeks before onsite review, the Division provides formal notification of the onsite review to the Contractor.

B. Two (2) weeks before onsite review, the Contractor submits the first documents, which include Populations for Samples, e.g., Prior Approval (PA) Logs.

C. Within three (3) days of receipt of above documents, the Division notifies Contractor of which samples will be reviewed.

D. One (1) week before onsite review, the Contractor uploads all documents to the Division’s File Transfer Protocol (FTP) site.

After Onsite Review Timeline

After the onsite review occurs, the following occur:

A. Six (6) weeks after the onsite review, the Division forwards a draft of its findings to the Contractor.

B. Within one week after above action, the Contractor may challenge The Division’s finding by submitting a Challenge Letter to the Division.

C. Nine (9) weeks after the onsite review, the Division issues its Final Report.

D. Eleven (11) weeks after the onsite review, the Contractor Corrective Action Plan(s) (CAP) is due to the Division.

E. Six (6) months after the Division approves the CAP approval – CAPs must be completed and closed.

The Process – Document Review

The Division reviews documents at the Contractor’s place of business (on-site), off-site, or a combination of both.

When the Division requests additional documents:

1. Before noon, the Contractor supplies the documents by close of business on the same day.

2. After noon, the Contractor supplies the documents by 9:00 a.m. on the following day.
**OR Categories**

OR Categories are:

A. Case Management (CM)

B. Claims and Information Systems (CIS)

C. Delivery Systems (DS)

D. General Administration (GA)

E. Grievance System (GS)

F. Maternal/Child Health and EPSDT (MCH)

G. Medical Management (MM)

H. Member Information (MI)

I. Quality Management (QM)

J. Reinsurance (RI)

K. Third Party Liability (TPL)

L. Corporate Compliance (CC).
Compliance Program Overview

The Corporate Compliance Program consists of the development, maintenance, and implementation of compliance policies and procedures, and the use of training materials, to ensure the Division and its personnel, and contract providers (e.g., Administrative Services Subcontractors, providers and agents) meet all legal and regulatory requirements in the performance of their duties.

The Program provides measures to prevent, detect and correct issues of non-compliance with applicable policies, federal and state regulations, and AHCCCS' contractual requirement to guard against fraud, waste and abuse (FWA).

The Division ensures compliance with all federal, state, and local requirements, including but not limited to, those identified in:

A. 42 Code of Federal Regulation (CFR)
B. Health Insurance Portability and Accountability Act (HIPAA)
C. Arizona Revised Statutes (ARS)
D. Arizona Administrative Code (AAC)
E. The Division’s Contract with the Arizona Health Care Cost Containment System (AHCCCS).
F. Centers for Medicare and Medicaid Services (CMS)

Definitions

A. Abuse - Related to this section, practices which are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Division or in reimbursement for services which are not medically necessary, or which fail to meet professionally recognized standards for health care.

B. Claim – Under the 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.

C. Corporate Compliance Program – a formal program specifying an organization’s policies, procedures, and actions within a process to help prevent and detect violations of laws and regulations. It is designed, structured and implemented to correct identified compliance issues and assist the Division, providers, agents, and subcontractors in meeting legal, regulatory, and contractual obligations pertaining the services provided on behalf of the Division.
D. 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.

E. 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.

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:

1. Knowingly presents (or causes to be presented) to the federal government a false or fraudulent claim for payment.

2. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the federal government.

3. Conspires with others to get a false or fraudulent claim paid by the federal government.

4. 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. Governing Body – The Division as body of persons or officers who establishes the rules and policies, having the authority to exercise governance over its providers, agents and subcontractors.

H. Member – The eligible person enrolled to receive services with the Division.

I. 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.

J. Preliminary Fact-Finding Investigation - When the Division receives a complaint of potential fraud and abuse from any source or identifies any questionable practices, it may conduct a preliminary fact-finding to determine whether there is sufficient basis to warrant a full investigation by the Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity.

K. Prevention - Keep something from happening.

L. 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 Manual. All providers of Arizona Long Term Care System (ALTCS) services must be registered with AHCCCS. Health Plans under contract with the Division are responsible for credentialing acute care providers.
M. **Waste** - As defined by the Arizona Health Care Cost Containment System (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.

**Corporate Compliance Structure**

The Corporate Compliance Program is designed to fulfill the Division’s commitment to foster a culture of compliance and an environment conducive to preventing, detecting and correcting non-compliance issues with all applicable policies, federal and state laws and regulations, and AHCCCS contractual requirements. In addition, the Corporate Compliance Program provides guidance to Division staff, providers, agents and subcontractors in guarding against fraud, waste and abuse all levels of the organization.

The Corporate Compliance Committee monitors, reviews, and assesses the effectiveness of the Corporate Compliance program and the timeliness of reporting to ensure that the Corporate Compliance Program structure facilitates compliance with all legal and governmental requirements.

Corporate Compliance Committee members include:

- Assistant Director/Chief Executive Officer
- Corporate Compliance Office/Deputy Assistant Director
- Office of Person Centered Care/Deputy Assistant Director
- Chief Financial Officer/Deputy Assistant Director
- Medical Chief Officers
- Legal & Regulatory Services Administrator
- Compliance Administrator
- Contract Compliance Officer
- Health Plan Compliance Officer
- Fraud, Waste and Abuse Manager
- Privacy Officer
- Policy Manager
- Chief Quality Officer
- Medical Management Manager
- DDD Human Resources Designee
- AzEIP Bureau Chief
- Legal Advisor/Attorney General’s Office/DES Legal Representation
The following personnel manage the Compliance Program to ensure compliance with all legal and governmental requirements:

- The Chief Compliance Officer, Corporate Compliance Committee, and all other Division Management
- Human Resources Department
- All other Division employees.

**Corporate Compliance Program Components**

The Corporate Compliance Program is based on the seven key elements of Compliance that facilitate prevention, detection and remediation of non-compliance with federal and state laws and regulations, AHCCCS contractual requirements and DES-DDD internal policies and procedures. The seven key elements are:

1. Written Policies, Procedures and Standards of Conduct
2. Corporate Compliance Program Oversight
3. Training and Education
4. Effective Lines of Communication
5. Enforcement of Standards
6. Monitoring and Auditing
7. Correcting Areas of Non-Compliance

The Corporate Compliance Program is centered on the Corporate Compliance Plan, compliance policies and procedures, oversight of compliance to law, and contractual obligations, education, monitoring, and enforcement. The Plan:

- Details the process and steps taken to prevent, detect, and remediate instances of non-compliance,
- Adheres to the Division’s contract with AHCCCS,
- Is submitted annually to the AHCCCS Office of Inspector General (OIG).

**A. Written Policies, Procedures and Standards of Conduct**

The Corporate Compliance Program is based on written Policies, Procedures, and Standards of Conduct that facilitate compliance with federal and state laws, regulations, and AHCCCS contractual requirements.

B. Corporate Compliance Program Oversight

The Division’s Chief Compliance Officer and Corporate Compliance Committee provides Division-wide oversight to ensure compliance with Program and Fiscal Integrity. The Chief Compliance Officer is responsible for the strategy, implementation and oversight of the Division’s Compliance Program.

The Corporate Compliance Program is structured to include Division staff responsible for the oversight of compliance related activities to include but not limited to:

1. Risk assessment and management of internal and external compliance
2. Development, implementation and/or monitoring of training and educational events for all Division staff, subcontractors, providers, and agents pertaining Corporate Compliance.
3. Provide technical assistance to all Division staff, subcontractors, providers and agents regarding compliance
4. Documentation of all referrals suspecting potential FWA or other issues of non-compliance
5. Development and monitoring of corrective action plans
6. Timely processing of referrals deemed credible of FWA and submission to AHCCCS OIG
7. Reporting to, and providing reports to, the Corporate Compliance Committee

C. Training and Education

1. Mandatory Training
   a. In a manner that can be verified by AHCCCS, the Division trains all employees (including Management) on the following:
      i. Compliance
      ii. Article 9
      iii. HIPAA (annually)
      iv. Standards of Conduct for State Employees
      v. Fraud Awareness (annually)
      vi. Business Continuity
      vii. Diversity
      viii. AHCCCS Overview
   b. The Division trains employees as appropriate to their job functions, including but not limited to:
i. Support Coordination/Member Services
ii. Network/Provider Relations
iii. Medical Management
iv. Quality Management
v. Claims/Business Operations

c. The Division provides refresher training to all employees as appropriate to their job functions, and as needed

2. Training Materials

The DES Office of Professional Development develops and maintains all training materials. Training materials are reviewed and updated as needed by the Corporate Compliance Unit.

3. Effective Lines of Communication

a. The Division provides updates to their personnel via the following formats:
   i. Unit meetings/AMS
   ii. Statewide meetings
   iii. E-mails
   iv. Echo Employee Newsletter
   v. Policies and Procedures

b. The Division may provide updates to contracted providers in the following formats:
   i. Provider/Coordination meetings
   ii. Vendor Blasts/e-mails
   iii. Policies and Procedure Manuals
   iv. Contract monitoring units.

D. Enforcement of Standards

1. Evaluate the ability of prospective providers to perform the activities to be delegated, and using accepted risk assessment criteria, as needed.

2. Establish a written agreement (as defined by the Division’s contract with AHCCCS) that:
   a. Specifies activities and reporting responsibilities delegated to the contractor
b. Provides for revocation of such delegation, and application of sanctions

c. Includes other specific requirements, as stated in the Division’s contract with AHCCCS.

3. Retain authority to direct delegated contract requirements

4. Communicate deficiencies to the provider so the provider is able to develop a Corrective Action Plan (42 CFR 438.230[b]).

E. Monitoring/Auditing and Enforcement

1. The Division monitors compliance via:
   a. Compliance-related reports based on Division and Provider/AdSS data,
   b. Investigations of allegations of non-compliance,
   c. Review of functional areas and related systems,
   d. Assessment of mechanisms to facilitate prevention, detection and remediation of non-compliance,
   e. Internal and external audits.

2. Reporting of Non-Compliance to the Division

   The Division maintains open lines of communication to support Division personnel, subcontractors, providers, agents, members, and all other individuals in reporting non-compliance. Toll-free hotlines and dedicated email addresses are identified in Division publications and available on the Division website for this purpose.

3. Correcting Areas of Non-Compliance

   Upon learning of a potential incident of fraud, waste or abuse involving an AHCCCS Program, the Division:
   a. May conduct a preliminary fact-finding to determine the nature of the incident,
   b. Completes the confidential AHCCCS Referral for Preliminary Investigation form available on the AHCCCS website (for member and provider cases),
   c. Notifies the AHCCCS-Office of the Inspector General, Arizona Health Care Cost Containment System (AHCCCS) Office of Program Integrity in accordance within ten days of discovery per AHCCCS ACOM Policy 103.
   d. Responds to compliance issues to the extent required by law and within the mandated timeframes.
   e. Enforces compliance and takes corrective actions as appropriate.
The Division generates regular compliance-related reports that include, but are not limited to:

a. Grievance System Report
b. Resolution System Report
c. CLT_0060 (high utilization by members) and CLT-0150 (underutilization by members); see Policy 6002-N Fraud and False Claims
d. Claims Dashboard
e. Encounters Report
f. Support Coordination Reports.
g. HIPAA violations report
<table>
<thead>
<tr>
<th>Chapter 100</th>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>100-D</td>
<td>Policy Manual Definitions</td>
</tr>
</tbody>
</table>

**Chapter 200**

**Chapter 300**

**Medical Policy for Acute Services**

<table>
<thead>
<tr>
<th>300</th>
<th>Chapter Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>310-A</td>
<td>Audiology</td>
</tr>
<tr>
<td>310-D</td>
<td>Dental Services</td>
</tr>
<tr>
<td>310-E</td>
<td>Dialysis</td>
</tr>
<tr>
<td>310-F</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>310-H</td>
<td>Health Risk Assessment and Screening Tests</td>
</tr>
<tr>
<td>310-I</td>
<td>Home Health Services</td>
</tr>
<tr>
<td>310-J</td>
<td>Hospice Services</td>
</tr>
<tr>
<td>310-K</td>
<td>Hospital Inpatient Services</td>
</tr>
<tr>
<td>310-L</td>
<td>Hysterectomy</td>
</tr>
<tr>
<td>310-M</td>
<td>Immunizations</td>
</tr>
<tr>
<td>310-N</td>
<td>Laboratory</td>
</tr>
<tr>
<td>310-O</td>
<td>Maternal and Child Health Services</td>
</tr>
<tr>
<td>310-P</td>
<td>Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services)</td>
</tr>
<tr>
<td>310-S</td>
<td>Observation Services</td>
</tr>
<tr>
<td>310-T</td>
<td>Physician Services</td>
</tr>
<tr>
<td>310-U</td>
<td>Foot and Ankle Services</td>
</tr>
<tr>
<td>310-V</td>
<td>Prescription Medication/Pharmacy Services</td>
</tr>
<tr>
<td>310-W</td>
<td>Radiology and Medical Imaging</td>
</tr>
<tr>
<td>310-X</td>
<td>Rehabilitative Therapy</td>
</tr>
<tr>
<td>310-Y</td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>310-AA</td>
<td>Total Parenteral Nutrition</td>
</tr>
<tr>
<td>310-BB</td>
<td>Transportation</td>
</tr>
<tr>
<td>Section Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>310-DD</td>
<td>Organ Transplant</td>
</tr>
<tr>
<td>310-FF</td>
<td>Monitoring Controlled and Non-Controlled Medication Utilization</td>
</tr>
<tr>
<td>320-A</td>
<td>Affiliated Practice Dental Hygienist</td>
</tr>
<tr>
<td>320-E</td>
<td>Health and Behavior Intervention</td>
</tr>
<tr>
<td>320-F</td>
<td>HIV/AIDS Treatment Services</td>
</tr>
<tr>
<td>320-G</td>
<td>Lung Volume Reduction Surgery</td>
</tr>
<tr>
<td>320-H</td>
<td>Medical Foods</td>
</tr>
<tr>
<td>320-I</td>
<td>Telehealth and Telemedicine</td>
</tr>
<tr>
<td>320-K</td>
<td>Tobacco Cessation Product</td>
</tr>
<tr>
<td>320-M</td>
<td>Medical Marijuana</td>
</tr>
<tr>
<td>320-P</td>
<td>Serious Mental Illness Eligibility Determination</td>
</tr>
<tr>
<td>320-U</td>
<td>Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment</td>
</tr>
<tr>
<td>320-V</td>
<td>Behavioral Health Residential Facilities</td>
</tr>
<tr>
<td>330</td>
<td>Covered Conditions and Services for Children’s rehabilitative Services Program</td>
</tr>
</tbody>
</table>

**Chapter 400**  
Medical Policy for Maternal and Child Health

<table>
<thead>
<tr>
<th>Section Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>410</td>
<td>Maternity Care Services</td>
</tr>
<tr>
<td>411</td>
<td>Women’s Preventative care Services</td>
</tr>
<tr>
<td>420</td>
<td>Family Planning</td>
</tr>
<tr>
<td>430</td>
<td>Early Periodic Screening, Diagnostic and Treatment Services</td>
</tr>
<tr>
<td>431</td>
<td>Oral Health Care (EPSDT-Age Members)</td>
</tr>
</tbody>
</table>

**Chapter 500**  
Care Coordination Requirements

<table>
<thead>
<tr>
<th>Section Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>510</td>
<td>Primary Care Providers</td>
</tr>
<tr>
<td>520</td>
<td>Member Transitions</td>
</tr>
<tr>
<td>530</td>
<td>Member Transfers Between Facilities</td>
</tr>
<tr>
<td>540</td>
<td>Other care Coordination Issues</td>
</tr>
<tr>
<td>541</td>
<td>Coordination of Care with other Government Agencies</td>
</tr>
<tr>
<td>Section</td>
<td>Title</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>550</td>
<td>Member Records and Confidentiality</td>
</tr>
<tr>
<td>570</td>
<td>Community Collaborative Care Teams (Reserved)</td>
</tr>
<tr>
<td><strong>Chapter 600</strong></td>
<td><strong>Provider Qualifications and Provider Requirements</strong></td>
</tr>
<tr>
<td>610</td>
<td>AHCCCS Provider Qualifications</td>
</tr>
<tr>
<td>640</td>
<td>Advance Directives</td>
</tr>
<tr>
<td>680-C</td>
<td>Pre-Admission Screening and Resident Review</td>
</tr>
<tr>
<td><strong>Chapter 700</strong></td>
<td><strong>School Based Claiming Program – Direct Services Claiming</strong></td>
</tr>
<tr>
<td>700</td>
<td>School Based Claiming for Medicaid</td>
</tr>
<tr>
<td><strong>Chapter 800</strong></td>
<td><strong>Fee-for-Service Quality and Utilization Management</strong></td>
</tr>
<tr>
<td>810</td>
<td>Utilization Management Overview</td>
</tr>
<tr>
<td><strong>Chapter 900</strong></td>
<td><strong>Quality Management and Performance Improvement Program</strong></td>
</tr>
<tr>
<td>910</td>
<td>Quality Management/Performance Improvement Program Administrative Requirements</td>
</tr>
<tr>
<td>920</td>
<td>Quality Management/Performance Improvement (QM/PI) Program Scope</td>
</tr>
<tr>
<td>950</td>
<td>Credentialing and Recredentialing Processes</td>
</tr>
<tr>
<td>960</td>
<td>Tracking and Trending of Member and Provider issues</td>
</tr>
<tr>
<td>970</td>
<td>Performance Measures</td>
</tr>
<tr>
<td>980</td>
<td>Performance Improvement Projects</td>
</tr>
<tr>
<td><strong>Chapter 1000</strong></td>
<td><strong>Medication Management</strong></td>
</tr>
<tr>
<td>1000</td>
<td>Chapter Overview</td>
</tr>
<tr>
<td>1010</td>
<td>Medical Management Administrative Requirements</td>
</tr>
<tr>
<td>1030</td>
<td>Reporting Requirements</td>
</tr>
<tr>
<td>1040</td>
<td>Outreach, Engagement, Reengagement, and Closure for Behavioral Health</td>
</tr>
<tr>
<td><strong>Chapter 1100</strong></td>
<td><strong>Reserved</strong></td>
</tr>
<tr>
<td><strong>Chapter 1200</strong></td>
<td><strong>Services and Settings</strong></td>
</tr>
<tr>
<td>1200</td>
<td>Overview</td>
</tr>
<tr>
<td>1210</td>
<td>Institutional Services and Settings</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>1230-A</td>
<td>Assisted Living Centers</td>
</tr>
<tr>
<td>1230-C</td>
<td>Room and Board</td>
</tr>
<tr>
<td>1240-A</td>
<td>Attendant Care and Homemaker</td>
</tr>
<tr>
<td>1240-C</td>
<td>Community Transition Services</td>
</tr>
<tr>
<td>1240-D</td>
<td>Emergency Alert Systems</td>
</tr>
<tr>
<td>1240-E</td>
<td>Habilitation Services</td>
</tr>
<tr>
<td>1240-G</td>
<td>Home Nursing</td>
</tr>
<tr>
<td>1240-H</td>
<td>Home Health Aide</td>
</tr>
<tr>
<td>1240-I</td>
<td>Home Modifications</td>
</tr>
<tr>
<td>1250-B</td>
<td>Hospice</td>
</tr>
<tr>
<td>1250-C</td>
<td>Medical and Acute Care Services</td>
</tr>
<tr>
<td>1250-D</td>
<td>Respite</td>
</tr>
<tr>
<td>1250-E</td>
<td>Therapies (Rehabilitative and Habilitative)</td>
</tr>
<tr>
<td>1250-F</td>
<td>Medical Supplies, Equipment, Appliances, and Customized Durable Medical Equipment</td>
</tr>
<tr>
<td>1250-G</td>
<td>Assessments and Nutritional Therapy</td>
</tr>
<tr>
<td>1250-H</td>
<td>Transportation</td>
</tr>
<tr>
<td>1280</td>
<td>State Funded Services</td>
</tr>
<tr>
<td>Exhibit 1240A-1</td>
<td>Attendant Care Supervision Requirements Age 17 and Under</td>
</tr>
<tr>
<td>Exhibit 1240A-2</td>
<td>Attendant Care Supervision Requirements Age 18 and Above</td>
</tr>
<tr>
<td>Exhibit 1240A-3</td>
<td>Attendant Care Supervision Documentation Requirements</td>
</tr>
<tr>
<td>Exhibit 1240G-1</td>
<td>Skilled Nursing Matrix</td>
</tr>
<tr>
<td><strong>Chapter 1300</strong></td>
<td>Reserved</td>
</tr>
<tr>
<td><strong>Chapter 1400</strong></td>
<td>Reserved</td>
</tr>
<tr>
<td><strong>Chapter 1500</strong></td>
<td>Reserved</td>
</tr>
<tr>
<td><strong>Chapter 1600</strong></td>
<td>Case Management</td>
</tr>
<tr>
<td>1610</td>
<td>Components of Support Coordination</td>
</tr>
<tr>
<td>1620-G</td>
<td>Behavioral Health Standards</td>
</tr>
<tr>
<td>Page</td>
<td>Title</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>1630</td>
<td>Administrative Standards</td>
</tr>
<tr>
<td>1640</td>
<td>Targeted Support Coordination Standards</td>
</tr>
</tbody>
</table>
100-D DEFINITIONS

REVISION DATE: 7/3/2015, 9/1/2014
EFFECTIVE DATE: June 30, 1994

1115 Waiver – The 1115 Waiver refers to section 1115 of the Social Security Act (SSA). States must comply with Title XIX (Medicaid) and Title XXI (Children’s Health Insurance Program) of the SSA. Since Arizona began providing Medicaid on October 1, 1982, the Arizona Health Care Cost Containment System (AHCCCS) has been exempt from specific provisions of the SSA, pursuant to an 1115 Research and Demonstration Waiver. The 1115 Waiver specifies provisions in the SSA and corresponding regulations AHCCCS is exempt from; terms and conditions that AHCCCS must fulfill; and approved federal budget amounts. (Arizona Section 1115 Demonstration Project Waiver).

Arizona Administrative Code (A.A.C.) - The Arizona Administrative Code is a publication of the official rules of the State of Arizona. Rules are adopted by state agencies, boards or commissions, with specific rulemaking authority from the State Legislature. Rule sections are published in Titles and Chapters.

Arizona Developmental Disabilities Planning Council (ADDPC) – The ADDPC works to support advocacy, bring about systems change and create increased capacity to support persons with developmental disabilities in the community. The ADDPC was established pursuant to Public Law 106-402, also known as the Developmental Disabilities Assistance and Bill of Rights Act of 2000. Pursuant of an Executive Order by the Governor of the State of Arizona on September 3, 2009, the Council was created. Council members are appointed by the Governor of Arizona.

Arizona Health Care Cost Containment System (AHCCCS) – The single State Medicaid agency, as described in A.R.S. § Title 36, Chapter 29, Arizona Medicaid Agency. AHCCCS is composed of the AHCCCS Administration, Contractors and other arrangements through which health care services (acute, long-term care, and behavioral) are provided to members.

Arizona Long Term Care System (ALTCS)- An AHCCCS program which delivers long term, acute, behavioral health care, and case management services as authorized by A.R.S. § 36-2931 et seq, to eligible members who are either elderly and/or have physical disabilities and to members with developmental disabilities, through contractual agreements and other arrangements.

Arizona Long Term Care System (ALTCS) Contractor- A contracted managed care organization (also known as a Program Contractor), that provides long term care, acute care, behavioral health and case management services to Title XIX eligible individuals who are either elderly and/or who have physical or developmental disabilities who are determined to be at immediate risk of institutionalization.


Assistant Director Approval – Includes approval from the Assistant Director’s designee.
Centers for Medicare and Medicaid Services (CMS) – An organization within the United States Department of Health and Human Services that administers the Medicare and Medicaid programs and the State Children’s Health Insurance Program (known as KidsCare in Arizona).

Code of Federal Regulations (CFR) - The general and permanent rules published in the Federal Register by the departments and agencies of the federal government.

Comprehensive Medical and Dental Program - The Comprehensive Medical and Dental Program (CMDP) is a health care program for Arizona’s children who are wards of the court and placed out of home. Eligibility is based on State law. Department of Child Safety (DCS) coordinates services related to CMDP.

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

Developmental Disabilities Advisory Council (DDAC) – Advisory Council to the Division of Developmental Disabilities whose duties have been established by A.R.S. § 36-553 whose voting members are also appointed by the Governor of Arizona.

Direct Care Worker – A person who assists individuals with activities necessary to allow them to reside in their home. These workers may also be known as Direct Support Professionals.

Durable Medical Equipment (DME) – An item or appliance that is not an orthotic or prosthetic; is designed for medical purpose; is generally not useful to a person in the absence of an illness or injury; can withstand repeated use; and, is generally reusable by others.

Durable Medical Equipment (DME), Customized - Equipment that has been altered or built to specifications unique to a member’s medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

Fee-For-Service (FFS) - A method of payment to an AHCCCS registered provider on an amount-per-service basis.

Focus – The automated web-based system used to maintain information on each member eligible for the Division.

Home and Community Based Services (HCBS) - Services provided, in lieu of institutionalization, to ALTCS members who reside in their own home or in an ALTCS approved home and community based alternative residential setting in order to maintain the member's highest level of functioning. Members enrolled in the ALTCS Transitional Program also receive HCBS.

Home Program – The Home Program provides for specific activities for the member to do with their families/caregivers during the course of their daily activities to enhance progress towards the chosen treatment goals.
Human Rights Committee (HRC) – This Committee provides independent oversight to monitor and ensure the civil and human rights for persons with developmental disabilities as guaranteed in the U.S. Constitution, federal law regulations, and the Arizona Revised Statutes.

Institutional Settings – Means a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).

Medically Necessary - As defined in A.A.C. R9-22-101, medically necessary means a covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.

Member – A person enrolled with the Division of Developmental Disabilities.

Planning Document – A plan which is developed by the Planning Team, such as an Individualized Family Service Plan (IFSP), Individualized Support Plan (ISP), and Person Centered Plan (PCP).

Primary Care Provider (PCP) - An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

Prior Authorization (PA) – Process by which the Division approves a service.

Program Review Committee (PRC) – As defined in agency rules at A.A.C. R6-6 903, the PRC is an assembly designated by the District Program Manager that reviews any behavior treatment plans which meet the criteria also outlined in the same rules. The PRC approves plans, or makes recommendations for changes as necessary.

Regional Behavioral Health Authority (RBHA) – As defined in A.R.S. § 36-3401, the RBHA is an organization under contract with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to administer covered behavioral health services in a geographically specific service area of the state. Tribal governments, through an agreement with the ADHS/DBHS, may operate a Tribal Regional Behavioral Health Authority (TRBHA), as defined in A.A.C. R9-22-1201(w), for the provision of behavioral health services to American Indian members living on-reservation. Through an intergovernmental agreement with ADHS/DBHS, the Division is responsible for all behavioral health services provided to members eligible for ALTCS.

Service Plan Year – The annual period of time beginning at the member’s “ISP Start Date” as identified in Focus through the “ISP End Date” as identified in Focus.

Title XIX - Known as Medicaid, Title XIX of the Social Security Act provides for federal funds to the states for medical assistance programs.
200 RESERVED
300  CHAPTER OVERVIEW

EFFECTIVE DATE: June 30, 1994

The services described in this Chapter are available to members enrolled in Title XIX. This includes Targeted (Title XIX Acute) and Arizona Long Term Care Services (ALTCS) members.

Contracted Health Plans

Members who are eligible for Long Term Care services are required to join one of the Division’s contracted health plans, where available. The exception is Native Americans who may choose to enroll in American Indian Health Plan.

The contracted health plan subcontracts with physicians, hospitals, therapists, dentists, laboratories, pharmacies, medical equipment suppliers, and other providers to deliver acute care services to enrolled members.

All services must be delivered or ordered by the Primary Care Provider (PCP), determined to be medically necessary by the health plan and delivered by a contracted provider. The PCP is the member’s designated physician who coordinates all aspects of the member’s medical care. Members who are eligible for Long Term Care services that fail to follow these procedures and receive services that are not approved/provided by a health plan provider are responsible to pay for these services.

The members who are eligible for Long Term Care services may choose to use their own doctor if the physician is an Arizona Health Care Cost Containment System (AHCCCS) registered provider and is contracted with the health plan. In these instances, the health plan’s or the Division’s approval is still needed for services covered by Arizona Long Term Care System (ALTCS).

If the member who is long term care eligible is enrolled in a health plan and has a PCP, but also chooses to use another physician who may not be registered with AHCCCS, services provided or ordered by this physician are not covered by the AHCCCS. Services by a physician who is not registered with the AHCCCS can be covered by the health plan if approved by the PCP and the health plan. If approval is not received from the PCP and the health plan, the member will be required to pay for the services personally or through private insurance.

Children's Rehabilitative Services

Members eligible for ALTCS may also be eligible for Children’s Rehabilitative Services (CRS). Members eligible for the Division and CRS will receive CRS specialty services and behavioral health services through United Healthcare Community Plan or its successor. These members will continue to receive acute care services through their Division acute health plan.
Extended Care Coverage

Health plans for members who are eligible for Long Term Care are financially responsible for a maximum of 90 days. This financial responsibility includes nursing facility care, and room and board, after hospital discharge. Nursing Facility (NF) care must be in lieu of hospitalization. If the member’s place of residence prior to hospitalization was a NF the health plan is not financially responsible for placement. Members requiring nursing facility placement beyond 90 days are the financial responsibility of the Division. Preadmission Screening/Annual Resident Review (PASRR) Level II reviews must occur for each member whose expected stay in the NF will exceed 90 days.

Division staff will work expeditiously with the health plan's discharge planners to place the member in the least restrictive environment as required by state law.

Comprehensive Medical and Dental Program

The Comprehensive Medical and Dental Program (CMDP) is a health care program for Arizona’s children who are wards of the court and placed out of home. Eligibility is based on State law. Department of Child Safety (DCS) coordinates services related to CMDP.

Member Acute Care Card

Members who are determined eligible for Long Term Care services will receive a membership card from the Division or the Division’s contracted acute health plan, and will be enrolled in a contracted acute health plan by the Division or receive services on a fee-for-service basis through the Division.

Health Plan Responsibilities

Each contracted acute health plan is required to send members a health plan member handbook. The handbook explains the services that are covered, how to access these services, and what to do when emergency services are needed. It outlines the member’s responsibility to follow procedures. All services must be provided or approved by the primary care provider.

An ALTCS member who fails to follow procedures outlined in the member handbook and receives services that are not approved or provided by a health plan contracted physician may be responsible to pay for those services.

The Division may delegate some or all of its responsibility to a health plan for the following non-inclusive health care responsibilities. These services are rendered on behalf of members who are ALTCS members and enrolled with the health plan:

A. Prior authorization of services and procedures as specified by the health plan.
B. Claims processing according to policies and procedures defined by the health plan.
C. Concurrent review, including certification and denial of inpatient hospital stay days, according to health plan procedures.
D. Investigation and resolution of complaints and grievances according to policy and procedure specified by both AHCCCS and the health plan.

E. Provider relations and member services activities.

F. Financial monitoring and reporting as mandated under AHCCCS rules.


All such services/responsibilities must be in compliance with AHCCCS/ALTCS Rules and Regulations (azahcccs.gov/Regulations/Arizona).
310-A AUDIOLOGY

EFFECTIVE DATE: March 3, 2017

REFERENCES: 42 CFR 440.110

The Division of Developmental Disabilities (Division) covers medically necessary audiology services to evaluate hearing loss for all members, on an inpatient and outpatient basis. Only an AHCCCS-registered dispensing audiologist or an AHCCCS-registered individual with a valid hearing aid dispensing license may dispense hearing aids. Hearing aids, provided as a part of audiology services, are covered only for members for members age 21 and under who are eligible for AHCCCS.

Audiology services must be provided by an audiologist who is licensed by the Arizona Department of Health Services (ADHS) and who meets the federal requirements specified under Title 42 of the Code of Federal Regulations (42 CFR 440.110). Out-of-state audiologists must meet the federal requirements.

The federal requirements mandate that the audiologist have a master's or doctoral degree in audiology and meet one of the following conditions:

A. Have a certificate of clinical competence in audiology granted by the American Speech-Language-Hearing Association (ASHA), or

B. Have successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or be in the process of accumulating such supervised clinical experience under the supervision of a qualified master's or doctoral-level audiologist), performed at least nine months of supervised full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology or a related field, and successfully completed a national examination in audiology approved by the Secretary of the U.S. Department of Health and Human Services.
**310-D DENTAL SERVICES**

EFFECTIVE DATE: June 30, 1994  
REFERENCES: A.R.S. § 32-1207 and 32-1231.

**Dental Services for Members Aged 0-21**

Dental services for members who are Arizona Long Term Care System (ALTCS) eligible aged 0 to 21 years are covered when provided by a dentist licensed per A.R.S. § 32-1207 and A.R.S. § 32-1231 for maintenance of dental health, prevention and treatment of disease and injury, in an appropriate dental facility.

Informed consent must be obtained from the member or responsible person(s) prior to any treatment including those noted in covered services. Written consent must be obtained prior to major outpatient treatments. The dentist must obtain the consent.

The following services are covered:

A. Preventive dental services - performed annually unless otherwise requested by Primary Care Provider (PCP) include:

   1. Oral examinations
   2. Radiological and medical imaging services
   3. Oral prophylaxis - includes scaling and polishing and application of topical fluoride and sealants, if appropriate
   4. Dental treatment plan
   5. Dental education

B. Restorative treatment, including:

   1. Restorative and primary amalgams
   2. Composite restoration (anterior teeth)
   3. Sedative base
   4. Permanent teeth

C. Orthodontia when medically necessary and prior authorized by the health plan or the Division's Medical Director.

D. Endodontic services (pulp capping, pulpotomy, and recalcification)

E. Crown and bridge services

F. Prosthetics
G. Oral surgery (includes extraction of symptomatic teeth and post-operative visits)

H. Orthognathic surgery

I. Medically necessary dentures.

**Dental Services for Members Aged 21 and Older**

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

**Emergency Dental Care/Extractions for ALTCS Members of All Ages**

Emergency dental care and extractions are covered for all members who are eligible for ALTCS regardless of age.
310-E DIALYSIS

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers hemodialysis and peritoneal dialysis are covered services when provided by participating hospitals and End Stage Renal Disease facilities. All services, supplies, diagnostic testing (including routine medically necessary laboratory tests), and drugs medically necessary for the dialysis treatment are covered.

A. Medically necessary outpatient dialysis treatments are covered. Inpatient dialysis treatments are covered when the hospitalization is for the following:

1. Acute medical condition requiring dialysis treatments (hospitalization related to dialysis)

2. Division-covered medical condition requiring inpatient hospitalization experienced by a member routinely maintained on an outpatient chronic dialysis program

3. Placement, replacement, or repair of the chronic dialysis route.

B. Hospital admissions solely to provide chronic dialysis are not covered.

C. Hemoperfusion is covered when medically necessary.
The Division of Developmental Disabilities (Division) covers emergency medical services for members eligible for ALTCS and Fee For Service (FFS)/American Indian Health Plan (AIHP). Emergency medical services are provided for the treatment of an emergency medical condition. An emergency medical condition is a medical condition, including labor and delivery, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in any of the following:

A. Placement of the patient's health in serious jeopardy
B. Serious impairment of bodily functions
C. Serious dysfunction of any bodily organ or part.

Emergency medical services are covered when there is a demonstrated need and/or after triage/emergency medical assessment services indicate an emergency condition.

A provider is not required to obtain prior authorization for emergency services.

Providers must notify the health plan within 12 hours of emergency service provision. Non-emergency services out of the member's service area may not be covered.

Emergency services may be obtained when the member is out of the service area.

Emergency Services will not be provided to a member outside the United States.

**Use of Emergency Services**

The Division and its Administrative Services Subcontractors must educate their members regarding the appropriate use of emergency room services. Members should be encouraged to obtain services from non-emergency facilities (e.g., urgent care centers) to address member non-emergency care after regular office hours or on weekends.
310-H HEALTH RISK ASSESSMENT AND SCREENING TESTS

EFFECTIVE DATE: MAY 13, 2016

A. The Division covers health risk assessment and screening tests provided by a physician, primary care provider or other licensed practitioner within the scope of his/her practice under State law for all members.

B. These services include appropriate clinical heath risk assessments and screening tests, immunizations, and health education, as appropriate for age, history and current health status. Health risk assessment and screening tests are also covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program.

C. Preventive health risk assessment and screening test services are covered for adults, except when the adult member is hospitalized. Services include, but are not limited to:

1. Hypertension screening (annually).
2. Cholesterol screening (once, additional tests based on history).
3. Routine mammography annually after age 40 and at any age if considered medically necessary.
4. Cervical cytology, including pap smears (annually for sexually active women; after three successive normal exams the test may be less frequent).
5. Colon cancer screening (digital rectal exam and stool blood test, annually after age 50, as well as baseline colonoscopy after age 50).
6. Sexually transmitted disease screenings (at least once during pregnancy, other based on history).
7. Tuberculosis screening (once, with additional testing based on history, or, for members residing in a facility, as necessary per health care institution licensing requirement).
8. HIV screening.
9. Immunizations (See AHCCCS Policy AMPM 310 M for details).
10. Prostate screening (annually after age 50; and, screening is recommended annually for males 40 and older who are at high risk due to immediate family history), and
11. Physical examinations (includes well visits and well exams), periodic health
examinations or assessments, diagnostic work ups or health protection packages designed to:

a. Provide early detection of disease,

b. Detect the presence of injury or disease,

c. Establish a treatment plan,

d. Evaluate the results or progress of a treatment plan or the disease, or

e. Establish the presence and characteristics of a physical disability, which may be the result of disease or injury.

D. Screening services provided more frequently than these professionally recommended guidelines will not be covered unless medically necessary.

**Exclusions**

Physical examinations not related to covered health care services or performed to satisfy the demands of outside public or private agencies such as the following are not covered services:

A. Qualification for insurance.

B. Pre-employment physical examination.

C. Qualifications for sports or physical exercise activities.

D. Pilots examinations (Federal Aviation Administration).

E. Disability certification for the purpose of establishing any kind of periodic payments.

F. Evaluation for establishing third party liability.
310-I  HOME HEALTH SERVICES

REVISION DATE:  7/3/2015, 9/15/2014
EFFECTIVE DATE:  June 30, 1994

Home health services through the health plan are those services provided by a Home Health Agency that coordinate in-home intermittent services. These services include, home health aide services, medical supplies, equipment and appliances. The service must be ordered by the Primary Care Provider (PCP) in lieu of hospitalization and referred by the health plan to a Medicare Certified Home Health Agency.

Travel Expenses (meals, Lodging, Transportation and Attendant Services)

Expenses incurred for meals, lodging, and transportation for a member while en route to or from a health care service site out of the member’s service area or county of residence are covered services.

The PCP must write an order for attendant care services. The Attendant Care Provider’s meals, lodging, and transportation expenses are covered. On occasion the Attendant Care Provider may accompany a member out of the service area or county of residence. These attendant care providers may also be a family member who lives in the same household as the member. Under these circumstances services are covered if a written order from the PCP is issued. The Attendant Care Provider’s salary is covered only if the attendant does not live in the same household as the member. Expense receipts must be sent to the health plan or Health Care Services for fee-for-service counties. Receipts for meals and lodging must not exceed the State per diem. Transportation will be reimbursed at 9 cents per mile.

The following exclusions and limitations apply:

A. Family household members, friends, and neighbors may be reimbursed for providing transportation services only if the services are ordered in writing by the PCP and free transportation or public transportation is not available;

B. A charitable organization providing transportation services at no cost. A charitable organization may not charge or seek reimbursement for the provision of such services to Arizona Long Term Care System (ALTCS); and,

C. Payment for meals, lodging, and transportation of a member, and an Attendant Care Provider, are funded when a member requires covered service that are not available in the health plan’s service area. This criterion also applies to the salary for an attendant.
HOSPICE SERVICES

REVISION DATE: 5/8/2019
EFFECTIVE DATE: November 17, 2017
REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, and Arizona’s Section 115(a) Medicaid Demonstration Extension.

This Policy establishes requirements for Hospice Services. Hospice services are covered for members eligible for AHCCCS. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989, and 42 CFR 418.20, for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member’s own home, an alternative residential setting, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

A. Hospital
B. Nursing care institution
C. Freestanding hospice.

Providers of hospice must be Medicare certified, licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, members receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

For dual eligible members, Medicare is the primary payer of hospice services.

Definitions

The following definitions apply to Hospice Services:

A. Bereavement Counseling - Emotional, psychosocial, and spiritual support and services provided before and after the death of a member to assist the family with issues related to grief, loss, and adjustment.

B. Continuous home care - Services provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous) to maintain residence in their own home as specified in 42 CFR 418.204(a). Care must be predominantly nursing care, provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN). Homemaker and home health aide services may also be provided to supplement the care.

C. Palliative care - Member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering and is provided to address physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice.

D. Period of crisis - A period (up to 24 hours per day) in which the hospice-eligible member
requires continuous care to achieve palliation or management of acute medical symptoms.

E. Terminally ill - A medical prognosis of life expectancy for six months or less if the illness runs its normal course.

Policy

Hospice Care is a comprehensive set of services identified and coordinated by an interdisciplinary group to provide palliative and support care for terminally ill members and their family members and caregivers for the physical, psychosocial, spiritual, and emotional needs as delineated in a specific patient plan of care.

Hospice Services are covered for all terminally ill members who meet the specified medical criteria and requirements under A.R.S. §§ 36-2907, 36-2939, and 36-2989, and 42 CFR Part 418 et seq.

In order to receive Hospice Care, Members must waive the right to duplicative services including: hospice care provided by a non-designated hospice service; services that are related to the treatment of the terminal condition or a related condition, unless provided by the designated hospice, provided by the attending physician, or provided as room and board by a nursing facility where the member is a resident as specified in CMS Medicaid Manual section 4305.2. This waiver does not apply to EPSDT-aged members.

If the Hospice agency is unable or unwilling to provide or cover medically necessary services related to the hospice diagnosis, the services must be provided by the Contractor. The Contractor however must report such cases to ADHS as the hospice licensing agency in Arizona.

A. Eligibility

1. A physician must provide a signed certification stating that the member’s prognosis is terminal, with the member’s life expectancy not exceeding six months. However, due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months, provided additional physician certifications are completed.

2. A member may elect to receive Hospice Care during one or more of the following election periods:
   a. An initial 90-day period,
   b. A subsequent 90-day period, or
   c. An unlimited number of subsequent 60-day periods.

3. As specified in Section 2302 of the Affordable Care Act, EPSDT-aged members may continue to receive curative treatment for a terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care related to the terminal diagnosis but may continue to receive services unrelated to the hospice diagnosis.

B. Hospice Services

Hospice services provide palliative and support care for terminally ill members and
their family members and caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement. When the conditions of participation are met as specified in 42 CFR Part 418, hospice services are provided in the member’s own home, or the following inpatient settings:

1. Hospital.
2. Nursing care institution.
3. Free standing Hospice Unit.

Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services, and inpatient services available as necessary to meet the member’s needs. The following bundled hospice services are covered when provided in approved settings:

1. Physicians’ services for the treatment of the member’s terminal illnesses and related administrative and general supervisory activities, except for attending physician services provided by non-hospice employees;
2. Continuous Home Care;
3. Dietary services, which include a nutritional evaluation and dietary counseling when necessary;
4. Home health aide services;
5. Homemaker services;
6. Nursing services provided by or under the supervision of a registered nurse;
7. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology, or a related field and who is appropriately licensed or certified;
8. Hospice respite care services which are provided on an occasional basis, not to exceed more than five consecutive days at a time. Respite care may not be provided when the member is a nursing facility resident or is receiving services in an inpatient setting;
9. Routine Home Care;
10. Social services provided by a qualified social worker;
11. Therapies that include physical, occupational, or speech therapy;
12. A 24 hour on-call availability to provide services such as reassurance, information, and referral for members and family members and caregivers;
13. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee. Under 42 C.F.R. 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services;
14. Medical supplies, appliances, and equipment, including:
   a. Pharmaceuticals, which are used in relationship to the palliation or management of the member’s terminal illness; and
   b. Medical equipment and appliances may include but are not limited to:
      i. Wheelchairs,
      ii. Hospital beds, and
      iii. Oxygen equipment.

15. Bereavement counseling to the member’s family and caregiver both before and up to 12 months following the death of that member. Bereavement Counseling, to the member’s family and caregiver both before and up to 12 months following the death of the member, is part of the bundled hospice services and is not separately reimbursable, as specified in 42 CFR 418.204.30.
**310-K HOSPITAL INPATIENT SERVICES**

EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 32-801 through 871

The Division of Developmental Disabilities (Division) covers medically necessary inpatient hospital services, provided by a licensed participating hospital, for all members eligible for ALTCS. Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

Inpatient hospital services for members include, but are not limited to, the following:

**A. Hospital accommodation, and appropriate staffing, supplies, equipment and services for any or all of the following:**

1. Acute physical care and behavioral health care
2. Intensive care and coronary care
3. Neonatal intensive care
4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services
5. Nursery for newborns and infants
6. Surgery including surgical suites and recovery rooms, and anesthesiology services
7. Nursing services necessary and appropriate for the member's medical condition, including assistance with activities of daily living as needed
8. Medical detoxification and treatment services
9. Behavioral health forensic services
10. Dietary services
11. Medical supplies, appliances and equipment consistent with the level of accommodation
12. Perfusion and perfusionist services.

**B. Ancillary Services**

Ancillary services include any or all of the following:

1. Audiology services
2. Chemotherapy
3. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)
4. Dental surgery for members 21 years of age and older within limitations as described in Division Medical Policy 310-D
5. Dialysis
6. Laboratory services
7. Pharmaceutical services and prescribed drugs
8. Radiological and medical imaging services
9. Rehabilitation services including physical, occupational and speech therapies
10. Respiratory therapy
11. Behavioral health assessments, and behavioral health therapy (including electroconvulsive therapy)
12. Services and supplies necessary to store, process, and administer blood and blood derivatives
13. Total parenteral nutrition

Limitations and Exclusions

The Division covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

The Division does not separately cover home-based services, such as Attendant/Personal Care, while the member is in inpatient settings.
HYSTERECTOMY

EFFECTIVE DATE: November 17, 2017
REFERENCES: 42 CFR 441.250 et seq

Medically necessary hysterectomy services are covered in accordance with federal regulations 42 CFR 441.250 et seq. Federal regulation 42 CFR 441.251 defines a hysterectomy as “a medical procedure or operation for the purpose of removing the uterus.” Sterilization is defined by this regulation as “any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.”

The Division does not cover a hysterectomy procedure if:

A. It is performed solely to render the individual permanently incapable of reproducing, or
B. There was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

Coverage of hysterectomy services is limited to those cases in which medical necessity has been established by careful diagnosis and there has been a trial of medical or surgical therapy which has not been effective in treating the member’s condition, except for those conditions as specified below.

**Examples of Conditions When Hysterectomy May Be Indicated**

A. Dysfunctional Uterine Bleeding or Benign Fibroids associated with Dysfunctional Bleeding: A hysterectomy may be considered for members for whom medical and surgical therapy has failed, and childbearing is no longer a consideration.

B. Endometriosis: A hysterectomy may be considered for members with severe disease when future child-bearing is not a consideration, and when disease is refractory to medical or surgical therapy.

C. Uterine Prolapse: A hysterectomy may be considered for the symptomatic women for whom childbearing is no longer a consideration and for whom non-operative and/or surgical correction (i.e., suspension or repair), will not provide the member adequate relief.

**Conditions Where Therapy Is Not Required Prior to Hysterectomy**

Hysterectomy services may be considered medically necessary without prior trial of therapy in the following cases:

A. Invasive carcinoma of the cervix
B. Ovarian carcinoma
C. Endometrial carcinoma
D. Carcinoma of the fallopian tube
E. Malignant gestational trophoblastic disease
F. Life-threatening uterine hemorrhage, uncontrolled by conservative therapy
G. Potentially life-threatening hemorrhage as in cervical pregnancy, interstitial pregnancy, or placenta abruption.

The provider is not required to complete a Consent to Sterilization form prior to performing hysterectomy procedures and the 30-day waiting period required for sterilization does not apply to hysterectomy procedures described in this section.

**Prior Acknowledgment and Documentation**

Except as described in *Exceptions from Prior Acknowledgement* below, the provider must comply with the following requirements **prior** to performing the hysterectomy:

A. Inform the member and her representative, if any, both orally and in writing that the hysterectomy will render the member incapable of reproducing (i.e., result in sterility).
B. Allow 30-day waiting period.
C. Obtain from the member or representative, if any, a signed, dated written acknowledgment stating that the information in “A” above has been received and that the individual has been informed and understands the consequences of having a hysterectomy (i.e., that it will result in sterility). This documentation must be kept in the member’s medical record. A copy must also be kept in the member’s medical record maintained by the primary care provider if enrolled with an Administrative Services Subcontractor.

**Exceptions from Prior Acknowledgement**

The physician performing the hysterectomy is not required to obtain prior acknowledgment in either of the following situations:

A. The member was already sterile before the hysterectomy. In this instance the physician must certify in writing that the member was already sterile at the time of the hysterectomy and specify the cause of sterility.
B. The member requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible. In this circumstance, the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible.
310 – M IMMUNIZATIONS

REVISION DATE: 4/24/2019
EFFECTIVE DATE: November 17, 2017
REFERENCES: AMPM Chapter 400

The purpose of this policy is to establish guidelines for immunization covered by the Division of Development Disabilities (Division).

Definitions

A. Vaccine - preparation administered to stimulate the production of antibodies and provide immunity against one or several diseases.

B. Immunization - administration of a vaccine to promote the development of immunity or resistance to an infectious disease.

C. Child - individual under the age of 19 years.

D. Adult - individual 19 years of age and older.

Policy

The Division covers immunizations as appropriate for age, history, and health risk, for adults and children.

The Division follows recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP).

Prior authorization is not required for medically necessary covered immunizations when administered by an AHCCCS-registered provider.

Covered immunizations for adults include, but are not limited to:

A. Diphtheria-tetanus
B. Influenza
C. Pneumococcus
D. Rubella
E. Measles
F. Hepatitis A
G. Hepatitis-B
H. Pertussis, as currently recommended by the CDC or ACIP
I. Zoster vaccine, for members 50 years of age and older
J. HPV vaccine for up through 26 years of age.

Immunizations are not covered by the Division for members for passport, visa clearance, or for travel outside of the United States.

Pharmacy reimbursement for adult immunizations is covered under AMPM 310-V.
Clinical Laboratory, Radiological and Medical Imaging Services (Acute Care Services)

Clinical laboratory procedures (including routine screening for Hepatitis B), radiological and medical imaging services prescribed by a Primary Care Provider (PCP) or by another physician, practitioner, or dentist upon referral by a PCP, and which are ordinarily administered in hospitals, clinics, physicians’ offices or other health care facilities by licensed health care providers, shall qualify as covered services if medically necessary.

Clinical laboratory, radiological, and medical imaging service providers shall satisfy all applicable State license and certification requirements, be registered with the Arizona Health Care Cost Containment System (AHCCCS), and shall perform only those services specific to their license and certification.
310-O  MATERNAL AND CHILD HEALTH SERVICES

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities covers a comprehensive set of services for pregnant women, newborns, and children that includes maternity care, family planning services, and services provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

Refer to Chapter 400 of this Manual for a complete discussion of covered maternal and child health services.
310-P  MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND PROSTHETIC DEVICES (ACUTE CARE SERVICES)

EFFECTIVE DATE: June 30, 1994
REFERENCES: §36-2907; Laws 2015, Chapter 264, Section 3 (HB 2373); §36-2907.

A. Medical supplies, durable medical equipment (DME) orthotic and prosthetic devices provided to members who are eligible for Arizona Long Term Care System (ALTCS) services qualify as covered services if prescribed by a specialist physician, practitioner or dentist upon referral by a Primary Care Provider (PCP).

Medical supplies and DME include:

1. Surgical dressings, splints, casts, and other disposable items covered by Medicare (Title XVIII).
2. Rental or purchase of DME, including, customized equipment.
3. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

B. Requirements for specific services:

1. Incontinence Briefs
   a. Incontinence briefs for members over the Age of 21 Years:
      i. The Division’s acute care contracted health plans shall provide incontinence briefs, including pull-ups, for members 21 years of age and older to treat a medical condition or to prevent skin breakdown when all the following are met:
         - The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder.
         - The Primary Care Provider (PCP) or attending physician has issued a prescription ordering the incontinence briefs.
         - Incontinence briefs do not exceed 180 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 180 briefs per month.
         - The member obtains incontinence briefs from vendors within the Contractor’s network.
– Prior authorization has been obtained if required by the Administration, Contractor, or Contractor’s designee, as appropriate. Contractors shall not require a new prior authorization to be issued more frequently than every 12 months.

ii. Authorized services must be for at least a 12 month period of time.

iii. Contractors may require a new prior authorization to be issued no more frequently than every 12 months.

iv. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

v. If a member is eligible for Fee-For-Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

vi. Any exceptions to this policy section must have the approval of the Assistant Director.

b. Incontinence briefs for members over three and under the Age of 21 Years:

Incontinence briefs are covered for members when necessary to treat a medical condition and/or for preventative purposes. For information on coverage and limitations see the Division Medical Policy Manual Chapter 400, Section 430.

2. DME means sturdy, long lasting items and appliances that can withstand repeated use, are designed to serve a medical purpose and are not generally useful to a person in absence of a medical condition, illness or injury.

Experience has demonstrated that the cost-effective provision of Durable Medical Equipment (DME) includes the involvement of a physical therapist in ordering and fitting customized equipment.

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment.

a. Orthotics- A device prescribed by a physical or other licensed practitioner to support a weak, injured, or deformed portion of the body.

i. Members 21 years of age and older:
Orthotics are covered within certain limitations if all of the following apply:

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines.
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.
- The orthotic is ordered by a Physician or Primary Care Practitioner.

ii. Members under 21 years of age:

Orthotics are covered for members under the age of 21 as outlined in the Division Medical Policy Manual Chapter 400 Section 430-C.

iii. Orthotics Limitations- Reasonable repairs or adjustments of purchased orthotics are covered for all members to make the orthotic serviceable and/or when the repair cost is less than purchasing another unit. The component will be replaced if, at the time authorization is sought, documentation is provided to establish that the component is not operating effectively.
310-S OBSERVATION SERVICES

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers Observations services. Observation services are those reasonable and necessary services provided on a hospital's premises for evaluation to determine whether the member should be admitted for inpatient care, discharged, or transferred to another facility. Observation services include: the use of a bed, periodic monitoring by a hospital's nursing or, if appropriate, other staff necessary to evaluate, stabilize or treat medical conditions of a significant degree of instability and/or disability on an outpatient basis.

It is not Observation when a member with a known diagnosis enters a hospital for a scheduled procedure/treatment that is expected to keep the member in the hospital for less than 24 hours (this is an outpatient procedure, regardless of the hour in which the member presented to the hospital, whether a bed was utilized, or whether services were rendered after midnight).

Extended stays after outpatient surgery must be billed as recovery room extensions.

Observation must be ordered in writing by a physician, or other individual authorized by hospital staff bylaws, in order to admit patients to the hospital or to order outpatient diagnostic tests or treatments. There is no maximum time limit for Observation services as long as medical necessity exists. The medical record must document the basis for Observation services.

Factors That Must Be Considered by the Physician or Authorized Individual When Ordering Observation

The following factors must be considered by the physician or authorized individual when ordering Observation:

A. Severity of the signs and symptoms of the member
B. Degree of medical uncertainty that the member may experience an adverse occurrence
C. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the member to remain at the hospital for 24 hours or more) to assist in assessing whether the member should be admitted
D. The availability of diagnostic procedures at the time and location where the member presents
E. It is reasonable, cost effective and medically necessary to evaluate a medical condition or to determine the need for inpatient admission
F. Length of stay for Observation is medically necessary for the member's condition.
**Required Medical Record Documentation**

The following are requirements for documenting medical records:

A. Orders for Observation must be written on the physician's order sheet, not the emergency room record, and must specify, "Observation." Rubber-stamped orders are not acceptable.

B. Follow-up orders must be written within the first 24 hours, and at least every 24 hours if Observation is extended.

C. Changes from "Observation to inpatient" or "inpatient to Observation" must be made per physician order.

D. Inpatient/outpatient status change must be supported by medical documentation.

**Limitations**

The following services are not Division-covered Observation services:

A. Substitution of Observation services for physician ordered inpatient services

B. Services that are not reasonable, cost effective and necessary for diagnosis or treatment of member

C. Services provided solely for the convenience of the member or physician

D. Excessive time and/or amount of services medically required by the condition of the member

E. Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for Observation.
**310-T PHYSICIAN SERVICES**

**EFFECTIVE DATE:** March 3, 2017


The Division of Developmental Disabilities (Division) covers physician services for all members eligible for ALTCS within certain limits based on member age and eligibility. Physician services include medical assessment, treatment, and surgical services performed in the office, clinic, hospital, home, nursing facility, or other location by a licensed doctor of medicine or osteopathy.

Physician services are covered as appropriate to the member's medical need and the physician's scope of practice. Refer to Chapter 400 of this Policy Manual, for criteria related to covered services for members under the age of 21.

Physical examinations and well visits for members are covered to:

A. Determine risk of disease.

B. Provide early detection.

C. Establish a prevention or treatment plan.

D. Monitor health status.

**Limitations**

A. Services Not Directly Related to Medical Care - The Division does not cover physician services routinely performed and not directly related to the medical care of a member (e.g., physician visits to a nursing facility for the purpose of 30-60 day certification).

B. Moderate Sedation - The Division does not cover moderate sedation (i.e., conscious sedation) performed by the physician performing the underlying procedure for which sedation is desired, or by another provider except as described below, for the adult population.

The Division does cover monitored anesthesia care, including all levels of sedation, provided by qualified anesthesia personnel (physician anesthesiologist or certified registered nurse anesthetist) for the adult population and members under the age of 21. Anesthesia services (except epidurals) require the continuous presence of the anesthesiologist or certified registered nurse anesthetist.

C. Allergy Immunotherapy - The Division does not cover allergy immunotherapy including desensitization treatments administered via subcutaneous injections (allergy shots), sublingual immunotherapy (SLIT) or via other routes of administration, for persons age 21 years and older. However, the Division covers allergy immunotherapy for members under the age of 21 who are under Early Periodic Screening, Diagnosis and Treatment (EPSDT), when medically necessary.
Exceptions

A. Allergy Testing – The Division does not cover allergy testing, including testing for common allergens, for persons age 21 years and older unless the member has either sustained an anaphylactic reaction to an unknown allergen or has exhibited such a severe allergic reaction (e.g., severe facial swelling, breathing difficulties, epiglottal swelling, extensive [not localized] urticaria) where it is reasonable to assume further exposure to the unknown allergen may result in a life-threatening situation. In the above instances, the Division covers allergy testing to identify the unknown allergen where such identification may help the member avoid repeat exposures to that particular allergen. The Division covers allergy testing for persons under the age of 21 under EPSDT when medically necessary.

B. Self-administered epinephrine – The Division covers self-administered epinephrine for all members with a history of previous severe allergic reactions, whether or not the specific cause of that reaction has been identified.

For prescription medication coverage exceptions, refer to Policy 310-V in the Policy Manual.

C. Medical Marijuana – The Division does not cover office visits or any other services that are primarily for determining whether a member would benefit from medical marijuana. Refer to Policy 320-M in this Policy Manual.

Genetic Subspecialists

Genetic subspecialists are subject to the limitations described in Policy 310-N, Genetic Testing Provisions subsection in this Policy Manual.
310-U FOOT AND ANKLE SERVICES (RETIRED)

RETIRE DATE: October 1, 2018
EFFECTIVE DATE: June 30, 1994

Policy 310-U, Foot and Ankle Services, has been retired to comport with A.R.S. § 36-2907, which states that podiatry services are covered when they are performed by a podiatrist who is licensed pursuant to title 32, chapter 7 and ordered by a primary care physician or primary care practitioner. AHCCCS Medical Policy Manual Policy 310-U has also been retired.
310-V  PRESCRIPTION MEDICATION/PHARMACY SERVICES

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Pharmaceutical services include medically necessary drugs prescribed by Primary Care Provider (PCP), other physicians, practitioners, or dentists upon referral by a PCP. Psychotropic drugs for the control of seizures and spasticity shall be covered, as well as vaccines used to prevent Hepatitis B. At a minimum, items listed in the Division’s Formulary shall be included as covered benefits for members who are eligible for Arizona Long Term Care System (ALTCS) services.

Psychotropic drugs for behavioral health symptoms shall be covered according to the Arizona Health Care Cost Containment System (AHCCCS) Rules.

Prescriptions shall be dispensed with a 30-day supply of medication, if authorized by the prescriber.

Pharmaceutical services shall be available to members during customary business hours and shall be located within reasonable travel distance.
310-W  RADIOLGY AND MEDICAL IMAGING

EFFECTIVE DATE: March 3, 2017

REFERENCES: A.A.C. R9-22-201, et seq.

The Division of Developmental Disabilities covers all radiology and medical imaging services for all members eligible for AHCCCS when ordered by a primary care provider, other practitioner, or dentist, for diagnosis, prevention, treatment or assessment of a medical condition, as defined in 9 A.A.C. Chapter 22, Article 2. Settings for the provision of services include hospitals, clinics, physician offices, and other health care facilities.
310-X  REHABILITATIVE THERAPY

REVISION DATE:  7/3/2015, 9/15/2014
EFFECTIVE DATE:  June 30, 1994

Rehabilitation is the process of re-establishing former functions or skills. This includes physical, occupational, and speech therapies. This service may occur after a trauma has decreased the functioning of a member. Rehabilitative therapies are not designed to build a skill or functioning level that had not been previously present in the member.
310–Y    RESPIRATORY THERAPY

EFFECTIVE DATE: March 3, 2017
REFERENCES: A.R.S. § 32-3501

The Division of Developmental Disabilities (Division) covers respiratory therapy treatment service for members eligible for ALTCS, when ordered by a primary care provider, to restore, maintain, or improve respiratory functioning.

Services include:

A. Administering pharmacological, diagnostic, and therapeutic agents related to respiratory and inhalation care procedures

B. Observing and monitoring signs and symptoms

C. General behavioral and physical response(s) to respiratory treatment and diagnostic testing, including a determination of whether these signs, symptoms, reactions, or response(s) exhibit abnormal characteristics

D. Implementing appropriate reporting referral

E. Implementing respiratory care protocols or changes in treatment based on observed abnormalities.

The Division covers medically necessary respiratory therapy services for all members eligible for ALTCS on both an inpatient and outpatient basis. Services must be provided by a qualified respiratory practitioner under A.R.S. § 32-3501 (respiratory therapist or respiratory therapy technician), licensed by the Arizona Board of Respiratory Care Examiners. Respiratory practitioners providing services to Division members outside the State of Arizona must meet the applicable state and/or federal requirements.
310–AA  TOTAL PARENTERAL NUTRITION (TPN)

EFFECTIVE DATE: November 17, 2017

Total Parenteral Nutrition (TPN) is the provision of total caloric needs by intravenous route for individuals with severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual’s general condition. Nutrients are provided through an indwelling intravenous catheter.

The Division of Developmental Disabilities (Division) follows Medicare guidelines for the provision of TPN services. TPN is covered for members over age 21 when it is medically necessary and the only method to maintain adequate weight and strength.

The Division covers TPN for members receiving Early and Periodic Screening, Diagnosis and Treatment, also known as “EPSDT,” when medically necessary.
310-BB TRANSPORTATION

EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. § 28-2515; A.A.C. R9-22-211

The Division of Developmental Disabilities (Division) covers transportation within certain limitations for members. Covered transportation services include:

A. Emergency transportation
B. Medically necessary non-emergency transportation
C. Medically necessary maternal and newborn transportation.

Definitions

The definitions relating to covered transportation services are as follows:

A. Air ambulance - helicopter or fixed wing aircraft licensed under Arizona Department of Health Services (ADHS) as mandated by Arizona Revised Statutes to be used in the event of an emergency to transport members or to obtain services.

B. Ambulance - motor vehicle licensed by ADHS pursuant to Arizona Revised Statutes especially designed or constructed, equipped and intended to be used, maintained, and operated for the transportation of persons requiring ambulance services.

C. Ambulatory vehicle – a vehicle other than a taxi but includes vans, cars, minibus or mountain area transport. The member must be able to transfer with or without assistance into the vehicle and not require specialized transportation modes.

D. Stretcher van – vehicle specifically designed for the purpose of transportation of a member on a medically approved stretcher device. The stretcher must be secured to avoid injury to the member or other passengers. Safety features of stretcher vans must be maintained as necessary. Any additional items being transported must also be secured for safety. The member must need to be transported by stretcher and must be physically unable to sit or stand and any other means of transportation is medically contraindicated.

E. Wheelchair van - vehicle specifically equipped for the transportation of an individual seated in a wheelchair. Doors of the vehicle must be wide enough to accommodate loading and unloading of a wheelchair. Wheelchair vans must include electronic lifts for loading and unloading wheelchair bound transports. The vehicle must contain restraints for securing wheelchairs during transit. Safety features of wheelchair vans must be maintained as necessary. Any additional items being transported must also be secured for safety. The member must require transportation by wheelchair and must be physically unable to use other modes of ambulatory transportation.

F. Taxi – vehicle that has been issued and displays a special taxi license plate pursuant to A.R.S. § 28-2515.
Emergency Transportation

Emergency Transportation - emergency ground and air ambulance services required to manage an emergency medical condition of a member at an emergency scene and transport to the nearest appropriate facility are covered for all members. Emergency transportation is needed due to a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

A. Placing the member's health in serious jeopardy
B. Serious impairment of bodily functions, or
C. Serious dysfunction of any bodily organ or part.

Emergency transportation may be initiated by an emergency response system call "9-1-1," fire, police, or other locally established system for medical emergency calls. Initiation of a designated emergency response system call by a member automatically dispatches emergency ambulance and Emergency Medical Technician (EMT) or Paramedic team services from the Fire Department. At the time of the call, emergency teams are required to respond; however, when they arrive on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:

A. Emergent
B. Non-emergent, but medically necessary, or
C. Not medically necessary.

Maternal and Newborn Transportation - The Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP) administered by the ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center. The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport.

Emergency transportation coverage is limited to those emergencies in which specially staffed and equipped ambulance transportation is required to safely manage the member's medical condition. Basic Life Support, Advanced Life Support, and air ambulance services are covered, depending upon the member's medical needs.

Emergency medical transportation includes the transportation of a member to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility. Emergency medical transportation is covered only to the nearest appropriate facility. The Division and Administrative Services Subcontractors (AdSSs) may establish preferred hospital arrangements, which must be communicated with emergency services providers. If the provider transports the member to the preferred hospital, the provider's claim must be honored even though that hospital may not be the nearest appropriate facility. However, the provider must not be penalized for taking the member to the nearest appropriate facility whether or not it is the preferred facility.
Acute conditions requiring emergency transportation to obtain immediate treatment include, but are not limited to, the following:

A. Untreated fracture or suspected fracture of spine or long bones
B. Severe head injury or coma
C. Serious abdominal or chest injury
D. Severe hemorrhage
E. Serious complications of pregnancy
F. Shock, heart attack or suspected heart attack, stroke or unconsciousness
G. Uncontrolled seizures
H. Condition warranting use of restraints to safely transport to medical care.

For utilization review, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services. Determination of whether a transport is an emergency is based on the member’s medical condition at the time of transport.

Refer to the section of this policy regarding medically necessary transportation furnished by an ambulance provider, for information related to transportation initiated by an emergency response system call.

Air ambulance services are covered under any of the following conditions:

A. The point of pickup is inaccessible by ground ambulance
B. Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities
C. The medical condition of the member requires ambulance service, and ground ambulance services will not suffice.

Air ambulance vehicles must meet ADHS licensing requirements and requirements set forth by the Federal Aviation Administration. Air ambulance companies must be licensed by the ADHS and be registered as a provider with AHCCCS.

Emergency Transportation Provider Requirements for Emergency Transportation Services Provided for Division Fee-For-Service, American Indian Health Plan

Emergency Transportation Services - In addition to other requirements specified in this policy, emergency transportation providers rendering services on an American Indian Reservation must meet the following requirements:

A. Tribal emergency transportation providers must be certified by the Tribe and Center for Medicare and Medicaid Services (CMS) as a qualified provider and registered as an AHCCCS provider.
B. If non-tribal emergency transportation providers render services under a contract with a Tribe either on-reservation or to and from an off-reservation location the provider must be State licensed and certified, and registered as an AHCCCS provider, or

C. Non-tribal transportation providers not under contract with a Tribe must meet requirements specified in this policy for emergency transport providers.

As with all emergency transportation, services are covered to manage an emergency medical condition at the emergency scene and in transport to the nearest appropriate facility.

**Medically Necessary Non-Emergency Transportation Furnished by Non-Emergency Transportation Providers for Medical and Behavioral Health Services**

Non-emergency medically necessary transportation is transportation, as specified in A.A.C. R9-22-211, and furnished by providers included therein, to transport the member to and from a covered medical service. Such services may also be provided by emergency transportation providers after assessment by the EMT or Paramedic team that the member's condition requires medically necessary transportation.

Medically necessary non-emergency transportation services are covered under the following conditions:

A. The medical or behavioral health service for which the transportation is needed is a covered Division service.

B. The member is not able to provide, secure, or pay for their own transportation, and free transportation is not available, and

C. The transportation is provided to and from the nearest appropriate AHCCCS-registered provider.

**Medically Necessary Non-Emergency Transportation Furnished by Non-Ambulance Providers**

The following must be adhered to:

A. The member must not require medical care enroute.

B. Passenger occupancy must not exceed the manufacturer’s specified seating occupancy.

C. Members, escorts, and other passengers must follow state laws regarding passenger restraints for adults and children.

D. Vehicle must be driven by a licensed driver, following applicable State laws.

E. Vehicles must be insured.

F. Vehicles must be in good working order.
G. Members must be transported inside the vehicle.

H. School-based providers should follow the school-based policies in effect (AMPM Chapter 700).

**Medically Necessary Non-Emergency Transportation Furnished By Ambulance Providers**

Medically necessary non-emergency transportation furnished by ambulance providers is appropriate if:

A. Documentation that other methods of transportation are contraindicated, and

B. The member’s medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.

For hospital patients only:

Round-trip air or ground transportation services may be covered if a member who is inpatient goes to another facility to obtain necessary specialized diagnostic and/or therapeutic services (such as a computerized tomography (“CT”) scan or cobalt therapy). Such transportation may be covered if services are not available in the hospital in which the member is inpatient.

Transportation services to the nearest medical facility that can render appropriate services are also covered, when the transport was initiated through an emergency response system call and, upon examination by emergency medical personnel, the member’s condition is determined to be non-emergent but one which requires medically necessary transportation. At the Division’s or AdSS’s discretion, medically necessary non-emergency ambulance transportation may not require prior authorization or notification, but it is subject to review for medical necessity. Medical necessity criteria are based upon the medical condition of the member and include ground ambulance services provided because the member’s medical condition was contradictory to any other means of transportation. This may include after-hour calls.
310-DD       ORGAN TRANSPLANT

REVISION DATE:  7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Organ transplant services and procurement shall be in accordance with Arizona Health Cost Containment System (AHCCCS) Rules (www.azhcccs.gov/Regulations). Organ transplant services also require written prior authorization from the Division of Developmental Disabilities (DDD) and AHCCCS.
310-FF MONITORING CONTROLLED AND NON-CONTROLLED MEDICATION UTILIZATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: Section F3, Contractor Chart of Deliverables
DELIVERABLES: Pharmacy and/or Prescriber - Member Assignment/Restrictions Report

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Medical Policy Manual 320-FF, Monitoring Controlled and Non-Controlled Medication Utilization for the Division policy governing AdSS responsibilities regarding this topic.
320-A AFFILIATED PRACTICE DENTAL HYGIENIST

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers oral health care services as described in this Policy Manual Chapter 400, Policy 430, Early Periodic Screening, Diagnosis and Treatment Services. As allowed by State law, A.R.S. §§ 32-1281 and 32-1289, and described in this policy, dental hygienists with an affiliated practice agreement may provide dental hygiene services to members eligible for ALTCS and Targeted Programs who are 18 years of age and younger.

The Division covers dental hygiene services provided by Arizona-licensed dental hygienists subject to the terms of the written affiliated practice agreement entered into between a dentist and a dental hygienist.

Each affiliated dental hygienist, when practicing under an affiliated practice relationship, may perform only those duties specified within the terms of the affiliated practice relationship and they must maintain an appropriate level of contact, communication, and consultation with the affiliated practice dentist.

In addition to the requirements specified in A.R.S. §§ 32-1281 and 32-1289, the following are required:

A. Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.

B. The affiliated practice dental hygienist must maintain individual medical records in accordance with the Arizona State Dental Practice Act. At a minimum, this must include member identification, parent/guardian identification, signed authorization (parental consent) for services, member medical history, and documentation of services rendered.

C. The affiliated practice dental hygienist must register with AHCCCS and bill for services under their individual AHCCCS provider identification number/National Provider Identifier (NPI) number.

D. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with State regulations, Division and AHCCCS policy, the AHCCCS provider agreement, and their affiliated practice agreement.

Reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.
Health and behavioral assessment procedures (CPT codes 96150-96155) are used to identify and treat the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, and management of physical health problems. The focus of the assessment is not on mental health, but on the stresses, expectations, lifestyle, and perceptions that are associated with the underlying medical condition. Codes 96150-96155 describe services offered to members who present with primary physical illnesses, diagnosis, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the member's health. These services do not represent preventative medicine counseling and risk factor reduction interventions. Therefore, evaluation and management services codes (including preventative medicine, individual counseling codes 99401-99404 and preventative medicine, group counseling codes 99411-99412) should not be reported on the same day.

The Division of Developmental Disabilities covers medically necessary health and behavioral assessment procedures (CPT codes 96150-96155). The focus of the assessment/interventions is not on mental health but the biopsychosocial factors important to physical health problems and treatment. The focus of the intervention is to improve the member's health and well-being, using cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems.

Individuals requiring the service(s) described above must not be referred to a Behavioral Health Provider.

**Codes**

A. 96150 - Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.

B. 96151 - Re-assessment

C. 96152 - Health and behavior intervention, each 15 minutes, face-to-face; individual

D. 96153 - Group (two or more patients)

E. 96154 - Family (with the patient present)

F. 96155 - Family (without the patient present)

The following professionals are approved to provide health and behavioral assessments/interventions:

A. Psychologist

B. Licensed clinical social worker

C. Licensed marriage and family therapist
D. Licensed professional counselor
E. Psychiatric nurse practitioner.

Health and behavior intervention services may be performed in the following places of service:

A. Federally Qualified Health Clinic (FQHC)
B. Rural Health Clinic
C. Provider Office
D. The member’s home
E. Indian Health Service (IHS) Freestanding Facility
F. IHS Provider Based Facility
G. Tribal 638 Freestanding Facility
H. Tribal 638 Provider Based Facility
I. Integrated Behavioral Health Residential Facility.

**Limitations**

A. Services are limited to 48 units annually (unit is equal to 15 minutes).

B. Members with mental health treatment needs exceeding the scope or duration of services described (which are medical codes for behavioral health interventions) should be appropriately referred for behavioral health services that will require the specific use of behavioral health codes.

C. Services are limited to the providers and settings listed above.
320-F HIV/AIDS Treatment Services

EFFECTIVE DATE: November 17, 2017
REFERENCES: A.A.C. R4-16-101

The Division of Developmental Disabilities (Division) covers medically necessary treatment services rendered by qualified providers, for members who are eligible for the Division, ALTCS, or American Indian Health Plan (AIHP), and who have been diagnosed with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS). The Division and the Administrative Services Subcontractors (AdSS) must follow the Centers for Disease Control and Prevention (CDC) guidelines for the treatment of HIV/AIDS. The Division and the Administrative Services Subcontractors are responsible for distributing these guidelines, and all updates, to HIV/AIDS treatment professionals included in their network.

As appropriate, AHCCCS reviews new technological advances in HIV/AIDS treatment, including recommended pharmacological regimens.

This review shall include the AHCCCS Chief Medical Officer, the AHCCCS Medical Director, the Division Medical Director, the Administrative Services Medical Director, and physician experts in the treatment of HIV/AIDS.

The review may include, but is not limited to, information regarding:

A. Established treatment and pharmaceutical regimens
B. Changes in technology and treatment protocols
C. Cost implications of treatment/pharmaceutical regimens.

Monitoring

The Division and the AdSS must develop policies and protocols that document care coordination services provided to members with HIV/AIDS. This includes monitoring of member medical care in order to ensure that medical services, medication regimens, and necessary support services (e.g., transportation) are provided within specified timelines, as defined in contractual arrangements with the Division, and that these services are used appropriately. Support services may be coordinated with existing community resources.

The AdSS must also ensure that the care for members diagnosed with HIV/AIDS, who are receiving services specified by, and in accordance with, the guidelines set by AHCCCS, is well coordinated and managed in collaboration with the member's treating physician.

If a conflict regarding treatment or denial of treatment arises between the member's treating physician and the Division's Medical Director, the issue may be referred to the AHCCCS Medical Director or designee. However, this does not preclude the member's right to file an appeal.
HIV/AIDS Treatment Professionals

AHCCCS compiles, updates, and makes available, upon request, a listing of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners, and/or physician assistants). The listing will be based on information submitted by the Division as specified in contractor reporting requirements.

A qualified HIV/AIDS treatment professional, for the purpose of this policy, is defined as a physician or practitioner who:

A. Is recognized in the community as having a special interest, knowledge, and experience, in the treatment of HIV/AIDS
B. Agrees to adhere to CDC treatment guidelines for HIV/AIDS
C. Agrees to provide primary care services and/or specialty care to AHCCCS members with HIV/AIDS
D. Demonstrates ongoing professional development by clinically managing at least five patients with HIV/AIDS during the last year
E. Meets one of the criteria below:
   1. Current Board Certification or Recertification in Infectious Diseases, or
   2. Annual completion of at least ten hours of HIV/AIDS-related Continuing Medical Education (CME), which meet the CME requirements under A.A.C. R4-16-101.

Limitations

A physician or practitioner not meeting the criteria to be a qualified HIV/AIDS treatment professional who wishes to provide primary care services to a member with HIV/AIDS must send documentation to the Division or AdSS demonstrating that s/he has an established consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional as identified in this policy.

This documentation must be maintained in the Division and AdSS’ credentialing file. These practitioners may treat members with HIV/AIDS under the following circumstances:

A. In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS-registered network HIV/AIDS treatment professionals meeting this criteria, or
B. When a member with HIV/AIDS chooses a provider who does not meet the criteria.
**Contract Network**

The Division and the AdSS must include in its individual provider network sufficient numbers of qualified HIV/AIDS treatment professionals (physicians, nurse practitioners and/or physician assistants). The AdSS must also have policies and procedures to assure that provider requirements and standards specified in the Division Policy Manuals and the AMPM are met. Each provider network of HIV/AIDS treatment professionals is subject to review and approval by AHCCCS, Division of Health Care Management (DHCM). The AdSS must submit, annually by December 15, a list of HIV/AIDS treatment providers (to the Division Health Care Services Unit, through the Compliance Unit) that includes:

A. Name and location of all qualified HIV/AIDS treatment professionals treating members with HIV/AIDS

B. For each Primary Care Provider (PCP) treating members with HIV/AIDS who is not a qualified HIV/AIDS treatment specialist, the name and location of the consulting HIV/AIDS treatment professional.

The AdSS must also notify the Division of any material change to the HIV/AIDS provider network during the year. The Division will notify AHCCCS of any major changes.

AdSS policies must reflect that members with HIV/AIDS have freedom of choice to select an HIV/AIDS provider from the AdSS’s network. If the member selects a PCP in the AdSS’s network who is not a provider designated by the AdSS as a qualified HIV/AIDS disease treatment professional, the member must be informed that only those designated providers are authorized to render treatment regimens such as antiretroviral therapies. The selected PCP must consult with a qualified HIV/AIDS provider and follow the recommendations of the consultant in order for the treatment regimen (such as protease inhibitors) to be a covered service.
320-G LUNG VOLUME REDUCTION SURGERY

EFFECTIVE DATE: March 3, 2017

The Division of Developmental Disabilities (Division) covers Lung Volume Reduction Surgery (LVRS), or reduction pneumoplasty, for members eligible for ALTCS with severe emphysema. This surgery must be performed at a facility approved by Medicare in accordance with all of the established Medicare guidelines.

The member’s treating physician is responsible for providing appropriate documentation, establishing medical necessity, and verification of compliance with Medicare, Division of Developmental Disabilities (Division), and AHCCCS guidelines. When requesting authorization, the documentation must be sent to the Division’s Administrative Services Subcontractor (AdSS) Medical Director or to the Division’s Medical Director for Division's American Indian Health Plan (AIHP) (Fee-For-Service) members.

When possible, such surgeries, and the required pre- and post-operative therapies, will be performed at facilities approved by Medicare for LVRS reimbursement within the State of Arizona. However, this procedure may be covered at out-of-state facilities, if needed. All facilities must meet Medicare LVRS facility requirements as well as AHCCCS Provider Registration requirements.

If medically necessary, the Division or AdSS may pay for an adult caregiver to accompany members when out-of-state-travel is required. Transportation, lodging, and board may be covered as appropriate.

Medicare Criteria

The Centers for Medicare and Medicaid Services (CMS) has issued a National Coverage Decision (NCD) for LVRS specifying covered and non-covered criteria. Medicare established guidelines are followed for this procedure according to the NCD effective 11/17/2005. NCD for LVRS is contained in Exhibit 320-1, as adopted by the Division for use, and found in the AHCCCS Medical Policy Manual.
320-H MEDICAL FOODS

EFFECTIVE DATE: May 13, 2016

Description of Benefit

The Division covers medical foods, within the limitations specified in this Policy, for any member diagnosed with one of the following inherited metabolic conditions:

A. Phenylketonuria
B. Homocystinuria
C. Maple Syrup Urine Disease
D. Galactosemia (requires soy formula)
E. Beta Keto-Thiolase Deficiency
F. Citrullinemia
G. Glutaric Acidemia Type I
H. 3 Methylcrotonyl CoA Carboxylase Deficiency
I. Isovaleric Acidemia
J. Methylmalonic Acidemia
K. Propionic Acidemia
L. Arginosuccinic Acidemia
M. Tyrosinemia Type I
N. HMG CoA Lyase Deficiency
O. Cobalamin A, B, C Deficiencies

Definitions

A. Medical foods: Metabolic formula or modified low-protein foods that are produced or manufactured specifically for persons with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is also included within the limitations set by this Policy when used by persons diagnosed with galactosemia.

B. Metabolic nutritionist: A provider registered with the Arizona Health Care Cost Containment System (AHCCCS) who is a registered dietitian specializing in nutritional assessment and treatment of metabolic conditions.
Conditions, Limitations and Exclusions

A. The diagnosis of the member’s inherited metabolic condition is documented in the member’s medical record by the Primary Care Provider (PCP), attending physician or appropriate specialist. Documentation also includes test results used in establishing the diagnosis.

B. Metabolic formula and modified low-protein foods must be:

1. Essential to sustain the member's growth within nationally recognized height/weight or BMI (body mass index) levels, maintain health and support metabolic balance;
2. Obtained only under physician order; and
3. Supervised by the member’s PCP, attending physician or appropriate specialist for the medical and nutritional management of a member who has:
   a. Limited capacity to metabolize typical foods or certain nutrients contained in typical food; or
   b. Other specific nutrient requirements as established by medical evaluation.

C. Metabolic formulas ordered for a member must be processed for the specific dietary management of the member’s metabolic condition. The formula must meet the member's distinctive nutritional requirements that are established through medical evaluations by the member’s PCP, attending physician or appropriate specialist, and/or the metabolic nutritionist.

D. Modified low-protein foods must be formulated to contain less than one gram of protein per unit or serving. For purposes of this Policy, modified low-protein foods do not include foods that are naturally low in protein.

E. Soy formula is covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, who are diagnosed with galactosemia, only until they are able to eat solid lactose-free foods.

F. Members receiving EPSDT services, who are diagnosed with a metabolic disorder included in this Policy, are eligible for services through Children's Rehabilitation Services (CRS).

1. Members receiving EPSDT services must receive metabolic formula through CRS.
2. Members receiving EPSDT services who require modified low-protein foods receive them through the Division.

G. The Division provides both necessary metabolic formula and modified low protein foods for members 21 years of age and older who have been diagnosed with one of the inherited metabolic disorders included in this Policy.
H. The Division is responsible for initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist, lab tests and other services related to the provision of medical foods for enrolled members diagnosed with a metabolic disorder included in this Policy.

I. Medical foods must be ordered from a supplier of metabolic formula, modified low-protein foods or soy formula that is approved by the Division. Foods purchased through grocery or health food stores are not covered.
320-I  TELEHEALTH AND TELEMEDICINE

REVISION DATE: 11/17/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: AMPM Policy 431; Social Security Act, Section 1905(a)

The Division of Developmental Disabilities (Division) covers medically necessary consultative and/or treatment telemedicine services for all members eligible for AHCCCS, when these services are provided by an appropriate AHCCCS-registered provider.

Definitions

A. Asynchronous or "Store and Forward" - the transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

B. Consulting Provider - any AHCCCS-registered provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member.

C. Distant or Hub Site - the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

D. Originating or Spoke Site - the location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

E. Telecommunications Technology (which includes store and forward) - the transfer of medical data from one site to another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation. Services delivered using telecommunications technology, but not requiring the member to be present during their implementation, are not considered telemedicine. For information about coverage of these services, see Section titled Use of Telecommunications in this policy.

F. Teledentistry - the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by an AHCCCS-registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

Teledentistry includes the provision of preventive and other approved therapeutic services by the AHCCCS-registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.
Teledentistry does not replace the dental examination by the dentist; limited, periodic, and comprehensive examinations cannot be billed through the use of teledentistry alone.

G. Telehealth (or Telemonitoring) - use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under section 1905(a) of the Social Security Act).

H. Telemedicine - the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the originating and distant sites through real time interactive audio, video or data communications that occur in the physical presence of the member.

I. Telepresenter - a designated individual who is familiar with the member's case and has been asked to present the member's case at the time of telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily the medical expert, with the member's medical condition in order to present the case accurately.

Use of Telemedicine

The Division covers the following medically necessary services provided via telemedicine. These services must be provided in real-time visits, the cost of which would otherwise be reimbursed by the Division.

A. Cardiology
B. Dermatology
C. Endocrinology
D. Hematology/oncology
E. Infectious diseases
F. Neurology
G. Obstetrics/gynecology
H. Oncology/radiation
I. Ophthalmology
J. Orthopedics
K. Pain clinic
L. Pathology
M. Pediatrics and pediatric subspecialties
N. Radiology
O. Rheumatology
P. Surgery follow-up and consultations
Q. Behavioral Health
R. Diagnostic consultation and evaluation, including:
   1. Psychotropic medication adjustment and monitoring
   2. Individual and family counseling
   3. Case management.

Use of Telecommunications

Services delivered using telecommunications are generally not covered by the Division as a telemedicine service. The exceptions to this are described below:

A. A provider in the role of telepresenter may be providing a separately billable service under their scope of practice such as performing an ECG or an x-ray. In this case, that separately billable service would be covered, but the specific act of tele-presenting would not be covered.

B. A consulting provider at the distant site may offer a service that does not require real time interaction with the member. Reimbursement for this type of consultation is limited to dermatology, radiology, ophthalmology, and pathology and is subject to review by the Division.

C. In the special circumstance of the onset of acute stroke symptoms within three hours of presentation, the Division and AHCCCS recognize the critical need for a neurology consultation in rural areas to aid in the determination of suitability for thrombolytic administration. Therefore, when a member presents within three hours of onset of stroke symptoms, the Division will reimburse the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patients’ condition is such that real-time video interaction cannot be achieved due to an effort to expedite care.
Use of Teledentistry Services

The Division covers teledentistry for members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when provided by an AHCCCS-registered dental provider. Refer to AMPM Policy 431 for more information on “Oral Health Care for EPSDT Aged Members.”

Conditions, Limitations and Exclusions

A. Both the referring and consulting providers must be registered with AHCCCS.

B. A consulting service delivered via telemedicine by other than an Arizona-licensed provider must be provided by an AHCCCS-registered provider licensed to practice in the state or jurisdiction from which the consultation is provided. Consulting providers employed by an Indian Health Services (IHS), Tribal or Urban Indian Health Program, must be appropriately licensed based on IHS and 638 Tribal Facility requirements.

C. At the time of service delivery via real time telemedicine, the member’s health care provider may designate a trained telepresenter to present the case to the consulting provider if the member’s primary care provider or attending physician, or other medical professional who is familiar with the member’s medical condition, is not present. The telepresenter must be familiar with the member's medical condition in order to present the case accurately. Medical questions may be submitted to the referring provider when necessary but no payment is made for such questions.

D. Nonemergency transportation to and from the telemedicine originating site to receive a medically necessary consultation or treatment service is covered.
320-K TOBACCO CESSATION PRODUCT POLICY

EFFECTIVE DATE: March 3, 2017

REFERENCES: AHCCCS Medical Policy Manual Exhibit 320-K-1

The Division of Developmental Disabilities (Division) covers tobacco cessation products, ordered by a Primary Care Provider (PCP), which include Nicotine Replacement Therapy (NRT) and tobacco use medications, for members who are eligible for the ALTCS who wish to stop using tobacco. The Division encourages members to enroll in a tobacco cessation program offered by the Arizona Department of Health Services (ADHS).

The following criteria apply to members choosing to receive a tobacco cessation product.

A. Members 18 years and older are encouraged to enroll in a tobacco cessation program through ADHS. To enroll in an ADHS cessation program the member must call 1-800-556-6222.

B. Members must contact their Primary Care Provider (PCP) for a prescription for a tobacco cessation product. The PCP will identify an appropriate tobacco cessation product. This includes all tobacco cessation products, including those that are available over-the-counter.

C. The maximum supply a member may receive of a tobacco cessation product is a 12-week supply in a six-month time period. The six-month period begins on the date the pharmacy fills the first tobacco cessation product.

D. The Division has adopted the prior authorization protocol described in AHCCCS Medical Policy Manual Exhibit 320-K-1, which must be followed by the Administrative Services Subcontractors.
MEDICAL MARIJUANA

REVISION DATE: 4/17/2015
EFFECTIVE DATE: March 2, 2015

Medical marijuana is not a covered medical or pharmacy benefit. Office visits or any other services that are for the purpose of determining if a member would benefit from medical marijuana are also not covered. Under no circumstance shall any employee of the Department and any owner, director, principal, agent, employee, subcontractor, volunteer, and staff of the Division’s service providers administer or store medical marijuana for Division members.
320-P - SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATION

EFFECTIVE DATE: October 1, 2019

The Division of Developmental Disabilities (Division) contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS’ Medical Policy Manual 320-P, Serious Mental Illness Eligibility Determination, for the Division policy governing AdSS’ responsibilities regarding this topic.
320-U PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

EFFECTIVE DATE: October 1, 2019

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility for providing certain services in a manner that is compliant with law, its contract, and Division policy. See AdSS Medical Policy Manual 320-U, Pre-Petition Screening, Court-Ordered Evaluation, and Court-Ordered Treatment for the Division policy governing AdSS responsibilities regarding this topic.
320-V BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

EFFECTIVE DATE: April 24, 2019

This policy establishes requirements for the provision of care and services in a Behavioral Health Residential Facility (BHRF).

Definitions

A. Adult Recovery Team (ART) - A group of individuals who, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, collaborate and are actively involved in an assessment of the member of the Division (member), service planning and service delivery.

At a minimum, the team consists of the member, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include members of the enrolled member's family, physical health, behavioral health or social service providers, representatives or other agencies serving the member, professionals representing various areas of expertise related to the member's needs, designated representatives or other persons identified by the enrolled member.

B. Behavioral Health Condition - Mental, Behavioral, or Neurodevelopmental Disorder (F01-F99) diagnosis defined by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

C. Behavioral Health Residential Facility - As specified in A.A.C. R9-10-101, a health care institution that provides treatment to a member experiencing a behavioral health issue that limits the member's ability to be independent or causes the member to require treatment to maintain or enhance independence.

D. Behavioral Health Paraprofessional - As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

2. Is provided supervision by a behavioral health professional.

E. Behavioral Health Professional (BHP) –

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

   a. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251, or
b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101,

2. A psychiatrist as defined in A.R.S. § 36-501
3. A psychologist as defined in A.R.S. § 32-2061
4. A physician
5. A behavior analyst as defined in A.R.S. § 3 2-2091
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse
7. A registered nurse.

F. **Behavioral Health Technician (BHT)** –

As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
2. Is provided with clinical oversight by a behavioral health professional.

G. **BHRF Staff** - Any employee of the BHRF agency including but not limited to Administrators, Behavioral Health Paraprofessionals, Behavioral Health Professionals (BHP) and Behavioral Health Technicians.

H. **Child and Family Team (CFT)** - A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited by the child and family to participate. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and Contract as necessary to be successful on behalf of the child.

I. **Co-occurring** - Coexistence of both a behavioral health and a substance use disorder.

J. **Medication Assisted Treatment (MAT)** - Use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
K. **Natural Support** – Support provided by those individuals who know or are related to the member/family, but do not provide a paid service, such as a grandparent or neighbor who is connected to the member/family.

L. **Peer/Recovery Support Service** - Intentional partnerships, based on shared lived experiences, to provide social and personal support. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

M. **Peer/Recovery Support Specialist** - Individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS Program.

N. **Service Plan** - A complete written description, of all covered health services and other informal supports, which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

O. **Treatment Plan** - Complete written description of all services to be provided by Behavioral Health Residential Facility. The Treatment Plan must be based on the intake assessments, outpatient Service Plan, and must include input from the CFT/ART. The Treatment Plan will be reviewed and updated at the BHRF with the member and CFT/ART at least once a month.

**Policy**

Care and services provided in a BHRF are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board.

AdSS must ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA upon intake to and discharge from the BHRF.

References to CFT/ARTs pertain to AdSS and not to Fee-For-Services (FFS) Programs or FFS populations. A CFT/ART is not required for FFS members to receive services.

A. **Criteria for Admission**

AdSS must have admission criteria for medical necessity that, at a minimum, include the below elements. AdSS must publish the criteria, subject to Division approval as specified in the Contract. BHRF providers providing services to FFS members must adhere to the below elements.

If a member has a diagnosed Behavioral Health Condition that reflects the symptoms and behaviors necessary for a request for residential treatment, the Behavioral Health Condition causing the significant functional and/or psychosocial impairment must be evidenced in the assessment by the following:

1. At least one area of significant risk of harm within the past three months as a result of:
a. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent

b. Impulsivity with poor judgment/insight

c. Maladaptive physical or sexual behavior

d. Member’s inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports)

e. Medication side effects due to toxicity or contraindications

2. At least one area of serious functional impairment as evidenced by:

a. Inability to complete developmentally appropriate self-care or self-regulation due to member’s Behavioral Health Condition(s)

b. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care

c. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders

d. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications

e. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem

3. A need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community

4. Anticipated stabilization cannot be achieved in a less restrictive setting

5. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care

6. Member agrees to, and participates in, treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

B. Expected Treatment Outcomes

1. Treatment outcomes must align with all of the following:

a. The Arizona Vision-12 Principles for Children’s Behavioral Health Service Delivery as directed in AMPM Policy 430
b. The 9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract

c. The member’s individualized basic physical, behavioral, and developmentally appropriate needs.

2. Treatment goals must be:
   a. Specific to the member’s Behavioral Health Condition(s)
   b. Measurable and achievable
   c. Unable to be met in a less restrictive environment
   d. Based on the member’s unique needs and tailored to the member and the family’s/guardian’s/designated representative’s choices where possible
   e. Supportive of the member’s improved or sustained functioning and integration into the community.

C. Exclusionary Criteria

Admission to a BHRF must not be used as a substitute for the following:

1. An alternative to detention or incarceration

2. A means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment

3. A means of providing safe housing, shelter, supervision, or permanency placement

4. A behavioral health intervention when other less restrictive alternatives are available and meet the member’s treatment needs; including situations when the member/guardian/designated representative are unwilling to participate in the less restrictive alternative, or

5. An intervention for runaway behaviors unrelated to a Behavioral Health Condition.

D. Criteria for Continued Stay

AdSS must have medical necessity criteria for continued stay that, at a minimum, include the below elements. AdSS must publish those criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the below elements.

During Treatment Plan review BHRF staff, and as applicable the CFT/ART, must assess continued stay and update the Treatment Plan. Progress towards the treatment goals and continued display of risk and functional impairment must also be assessed.
Treatment interventions, frequency, crisis/safety planning, and targeted discharge must be adjusted accordingly to support the need for continued stay. The following criteria must be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a Behavioral Health Condition.

2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

E. Discharge Readiness

AdSS must have medical necessity criteria for discharge that, at a minimum, include the below elements. AdSS must publish that criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the minimum discharge elements below.

Discharge readiness must be assessed by the BHRF staff and as applicable by the CFT/ART during each Treatment Plan review and update. The following criteria must be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals.

2. Functional capacity is improved; essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care.

3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.

4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

F. Admission, Assessment, and Treatment Plan

AdSS must have a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with A.A.C. R9-10-707 and 708 and Contract requirements. BHRF Providers rendering services to Fee-For-Service members must follow the below outlined admission, assessment, and treatment planning requirements.

1. Except as provided in subsection R9-10-707(A)(9), a behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.

2. The CFT/ART/TRBHA, as applicable, is included in the development of the Treatment Plan within 48 hours of admission for members enrolled with the AdSS.
3. All BHRFs serving TRBHA members must coordinate care with the TRBHAs throughout the admission, assessment, treatment, and discharge process.

4. The Treatment Plan connects back to the member’s comprehensive Service Plan for members enrolled with the AdSS.

5. A comprehensive discharge plan is created during the development of the initial Treatment Plan and is reviewed and/or updated at each review thereafter. The discharge plan must document the following:
   a. Clinical status for discharge
   b. Member/guardian/designated representative and, CFT/ART/TRBHA as applicable, understands follow-up treatment, crisis and safety plan, and
   c. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made).

6. The BHRF staff and the CFT/ART as applicable meet to review and modify the Treatment Plan at least once a month.

7. A Treatment Plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours.

8. The provider has a system to document and report on timeliness of BHP signature/review when the Treatment Plan is completed by a BHT.

9. The provider has a process to actively engage family/guardians/designated representative in the treatment planning process as appropriate.

10. The provider’s clinical practices, as applicable to services offered and population served, must demonstrate adherence to best practices for treating the following specialized service needs, which include but are not limited to:
    a. Cognitive/intellectual disability
    b. Cognitive disability with comorbid Behavioral Health Condition(s)
    c. Older adults, and co-occurring disorders (substance use and Behavioral Health Condition(s), or
    d. Comorbid physical and Behavioral Health Condition(s).

11. Services deemed medically necessary through the assessment and/or CFT/ART/TRBHA as applicable, which are not offered at the BHRF, must be documented in the Service Plan and documentation must include a description of the need, identified goals and identified provider who will be meeting the need. The following services must be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:
    a. Counseling and Therapy (group or individual)
Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified in the Service Plan as a specific member need that cannot otherwise be met as required within the BHRF setting.

b. Skills Training and Development
   i. Independent Living Skills (e.g., self-care, household management, budgeting, avoidance of exploitation/safety education and awareness)
   ii. Community Reintegration Skill building (e.g., use of public transportation system, understanding community resources and how to use them)
   iii. Social Communication Skills (e.g., conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation)

c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services, including but not limited to:
   i. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan)
   ii. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners)
   iii. Medication education and self-administration skills
   iv. Relapse prevention
   v. Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building
   vi. Treatment for Substance Use Disorder (e.g., substance use counseling, groups)
   vii. Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814).

G. BHRF and Medication Assisted Treatment

AdSS and BHRF providers must have policies and procedures to ensure members on Medication Assisted Treatment (MAT) are not excluded from admission and are able to receive MAT to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018. First Special Session.
H. BHRF with Personal Care Services

BHRFs licensed to provide Personal Care Services must offer services in accordance with A.A.C R9-10-702 and A.A.C R9-10-715. AdSS and BHRF providers must ensure that all identified needs can be met in accordance with R9-10-814 (A)(C)(D) and (E).

The following are examples of services that may be provided:

1. Blood sugar monitoring, Accu-Check diabetic care
2. Administration of oxygen
3. Application and care of orthotic devices
4. Application and care of prosthetic devices
5. Application of bandages and medical supports, including high elastic stockings
6. ACE wraps, arm and leg braces, etc.
7. Application of topical medications
8. Assistance with ambulation
9. Assistance with correct use of cane/crutches
10. Bed baths
11. Care of hearing aids
12. Radial pulse monitoring
13. Respiration monitoring
14. Denture care and brushing teeth
15. Dressing member
16. Supervising self-feeding of members with swallowing deficiencies
17. Hair care, including shampooing
18. Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports
19. Measuring and recording blood pressure
20. Non-sterile dressing change and wound care
21. Passive range of motion exercise
22. Use of pad lifts
23. Shaving

24. Shower assistance using shower chair

25. Skin maintenance to prevent and treat bruises, injuries, pressure sores. Members with stage 3 or 4 pressure sore is not to be admitted to BHRF (A.A.C.R9-10-715(3)), and infections

26. Use of chair lifts

27. Skin and foot care

28. Measuring and giving insulin, glucagon injection

29. G-tube care

30. Ostomy and surrounding skin care

31. Catheter care
330 CHILDREN’S REHABILITATIVE SERVICES

REVISION DATE: 10/1/2018, 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S Title 32; A.A.C. R9-22-1301, A.A.C. R9-22-1303

Members eligible for Arizona Long Term Care System (ALTCS) with certain diagnoses may be eligible to receive Children Rehabilitative Services (CRS) at one the multi-specialty/interdisciplinary care settings, in addition to community based providers in independent offices. The respective Administrative Service Subcontractors (AdSS) provides covered medical, surgical, or therapy modalities for CRS enrolled members. The AdSS provides CRS covered services for CRS qualifying condition and conditions arising as a result of or related to the CRS qualifying condition when medically necessary. The AdSS does not cover routine, preventive, or other non-CRS related covered services. Members will receive acute care services through their Division acute health plan when being treated for a non-Children’s Rehabilitative Services (CRS) diagnoses. Members who are 21 years of age and older are subject to all limitations and exclusions applicable to the adult population.

CRS medical services are in accordance with Arizona Administrative Code Title 9, Chapter 22, Article 2. Coverage limitations and exclusions for members 21 years of age and older apply.

The AdSS or authorized subcontractors provide medically necessary CRS services in both inpatient and outpatient settings, including contracted hospitals, multispecialty interdisciplinary clinics (MSICs), community-based field clinics, community based provider offices, behavioral health, and skilled nursing facilities.

Certain services may be available only in limited types of service settings or may be medically appropriate only for members with a particular clinical presentation. Services may require prior authorization from the AdSS and may require additional documentation to determine the medical necessity of the service requested for treating the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

The AHCCCS Division of Member Services (DMS) will provide information to the AdSS related to the CRS qualifying condition(s) that are identified during the eligibility process. DMS may also provide information received for purposes of eligibility determination for the CRS designation regarding care, services or procedures that may have been approved or authorized by the member’s current health plan. The AdSS is responsible for ensuring that information provided by AHCCCS Division of Member Services is made available to the appropriate areas and staff within its organization who may need the information. The AdSS is responsible for appropriately transitioning members utilizing established transition processes. Members are permitted to opt out of, or refuse enrollment into, the CRS designation.

The AdSS provides services through an approach to service delivery that is family centered, coordinated and culturally competent, in a manner that considers the unique medical and behavioral holistic needs of the member.

CRS members may been seen for care and specialty services by the AdSS contracted network providers within the community that are qualified or trained in the care of the
member’s condition. CRS members may also benefit from treatment in clinic-based multi-specialty/interdisciplinary care settings when active treatment is required, in addition to care and services provided by community based providers in independent offices. The AdSS also provides community based services including services provided in field clinics. When medically necessary services are not available in state, the AdSS is required to provide services out of state.

Covered benefits for CRS Partially Integrated members are the same as those provided by the Acute Contractors and the Behavioral Health Contractors including any necessary placement settings such as skilled nursing facilities, chemotherapy, hospice, transplant services, and behavioral health placement settings, as determined to be medically necessary and resulting from the CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

**Definitions**

A. **Active Treatment** - a current need for treatment. The treatment is identified on the member’s service plan to treat a serious and chronic physical, developmental, or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that last, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.

B. **Chronic** - expected to persist over an extended period of time.

C. **CRS condition** - any of the covered medical conditions in A.A.C. R9-22-1303 which are referred to as covered conditions in A.R.S. 36-2912.

D. **CRS Fully Integrated** - a coverage type which includes members who receive all services from the CRS AdSS including acute health, behavioral health and CRS-related services.

E. **CRS Partially Integrated Acute** - a coverage types which includes American Indian members who receive all acute health and CRS-related services from the CRS AdSS and who receive behavioral health services from a Tribal Regional Behavioral Health Authority (TRBHA).

F. **CRS Partially Integrated Behavioral Health** - a coverage type which includes DDD members who receive all behavioral health and CRS-related services from the primary program of enrollment.

G. **CRS Only** - a coverage type which includes members who receive all CRS-related services from the CRS AdSS, who receive acute health services from the from the primary program of enrollment, and DDD American Indian member who receive behavioral health services from the TRBHA.

H. **CRS Provider** - a person who is authorized by employment or written agreement with the AdSS to provide covered CRS services to a member or covered support services to a member’s family.
I. **Field Clinic** - a “clinic” consisting of single specialty health care providers who travel to health care delivery settings close to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

J. **Functionally Limiting** - a restriction having a significant effect on an individual’s ability to perform an activity of daily living as determined by a CRS provider. (A.A.C. R9-22-1303)

K. **Medically Eligible** - meeting the medical eligibility requirements of A.A.C. R9-22-1303.

L. **Multi-Specialty Interdisciplinary Clinic (MSIC)** - an established facility where specialists form multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

**Medical Services**

Medical services are provided in accordance with A.A.C. R9-22, Article 2. The Administrative Services Subcontractor is responsible for the following services:

A. **Audiology Services**

Audiology is a covered service as described in Division Medical Policy 310-A-Audiology, within certain limitations, to evaluate and rehabilitate members with hearing loss. For purposes of providing CRS, the following applies:

1. Audiologic Assessments must be consistent with accepted standards of audioligic practice.

2. Hearing Aid Fittings and Evaluations are covered as follows:
   a. Hearing aids
      i. The member may have their hearing aid reevaluated annually.
      ii. A hearing aid may be replaced once every three years, unless the member experiences a change in hearing levels or is determined by a CRS contracted audiologist to require a hearing aid replacement due to the hearing aid being lost, broken, or non-functioning.

   b. Implantable bone conduction devices

   c. Cochlear implants. For further information, refer to Division Medical Policy 430, Early Periodic Screening, Diagnostic and Treatment (EPSDT) Services.
B. Dental and Orthodontia Services

Dental and Orthodontia Services are covered services, with certain limitations as described in Division Medical Policy 431 Oral Health Care (EPSDT-Age Members). For purposes of providing CRS, the following applies:

1. Dental Services

   Full ranges of dental services are covered for members eligible for CRS having at least one of the following:

   a. Cleft lip and/or cleft palate

   b. A cerebral spinal fluid diversion shunt where the member is at risk for subacute bacterial endocarditis

   c. A cardiac condition where the member is at risk for subacute bacterial endocarditis

   d. Dental complications arising as a result of treatment for a CRS condition

   e. Documented significant functional malocclusion

      i. When the malocclusion is defined as functionally impairing in a member eligible for CRS with a craniofacial anomaly or

      ii. When one of the following criteria is present:

         (a) Masticatory and swallowing abnormalities that affect the nutritional status of the individual resulting in growth abnormalities

         (b) Clinically significant respiratory problems, induced by the malocclusion, such as dynamic or static airway obstruction

         (c) Serious speech impairment, determined by a speech therapist, that indicates the malocclusion as the primary etiology for the speech impairment and that speech cannot be further improved by speech therapy alone.

2. Orthodontia Services

   Medically necessary Orthodontia Services are covered for a member eligible for CRS with a diagnosis of cleft palate or documented significant functional malocclusion as described in B.1.a. and B.1.e. (above).
C. Diagnostic Testing and Laboratory Services

Medically necessary diagnostic testing and laboratory services are covered as described in Division Medical Policy 310. For purposes of providing CRS, the following applies:

Limitations

1. Genetic testing is only covered when the results of such testing are necessary to differentiate between treatment options as described in Division Medical Policy 310, and when related to a CRS condition.

2. Follow-up laboratory evaluations for conditions unrelated to the CRS condition are excluded. The member must be referred to his or her primary care provider for follow-up care.

D. Durable Medical Equipment (DME)

Medically necessary DME is covered as described in Division Medical Policy 310-P Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services). For purposes of providing CRS, the following applies:

• Durable medical equipment for rehabilitative care
• Equipment repairs
• Equipment modifications.

1. Exclusion and Limitations of Durable Medical Equipment Services

Note: Refer to D.4 and D.5 (below) for specific information related to wheelchair and ambulation devices.

a. Members are eligible for equipment only when ordered by a CRS-contracted provider and/or authorized by the AdSS.

b. Cranial modeling bands are excluded except for members who are 24 months of age or younger who have undergone CRS-approved cranial modeling surgery and demonstrate postoperative progressive loss of surgically achieved correction and that without intervention would most likely require additional surgery.

2. Equipment Maintenance for Durable Medical Equipment Services

Covered services include equipment modifications necessary due to the member's growth or due to a change in the member’s orthopedic or health needs. The request for modification must come from a CRS contracted provider.
3. Equipment Replacement or Repair for Durable Medical Equipment Services

The AdSS must ensure that Durable Medical Equipment found to be unsatisfactory due to imperfect or faulty construction is corrected, adjusted, or replaced.

4. Wheelchairs and Ambulation Devices

a. Routine or custom wheelchairs and/or ambulation assistive devices (crutches, canes, and walkers) are provided for members eligible to receive CRS, based on medical necessity.

b. Medically necessary equipment modifications and replacement are covered.

c. Custom fit standards and parapodiums are covered for members eligible to receive CRS with spinal cord defects who have walking potential.

d. Trays for wheelchairs are provided when documentation indicates that the need is directly related to improvement in functional skill.

e. The member and/or their family must demonstrate that they can safely use all equipment provided to the member, as verified and documented by the treating provider or wheel chair fitting provider. Practical and functional use of the equipment must be documented in the CRS medical record.

5. Limitations and Exclusions Related to Wheelchairs and Ambulation Devices

a. Replacement of wheelchairs and ambulation devices is not a covered service when the equipment is functional and can be repaired such that the equipment is safe to operate.

b. Physical or structural modifications to a home are excluded.

c. After initial delivery, care and transportation of the equipment, including vehicle modifications, is the responsibility of the member and/or the member's guardian.

d. Repairs or maintenance to equipment that was not provided to the member by the AdSS are provided, when a CRS provider has determined the equipment to be safe and appropriate.

E. High Frequency Chest Wall Oscillation Therapy

High Frequency Chest Wall Oscillation (HFCWO) therapy is a covered service, for members under 21 years of age.

1. HFCWO is covered when there is:

a. A diagnosis of cystic fibrosis
b. Documentation of excessive sputum production combined with the member's inability to clear the sputum without assistance

c. Copy of chest x-ray report and pulmonary function tests showing findings consistent with moderate or severe Chronic Obstructive Pulmonary Disease (COPD)

d. Prescription signed by M.D. or D.O. with a specialty in pulmonary disease, indicating the need for at least daily chest physiotherapy

e. Member is two years of age or older, or has a documented chest size of 20 inches or greater, whichever comes first

f. Specific documentation supporting why HFCWO therapy for the member is superior to other more cost-effective therapy methods, including at least one of the following:

i. Promotes independent self-care for the individual

ii. Allows independent living or university or college attendance for the individual

iii. Provides stabilization in single adults or emancipated individuals without able partners to assist with Chest Physical Therapy (CPT), or

iv. Severe end-stage lung disease requiring complex or frequent CPT.

g. Evidence that the member can use the vest effectively, including continuing compliance with all forms of prescribed therapy and treatment and member and family acceptance of HFCWO therapy

h. Coordination prior to implementation of HFCWO therapy for long-term use between the CRS provider office/clinic or DDD Contractor, or other payer source has occurred.

2. Discontinuation Criteria for HFCWO

HFCWO services will be discontinued if there is:

1. Member and/or prescribing physician request, or

2. Patient treatment compliance at a rate of less than 50% usage, as prescribed in the medical treatment plan, that is verified at two and six months of use.

F. Home Health Care Services

Medically necessary home health care services, as described in Division Medical Policy 310-1 Home Health Services. Home health care services include professional nurse visits, therapies, equipment, and medications. Home health
care services must be ordered by a CRS contracted provider. The home health care service is covered for a CRS member when the home health service is specifically for the treatment of a CRS or CRS-related condition.

G. Inpatient Services

The AdSS covers medically necessary inpatient services, as described in Division Medical Policy 310-K Hospital Inpatient Services. The hospitalization is covered for a member when the hospitalization is for the treatment of a CRS condition or a condition that is related to, or the result of, the CRS condition.

CRS requirements for admission and coverage for an inpatient acute care stay are as follows:

1. CRS authorized providers with admitting privileges can admit and treat CRS members for CRS qualifying conditions or those conditions related to, or the result of, a CRS condition. Providers must have a contract with the AdSS or receive an authorization from the AdSS. The admitting provider must obtain prior authorization from the AdSS for all non-emergency hospital CRS-related admissions.

2. Prior authorization is not required for an emergency service.

3. The primary reason for hospitalization must be related to, or the result of, the CRS condition.

H. Growth Hormone Therapy

Growth hormone therapy is only covered for members with panhypopituitarism.

I. Nutrition Services

CRS covers medically necessary nutritional services. For purposes of the CRS designation, nutrition services include screening, assessment, intervention, and monitoring of nutritional status. The AdSS must cover nutrition services for CRS members with special nutritional needs when the nutritional need is related to a CRS condition or resulting from the CRS condition. The CRS designation covers nutritional supplements upon referral from CRS providers with consultation by a registered dietician.

Note: Covered services also include special formula to meet the nutritional needs of members with metabolic needs.

Limitations

1. A registered dietitian must provide nutrition services.

2. Total Parenteral Nutrition (TPN) for long-term nutrition is covered if medical necessity and is related to, or resulting from, the CRS condition.
J. Outpatient Services

The AdSS is responsible for outpatient services where the diagnosis is a CRS qualifying condition or a condition that is related to, or the result of, a CRS condition.

CRS outpatient services include:

1. Ambulatory/outpatient surgery
2. Outpatient diagnostic and laboratory services
3. Ancillary services: Laboratory, Radiology, Pharmacy Services, Medical Supplies, Blood, Blood Derivatives, Therapies, Ambulatory Surgeries
4. Clinic services
   a. CRS members may benefit from multi-specialty, interdisciplinary care teams, in addition to community-based providers. The AdSS shall make available these care teams throughout the state.

Community-based field clinics are specialty clinics that are held periodically in outlying towns and communities in Arizona, or on Indian Reservations.

b. CRS members may be seen by AdSS community based providers in independent offices for CRS qualifying conditions or conditions that are related to, or the result of, a CRS condition.

Limitations

The member's primary health care system must be used for routine and acute medical care that is not related to the CRS condition, such as periodic visits for scheduled immunizations and periodic physical examinations and check-ups.

K. Pharmaceutical Services

The AdSS covers medically necessary prescription medication and pharmacy services, as described in Division Medical Policy 310-V Prescription Medication and Pharmacy Services. Under the CRS designation, pharmaceuticals are covered when appropriate for the treatment of the CRS condition or a condition that is related to, or the result of, a CRS condition, when ordered by the CRS provider, and provided through a CRS contracted pharmacy. The AdSS is required to provide community-based pharmacy services.

Limitations

1. Pharmaceuticals or supplies that would normally be ordered by the primary care provider for the non-CRS covered condition(s) are not covered.
2. Medications covered under Medicare Part D for CRS members who are dual eligible (AHCCCS/Medicare) enrollees are not covered by the CRS designation.
L. Physical and Occupational Therapy Services

The Division covers medically necessary physical and occupational therapy services, as described in Division Medical Policies 310-K Hospital Inpatient Services and 310-X Rehabilitative Therapies. For purposes of the CRS designation, physical therapy and occupational therapy services are provided when the service is medically necessary and prescribed to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition. Limitations listed for members age 21 and older in AMPM Policy 310, Covered Services apply.

M. Physician Services

The Division covers medically necessary physician services, as described in Division Medical Policy 310-T Physician Services. For purposes of the CRS designation, physician services must be furnished by an AHCCCS registered, licensed physician and must be covered for members when rendered within the physician's scope of practice under A.R.S Title 32. The AdSS is responsible for contracting with physician specialists with expertise in pediatrics to provide CRS covered services. Medically necessary physician services may be provided in an inpatient or outpatient setting.

N. Prosthetic and Orthotic Devices

The Division covers medically necessary prosthetic and orthotic services, as described in Division Medical Policy 310-P Medical Supplies, Durable Medical Equipment and Prosthetic Devices (Acute Care Services). Under the CRS designation, prosthetic and orthotic devices are provided when medically necessary to treat the CRS condition and other conditions arising as a result of the CRS qualifying condition.

1. Maintenance and Replacement
   a. The CRS designation covers prosthetic and orthotic modifications or repairs that are related to the CRS condition and medically necessary.
   b. The CRS designation covers ocular prostheses and replacements when medically necessary and when related to a CRS condition.
   c. Prior authorization is required for replacement of lost or stolen prosthetic and orthotic devices.

   The CRS designation must provide or fabricate orthotic/prosthetic devices that assist CRS members in performing normal living activities and skills. Requirements include:

   i. All orthotic/prosthetic devices must be constructed or fabricated using high quality products.
   ii. All orthotics must be completed, modified or repaired, and
delivered to the CRS member within 15 working days of the provider's order.

iii. All prosthetics must be completed, modified or repaired, and delivered to the CRS member within 20 working days following the member's provider order.

iv. Orthotic/prosthetic repairs ordered by a CRS provider as urgent must be delivered within five working days.

v. Same day service must be provided for emergency adjustments for members unable to undertake their normal daily activities without the repairs and/or modifications.

d. The CRS designation will assure there will be no additional charge for modifications and/or repairs during the normal life expectancy of the device, except as required to accommodate a documented change in the member's physical size, functional level, or medical condition.

2. Limitations and Exclusions

a. Myoelectric prostheses are excluded.

b. Limitations for members age 21 and older apply as described in AMPM 310-JJ.

O. Psychology/Behavioral Health Services

For discussion of behavioral health services, please see AMPM Policy 310-B, Behavioral Health Services.

P. Second Opinions

The CRS designation covers second opinions by other CRS contracted physicians, when available. If not available, CRS will provide a second opinion by a contracted specialty provider able to treat the condition or a same specialty non-CRS contracted provider.

Q. Speech Therapy Services

The Division covers medically necessary speech therapy services, as described in AMPM Policy 310. Speech therapy services are provided by the CRS designation when the service is medically necessary and prescribed to treat the CRS diagnosed or a related condition. Limitation for members age 21 and older apply as per AMPM Policy 310, Covered Services.

R. Transplant Services

The CRS designation covers transplant services for CRS qualifying conditions or those conditions related to, or resulting from, the CRS condition.
S. Telemedicine

The Division covers telemedicine, as described in Division Medical Policy 320-I Telehealth and Telemedicine. The CRS designation covers telemedicine when it is related to the member’s CRS condition. The purpose of telemedicine is to provide clinical and therapeutic services by means of telemedicine technology. This technology is used to deliver care and services directly to the member and to maximize the provider network.

T. Transportation

The Division covers medically necessary transportation services, as described in Division Medical Policy 310-BB Transportation. The CRS designation covers transportation for a member who is receiving services for a CRS condition or a CRS-related service.

U. Vision Services

The CRS designation covers vision services including examinations, eyeglasses, and/or contact lenses for the treatment of a CRS or CRS-related condition.
410 MATERNITY CARE SERVICES

EFFECTIVE DATE: June 30, 1994
REFERENCES: A.A.C. R9-16-111 through 113, A.R.S. § 14-5101; AMPM 400:410; AMPM Appendix F; AMPM Attachment 410-B, C, D, and E; AMPM Exhibit 400-2A; Contract Exhibit C Deliverables

Maternity care services are covered for all members of childbearing age, eligible for ALTCS and Targeted Support Coordination. Maternity care services include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary education and prenatal services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. In addition, related services such as outreach and family planning services (Refer to Division Medical Policy 420) are provided, whenever appropriate, based on the member’s current eligibility and enrollment.

All maternity care services must be delivered by qualified physicians and non-physician practitioners, and they must be provided in compliance with the most current American Congress of Obstetricians and Gynecologists (ACOG) standards for obstetrical and gynecological services. Prenatal care, labor/delivery, and postpartum care services may be provided by licensed midwives, within their scope of practice, while adhering to AHCCCS risk-status consultation/referral requirements. According to ACOG guidelines, cesarean section deliveries must be medically necessary. Inductions and cesarean section deliveries prior to 39 weeks must be medically necessary. Cesarean sections and inductions performed prior to 39 weeks that are not found to be medically necessary based on nationally established criteria are not eligible for payment.

A. Requirements for Providing Maternity Care Services

The Division’s Administrative Services Subcontractors (AdSS’s) must establish and operate a maternity care program with program goals directed at achieving optimal birth outcomes. The minimum requirements of the maternity care program are:

1. Employment of sufficient numbers of appropriately qualified local personnel in order to meet the requirements of the maternity care program for eligible members and achieve contractual compliance.

2. Provision of written member educational outreach related to:

   a. Risks associated with elective inductions and cesarean sections prior to 39 weeks gestation

   b. Healthy pregnancy measures (e.g., addressing nutrition, sexually transmitted infections, substance abuse and other risky behaviors)

   c. Dangers of lead exposure to mother and baby during pregnancy

   d. Postpartum depression
e. Importance of timely prenatal and postpartum care

f. Other selected topics at a minimum of once every 12 months.

These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the twelve-month period. The AdSS may use multiple different venues to meet these requirements.

3. Conducting of outreach and education activities to identify currently enrolled members who are pregnant and enter them into prenatal care as soon as possible.

   a. Service providers notify the Division/assigned AdSS promptly when members test positive for pregnancy.

   b. In addition, the AdSS must have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all members who are pregnant. If activities prove to be ineffective, the AdSS must implement different activities.

4. Participation in community and quality initiatives within the communities served by the AdSS.

5. Implementation of written protocols to inform members who are pregnant and maternity care providers of voluntary prenatal HIV testing and the availability of counseling, if the test is positive.

   a. Each AdSS must include information to encourage members who are pregnant to be tested and provide instructions on where testing is available at least annually in the member newsletter, new member welcome packet, maternity packet, provider instructions, and the member handbook.

   b. AdSS must report to the Division the number of members who are pregnant who have been identified as HIV positive within the timeframes indicated in Contract Exhibit C, Deliverables.

6. Designation of a maternity care provider for each member who is pregnant for the duration of her pregnancy and postpartum care. Such designations must allow for freedom of choice, while not compromising the continuity of care. Members who transition to a different AdSS or become newly enrolled with an AdSS 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.

7. Provision of information, regarding the opportunity to change AdSS to ensure continuity of prenatal care, to newly-assigned members who are pregnant and those currently under the care of a non-network provider.

8. New member assessment procedures for the provider that include
identifying risk factors using a comprehensive assessment tool covering psychosocial, nutritional, medical and educational factors (available from the American Congress of Obstetricians and Gynecologists [ACOG] or the Mutual Insurance Company of Arizona [MICA]).

9. Mandatory availability of maternity care coordination services for members who are pregnant, who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the AdSS. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers.

10. Demonstration of an established process for assuring:

a. Network physicians, practitioners, and licensed midwives adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased-risk or high-risk pregnancies using ACOG or MICA criteria.

b. Maternity care providers educate members about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breast-feeding; other infant care information; and postpartum follow-up.

c. Members are referred for support services to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community-based resources to support healthy pregnancy outcomes. If a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.

d. Maternity care providers maintain a complete medical record, documenting all aspects of maternity care.

e. High-risk members who are pregnant have been referred to and are receiving appropriate care from a qualified physician.

f. Postpartum services are provided to members within 57 days of delivery.

11. Mandatory provision of initial prenatal care appointments within the established timeframes. The established timeframes are as follows:

a. First trimester - within 14 days of a request for an appointment
b. Second trimester - within seven days of a request for an appointment
c. Third trimester - within three days of a request for an appointment,
d. High-risk pregnancy care must be initiated within three days of
identification or immediately, if an emergency exists.

12. Primary verification of members who are pregnant, to ensure that the
above-mentioned timeframes are met, and to effectively monitor
members are seen in accordance with those timeframes.

13. Monitoring and evaluation of infants born with low/very low birth weight,
and implementation of interventions to decrease the incidence of infants
born with low/very low birth weight.

14. Monitoring and evaluation of cesarean section and elective induction rates
prior to 39 weeks gestation, and implementation of interventions to
decrease occurrence.

15. Identification of postpartum depression and referral of members to
the appropriate health care providers.

16. Process for monitoring provider compliance for perinatal/postpartum
depression screenings being conducted at least once during the
pregnancy and then repeated at the postpartum visit, with appropriate
counseling and referrals made, if a positive screening is obtained.

17. Return visits in accordance with ACOG standards. A process, with primary
verification, must be in place to monitor these appointments and ensure
timeliness. The AdSS must include the first and last prenatal care dates of
service and the number of obstetrical visits that the member had with the
provider on claim form regardless of the payment methodology. The AdSS
must continue to pay obstetrical claims upon receipt of claim after delivery
and must not postpone payment to include the postpartum visit. Rather,
the AdSS must require a separate “zero-dollar” claim for the postpartum
visit.

18. Timely provision of medically necessary transportation services,
as described in Division Medical Policy 310-BB, Transportation.

19. Postpartum activities must be monitored and evaluated, and interventions
to improve the utilization rate implemented, where needs are identified.

20. Participation of the AdSS in reviews of the maternity care services
program conducted by the Division or AHCCCS as requested, including
provider visits and audits.

B. Requirements for the Maternity/Family Planning Services Annual Plan

Each Administrative Services Subcontractor (AdSS) must have a written
Maternity/Family Planning Services Annual Plan that addresses minimum AdSS
requirements as specified in the prior section (numbers 1 through 20), as well as
the objectives of the AdSS’s program that are focused on achieving Division and
AHCCCS requirements. It must also incorporate monitoring and evaluation.
activities for these minimum requirements; see Maternity/Family Planning Services Annual Plan Checklist (AHCCCS Medical Policy Manual [AMPM] Exhibit 400-2A) as adopted for use by the Division. The Maternity/Family Planning Services Annual Plan must be submitted to Division Health Care Services Unit through the Division Compliance Unit no later than the date specified in Contract Chart of Deliverable and is subject to approval (see AMPM Exhibit 400-1, Maternal and Child Health Reporting Requirements). The Maternity/Family Planning Services Annual Plan must contain, at a minimum, the following:

1. **Maternity/Family Planning Services Care Plan** – A written, narrative description of all planned activities to address the AdSS’s minimum requirements as specified in the prior section (Requirements for Providing Maternity Care Services - Numbers 1 through 20) for maternity care and family planning services, including participation in community and/or quality initiatives within the communities served by the AdSS. The narrative description must also include AdSS activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

2. **Maternity/Family Planning Services Work Plan Evaluation** – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies and interventions used toward meeting stated objectives.

3. **Maternity/Family Planning Services Work Plan** that includes:
   
   a. **Specific measurable objectives**
      
      These objectives must be based on Division and AHCCCS established minimum performance standards. In cases where Division and AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue the AdSS’s improvement efforts must be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop additional specific measurable goals and objectives aimed at enhancing the maternity program when Division and AHCCCS Minimum Performance Standards have been met.

   b. **Strategies and specific measurable interventions to accomplish objectives** (e.g., member outreach, provider education and provider compliance with mandatory components of the Maternity/Family Planning Services program)

   c. **Targeted implementation and completion dates of work plan activities**

   d. **Assigned local staff position(s) responsible and accountable for meeting each established goal and objective**

   e. **Identification and implementation of new interventions, continuation of, or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation.**
4. Relevant policies and procedures, referenced in the Maternity/Family Planning Services Annual Plan, submitted as separate attachments.

C. Maternity Care Provider Requirements

1. Physicians and practitioners must follow the American Congress of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing health risk assessment.

2. Licensed midwives, if included in the AdSS’s provider network, adhere to the requirements contained within Division and AHCCCS policy, procedures, and contracts.

3. All maternity care providers will ensure that:
   a. High-risk members have been referred to a qualified provider and are receiving appropriate care.
   b. All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling must be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment,
   c. Members are educated about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breastfeeding; other infant care information; and postpartum follow-up.
   d. Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made, if a positive screening is obtained. Postpartum depression screening is considered part of the global service and is not a separately reimbursable service.
   e. Member medical records are appropriately maintained and document all aspects of the maternity care provided.
   f. Members must be referred for support services to the Special Supplemental Nutrition Program for WIC, as well as other community-based resources, in order to support healthy pregnancy outcomes.
   g. Members must be notified that, in the event they lose eligibility for services, they may contact Arizona Department of Health Services (ADHS) Hotline for referrals to low-cost or no-cost services.
h. The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, are recorded on all claim forms submitted to the AdSS regardless of the payment methodology used.

i. Postpartum services must be provided to members within 57 days of delivery using a separate “zero-dollar” claim for the postpartum visit.

D. Additional Covered Related Services

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

1. Circumcision is a covered service under EPSDT for males who are eligible for ALTCS or Targeted Support Coordination, when it is determined to be medically necessary. The procedure requires Prior Authorization (PA) by the AdSS Medical Director or Division Medical Director or designee for AIHP enrolled members.

2. Extended Stays for Newborns Related to Status of Mother’s Stay

   a. The Division covers no less than 48 hours of inpatient hospital care for a vaginal delivery without complications and no less than 96 hours of inpatient hospital care for a cesarean delivery without complications.

   b. The mother of the newborn may be discharged prior to the minimum 48/96 hour stay, if agreed upon by the mother in consultation with the physician or practitioner. A normal newborn may be granted an extended stay in the hospital of birth when the mother's continued stay in the hospital is beyond the minimum 48 or 96 hours stay, whichever is applicable. In addition, if the mother's stay is to extend beyond 48/96 hours, an extended stay for the newborn should be granted if the mother’s condition allows for mother-infant interaction and the child is not a ward of the state or is not to be adopted.

3. Home Uterine Monitoring Technology

   a. Medically necessary home uterine monitoring technology is covered for members with premature labor contractions before 35 weeks gestation, as an alternative to hospitalization.

   b. If the member has one or more of the following conditions, home uterine monitoring may be considered:

      i. Multiple gestation, particularly triplets or quadruplets

      ii. Previous obstetrical history of one or more births before 35 weeks gestation
iii. Hospitalization for premature labor before 35 weeks gestation with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home.

c. These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.

4. Labor and Delivery Services Provided in Freestanding Birthing Centers

a. For members who meet medical criteria specified in this policy, the Division covers freestanding birthing centers when labor and delivery services are provided by licensed physicians or certified nurse practitioners in midwifery (a.k.a. certified nurse midwives).

b. Freestanding birthing centers are defined as out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services and certified by the Commission for the Accreditation of Free Standing Birth Centers. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities must be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

c. Labor and delivery services rendered through freestanding birthing centers must be provided by a physician, (i.e., the member’s primary care provider or an obstetrician with hospital admitting privileges) or by a registered nurse who is accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services.

d. Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a freestanding birthing center. Risk status must be determined by the attending physician or certified nurse midwife, using the standardized assessment tools for high-risk pregnancies (American Congress of Obstetricians and Gynecologists, Mutual Insurance Company of Arizona, of National Association of Childbearing Centers). In any area of the risk assessment where standards conflict, the most stringent will apply. The age of the member must also be a consideration in the risk status evaluation; members younger than 18 years of age are generally considered high risk. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

5. Labor and Delivery Services Provided in a Home Setting

a. The Division covers labor and delivery services provided in the home by the member’s maternity provider (physicians, certified
nurse midwives, and licensed midwives).

b. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries nor appropriate for planned home-births or births in freestanding birthing centers.

c. Risk status must initially be determined at the time of the first visit, and each trimester thereafter, by the member’s attending physician, practitioner, or licensed midwife, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

d. A risk assessment must be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.

e. Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital in close proximity to the site where the services are provided in the event of complications during labor and/or delivery.

f. For each anticipated home labor and delivery, licensed midwives who render home labor and delivery services must have an established plan of action, including methods of obtaining services at an acute care hospital in close proximity to the site where services are provided. In addition, referral information to an AHCCCS registered physician who can be contacted immediately, if management of complications is necessary, must be included in the plan.

6. Licensed Midwife Services

a. The Division covers maternity care and coordination provided by licensed midwives for members, if licensed midwives are included in the AdSS’s provider network. In addition, members who choose to receive maternity services from this provider type must meet eligibility and medical criteria specified in this policy.

b. The age of the member must be included as a consideration in the
risk status evaluation. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births, or births in freestanding birthing centers.

c. Risk status must initially be determined at the time of the first visit, and each trimester thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

d. A risk assessment from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona must be conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified physician if necessary.

e. Before providing licensed midwife services, documentation certifying the risk status of the member’s pregnancy must be submitted to the member’s assigned AdSS. In addition, a consent form signed and dated by the member must be submitted, indicating that the member has been informed and understands the scope of services that will be provided by the licensed midwife, including risks to a home delivery. Members initially determined to have a high-risk pregnancy, or members whose physical condition changes to high-risk during the course of pregnancy, must immediately be referred to an AHCCCS registered physician within the provider network of the member’s assigned AdSS for maternity care services.

f. Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital in close proximity to the planned location of labor and delivery for referral, if complications should arise. This plan of action must be submitted to the AdSS Medical Director or Division Medical Director or designee for members enrolled with AIHP.

g. Upon delivery of the newborn, the licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (refer to A.A.C. R9-16-111 through 113).

h. In addition, the licensed midwife must notify the mother’s AdSS,
of the birth no later than three days after the birth, in order to enroll the newborn with AHCCCS.

7. **Supplemental Stillbirth Payment**

Implemented to cover the cost of delivery services. The supplemental payment applies to all births to women enrolled with the AdSS. The Division also pays this supplement to the AdSS when the infant is stillborn. Stillbirth refers to those infants, deemed a fetal demise prior to delivery with a gestational age greater than 24 and 0/7 weeks. In order for AdSS to be eligible to receive this payment, criteria must be met. The stillborn infant must have:

a. Attained a weight of at least 600 grams, or

b. Attained a gestational age of at least 24 and 0/7 weeks, as verified by Provider’s obstetrical prenatal records (History & Physical) including an Estimated Date of Confinement (EDC). An ultrasound report may also be used to verify EDC, when completed prior to 20 weeks gestation. A Ballard Assessment, done at delivery by nursing and/or physician staff to determine physical maturity of the infant, confirming a gestational age of at least 24 and 0/7 weeks may also be used.

For stillbirths meeting one of the above medical criteria, AdSS must submit to Division’s Health Care Services Unit through the Division’s Compliance Unit medical documentation to confirm infant’s weight and/or gestational age, as well as the date/time of delivery and zero APGARs, using the **AHCCCS Request for Stillbirth Supplement** form (AMPM Attachment 410-B) as adopted for use by the Division. For American Indian Health Program (AIHP), the request must be submitted to the Division’s Health Care Services through the Division’s Compliance Unit using secure email to the Division’s Health Care Services at dddddqaudits@azdes.gov and copying dddaltcscs@azdes.gov or by mailing it to the address indicated below.

- AHCCCSSEPSDT Maternal Child Health Manager in the Division’s Health Care Services Clinical Quality Management Unit/MCH Manager

  Mail Drop 2C91
  3443 N. Central Ave. Phoenix,
  AZ 85012P

No supplemental payment is provided for labor and delivery services rendered during the prior period coverage timeframe, or if the member was not assigned to the AdSS at the time labor and delivery services were rendered.
AdSS requests for the payment must be made within four months of the delivery date, unless an exemption is granted by the Division’s Chief Medical Officer or Medical Director through the Health Care Services Unit. Exemptions will be considered on a case-by-case basis.

8. Pregnancy Termination (including Mifepristone [Mifeprex or RU-486])
   
a. Pregnancy termination is covered if one of the following criteria is present:
   
i. The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
   
   ii. The pregnancy is a result of incest.
   
   iii. The pregnancy is a result of rape.
   
   iv. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health condition for the pregnant member by:
      
      • Creating a serious physical or behavioral health condition for the pregnant member.
      
      • Seriously impairing a bodily function of the pregnant member.
      
      • Causing dysfunction of a bodily organ or part of the pregnant member.
      
      • Exacerbating a health condition of the pregnant member.
      
      • Preventing the pregnant member from obtaining treatment for a health condition.
   
   b. Acknowledgement
      
The attending physician must acknowledge that a pregnancy termination was necessary based on the above criteria by submitting the AHCCCS Certificate of Necessity for Pregnancy Termination (AMPM Attachment 410-C) and supporting clinical documentation to the Division.
      
The certificate must be submitted to the Division’s Chief Medical Officer or designee for enrolled pregnant members eligible for ALTCS. The Certificate must certify that, in the physician’s professional judgment, one or more of the above criteria have
been met.

c. Additional Required Documentation

i. A written informed consent must be obtained by the provider and kept in the member’s chart for all pregnancy terminations. If the pregnant member is younger than 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. 14-5101), a dated signature of the pregnant member's parent or legal guardian indicating approval of the pregnancy termination procedure is required.

ii. When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number (if available), and the date the report was filed. This documentation requirement must be waived if the treating physician certifies that, in his or her professional opinion, the member was unable, for physical or psychological reasons, to comply with the requirement.

d. Additional Considerations Related to Use of Mifepristone

i. Mifepristone (also known as Mifeprex or RU-486) is not a post-coital emergency oral contraceptive. The administration of Mifepristone for the purposes of inducing intrauterine pregnancy termination is covered when a minimum of one required criterion is met for pregnancy termination, as well as the following conditions specific to Mifepristone:

• Mifepristone can be administered through 49 days of pregnancy.

• If the duration of pregnancy is unknown or if ectopic pregnancy is suspected, ultrasonography should be used for confirmation.

• Any Intrauterine Device (“IUD”) should be removed before treatment with Mifepristone begins.

• 800µ of Misoprostol must be given two days after taking Mifepristone unless a complete pregnancy termination has already been confirmed.

• Pregnancy termination by surgery is recommended in cases when Mifepristone and Misoprostol fail to induce termination of the pregnancy.
ii. When Mifepristone is administered, documentation of the following is also required:

- Duration of pregnancy in days
- The date IUD was removed if the member had one
- The date Mifepristone was given
- The date Misoprostol was given
- That pregnancy termination occurred.

e. Pregnancy Termination Monthly Report

Note: The AdSS must submit a standardized AHCCCS Monthly Pregnancy Termination Report (AMPM Attachment 410-E), as adopted for use by the Division, to Division’s Health Care Services Unit, which documents the number of pregnancy terminations performed during the month (including pregnancy terminations resulting from the use of Mifepristone). If no pregnancy terminations were performed during the month, the monthly report must still be submitted to attest to that information.

When pregnancy terminations have been authorized by the AdSS, the following information must be provided with the monthly report:

i. A copy of the completed AHCCCS Certificate of Necessity for Pregnancy Termination (AMPM Attachment 410-C), which has been signed by the AdSS’s Medical Director

ii. A copy of the completed AHCCCS Verification of Diagnosis by Contractor for a Pregnancy Termination Request (AMPM Attachment 410-D) confirming requirements for pregnancy termination have been met

iii. A copy of the official incident report, in the case of rape or incest unless the physician certifies in her or her professional opinion the member was unable for physical or psychological reasons to comply with the requirement to report the rape and/or incest to authorities

iv. A copy of documentation confirming pregnancy termination occurred

v. A copy of the clinical information supporting the justification/necessity for pregnancy termination.
f. Prior Authorization (PA)

Except in cases of medical emergencies, the provider must obtain a PA for all covered pregnancy terminations from the Division’s Chief Medical Officer or designee. All PA requests must include:

i. AHCCCS Certificate of Necessity for Pregnancy Termination (AMPM Attachment 410-C)

ii. TAHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request (AMPM Attachment 410-D)

iii. Any lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination.

The AdSS, or the Division for members eligible for AIHP, must contact the provider to confirm the qualifying diagnosis/condition within 24 hours of receiving the PA request for a pregnancy termination and must include a signature attesting that an authorization decision was made after contact with the provider to determine that the member had the qualifying diagnosis/condition and the supporting documentation had been received. The Division’s Chief Medical Officer or designee will review the PA request, the AHCCCS Certificate of Necessity for Pregnancy Termination, and the AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request forms and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Division for members eligible for AIHP or the AdSS PA Unit within two working days of the date on which the pregnancy termination procedure was performed.
411 WOMEN’S PREVENTATIVE CARE SERVICES

REVISION DATE: 7/3/2019
EFFECTIVE DATE: May 27, 2016

Annual well-woman preventative care visit(s) are a covered benefit for women to obtain the recommended preventive services, including preconception counseling.

A well-woman preventative care visit is covered on an annual basis when clinically indicated.

A. Well-Woman Preventative Care Services include:

1. Human Papillomavirus (HPV) vaccine – An immunization for a sexually transmitted infection available for both males and females beginning at a recommended age of 11 through 26 years of age (age 9 or 10 if in a high-risk situation).

2. Family Planning Counseling - The provision of accurate information and discussion with a health care provider to allow members to make informed decisions about the specific family planning methods available that align with the member’s lifestyle.

3. Mammogram - An x-ray of the breast used to look for early signs of breast cancer. Coverage does not include genetic testing.

4. Clinical Breast Exam - A physical examination of the breasts by a health care provider used as a primary diagnostic procedure for early detection of breast cancer.

5. Preconception Counseling – Counseling aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive.
   a. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception.
   b. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.
   c. Does not include genetic testing.

6. Well Exam - A physical examination in the absence of any known disease, symptom, or specific medical complaint by the member precipitating the examination.

B. Requirements for Well-Woman Preventative Care Services:

1. The Division’s contracted health plans are responsible for covering Well-Woman Preventative Care Services for Division members enrolled in one of
2. The Division covers Well-Woman Preventative Care Services for Division members enrolled in the American Indian Health Plan (AIHP).
Family planning services, when provided by physicians or practitioners, are covered for male and female members who voluntarily choose to delay or prevent pregnancy. Family planning services include covered medical, surgical, pharmacological, and laboratory benefits specified in this policy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available, as discussed below in section A.1. Members enrolled with a health plan may choose to obtain family planning services and supplies from any appropriate provider with the Administrative Subcontractors (AdSS) network. Members enrolled with American Indian Health Program (AIHP) may select any AHCCCS-registered provider.

Members whose eligibility continues, may remain with their assigned maternity provider or exercise their option to select another provider for family planning services.

A. Covered family planning services for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices [IUDs] and subdermal implantable contraceptives):

1. Contraceptive counseling, medication, and/or supplies, including, but not limited to; oral and injectable contraceptives, Long-Acting Reversible Contraceptives (LARC), diaphragms, condoms, foams, and suppositories

2. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning

3. Treatment of complications resulting from contraceptive use, including emergency treatment

4. Natural family planning education or referral to qualified health professionals

5. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (Mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception)

6. Sterilization

Clarification Related to Hysteroscopic Tubal Sterilization

- Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy.

- At the end of the three months, it is expected that a Hysterosolpingogram will be performed confirming that the member is sterile. After the confirmatory test the member is considered sterile.
B. Coverage for the following family planning services are as follows:

1. Pregnancy screening is a covered service.
2. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions.
3. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for both male and female members.
4. Sterilization services are covered for both male and female members when the requirements specified in this policy for sterilization services are met (including hysteroscopic tubal sterilizations).
5. Pregnancy termination is covered only as specified in Division Medical Policy 410 (including Mifeprsitone [Mifeprex or RU-486]).

C. Limitations

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

1. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility.
2. Pregnancy termination counseling.
3. Pregnancy terminations except as specified in Division Medical Policy 410 [including Mifeprsitone (Mifeprex or RU-486)].
4. Hysterectomies for the purpose of sterilizations.

**AdSS Requirements for Providing Family Planning Services**

The AdSS must ensure that service delivery, monitoring, and reporting requirements are met. The AdSS must:

A. Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available and how to request them. Notification must be in accordance with A.R.S. §36.2904(L). The information provided to members must include, but is not limited to:

1. A complete description of covered family planning services available.
2. Information advising how to request/obtain these services.
3. Information that assistance with scheduling is available.
4. A statement that there is no charge for these services.

B. Have policies and procedures in place to ensure that maternity care providers are educated regarding covered and non-covered services, including family planning services available to members.
C. Have family planning services that are:
   1. Provided in a manner free from coercion or behavioral/mental pressure
   2. Available and easily accessible to members
   3. Provided in a manner which assures continuity and confidentiality
   4. Provided by, or under the direction of, a qualified physician or practitioner
   5. Documented in the medical record. In addition, documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning services.

D. Incorporate medical audits for family planning services with quality management activities to determine conformity with acceptable medical standards.

E. Establish quality/utilization management indicators to effectively measure/monitor the utilization of family planning services.

F. Have written practice guidelines that detail specific procedures for the provision of LARC. (For more information on LARC, see “Arizona DRG Payment Policies” on the AHCCCS website at www.azahcccs.gov). These guidelines must be written in accordance with acceptable medical standards.

G. Implement a process to ensure that, prior to insertion of intrauterine and subdermal implantable contraceptives, the maternity care provider has provided proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include a statement to the member indicating if the implant is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.

Protocol for Member Notification of Family Planning Services and AdSS Reporting Requirements

The AdSS is responsible for providing family planning services and notifying members regarding the availability of covered services. The AdSS must establish processes to ensure the sterilization reports specified in this policy comply with the procedural guidelines for encounter submissions. The Division will notify all members eligible under the category of pregnant woman, who become ineligible for DD-long term care.

AdSS will provide information about covered family planning services to include:

A. Member notification of these covered services must meet the following minimum requirements:
   1. In accordance with A.R.S. §36-2904(L), AdSSs must notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them, and a plan to deliver those services to members who request them. Notification must include provisions for written notification,
other than the member handbook, and verbal notification during a member’s visit with the member’s primary care physician or primary care practitioner.

2. Notification of family planning services must include provision for written notification in addition to the Member Handbook and the member newsletter. Communications and correspondence dealing specifically with notification of family planning services are acceptable methods of providing this information. The communications and correspondence must be approved by the Division and conform to confidentiality requirements.

3. Notification is to be given at least once a year and must be completed by November 1st. For members who enroll with the AdSS after November 1st, notification must be sent at the time of enrollment.

4. Notification must include all of the covered family planning services as well as instructions to members regarding how to access these services.

5. As with other member notifications, notification must be written at an easily understood reading level.

6. Notification must be presented in accordance with cultural competency requirements as specified in ACOM Policy 405.

7. The AdSS must monitor compliance to ensure the Maternity Care Providers verbally notify members of the availability of family planning services during office visits.

8. The AdSS must report all members under 21 years of age, undergoing a procedure that renders the member sterilized, using the AHCCCS Sterilization Reporting Form for Members under 21 Years of Age (AMPM Attachment 420 B) as adopted for use by the Division. Documentation supporting the medical necessity for the procedure shall be submitted with the reporting form.

**AIHP Requirements for Family Planning Services**

**A.** Fee-for-service providers of family planning services must:

1. Comply with AHCCCS Division of FFS Management PA requirements for prescriptions and/or related family planning supplies.

2. Make referrals to appropriate medical professionals for services that are beyond the scope of family planning services. Such referrals are to be made at the family planning provider's discretion. If the member is eligible for full health care coverage, the referral must be made to an AHCCCS registered provider.

**Sterilization**

The following requirements regarding member consent for sterilization services apply to AdSSs (For more information refer to 42 CFR 50.203 and 204).

**A.** The following criteria must be met for the sterilization of a member to occur:
1. The member is at least 21 years of age at the time the consent is signed (AMPM Attachment 420-B).

2. The member has not been declared mentally incompetent.

3. Voluntary consent was obtained without coercion.

4. Thirty days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery or emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

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

1. Consent form requirements (Refer to 42 CFR. 50.204),

2. Answers to questions asked regarding the specific procedure to be performed,

3. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits,

4. Advice that the sterilization procedure is considered to be irreversible,

5. A thorough explanation of the specific sterilization procedure to be performed,

6. A description of available alternative methods,

7. A full description of the discomforts and risk that may accompany or follow the performing of the procedure, including an explanation of the types and possible effects of any anesthetic to be used,

8. A full description of the advantages or disadvantages that may be expected as a result of the sterilization,

9. Notification that sterilization cannot be performed for at least 30 days post consent.

C. Sterilization consents may not be obtained when a member:
1. Is in labor or childbirth,

2. Is seeking to obtain, or is obtaining, a pregnancy termination,

3. Is under the influence of alcohol or other substances that affect that member’s state of awareness.
430 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

EFFECTIVE DATE: June 30, 1994

Purpose

The purpose of Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) is to ensure the availability and accessibility of health care resources as well as to assist Division members in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, Early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for Division members less than 21 years of age.

EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral health conditions for Division 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. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

An EPSDT program is critical for ensuring that children and adolescents receive appropriate preventive, dental, physical, behavioral health, developmental, and specialty services. EPSDT includes but is not limited to; coverage of inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical equipment, medical appliances and medical supplies, orthotics, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes 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 focuses on continuum of care by assessing health needs, providing preventive Screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow-up.

Policy

The EPSDT/Well Child visit is all-inclusive and includes the following:

A. A comprehensive health and Developmental history, including growth and Developmental Screening which includes physical, nutritional, and behavioral health assessments. Refer to the Centers for Disease Control and Prevention website: www.cdc.gov/growthcharts/for Body Mass Index (BMI) and growth chart resources.

B. Nutritional Screening provided by a PCP.
C. Nutritional Assessment provided by a PCP

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

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

3. 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.

4. The 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.

5. To initiate the referral for a nutritional assessment, the PCP shall use the AdSS referral.

6. If a Division member qualifies for nutritional therapy due to a medical condition, the AdSS is the primary payor for the following:

   a. Infant formulas above the amount provided through the Women, Infants and Children (WIC) program or formula types deemed medically necessary that are not provided through the WIC program. This does not include formulas outside of those offered through the WIC program that are not medically necessary, such as formula types selected based on brand preference.

   b. For Division members under the age of five, requiring formula types deemed medically necessary that are not provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Attachment C) is to be submitted directly to the AdSS, as WIC is considered a secondary payor of specialty exempt formulas.

   c. For Division members, infants (0-1 year), requiring infant formulas above the amount provided through the WIC program, an AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (Attachment C) is to be submitted directly to the AdSS for the amount of formula that exceeds that provided through the WIC program.

D. Behavioral Health Screening and Services provided by a PCP

1. The Division covers behavioral health services for members eligible for EPSDT. PCPs may provide behavioral health services within their scope of practice.

2. American Indian members may receive behavioral health services through an Indian Health Service or Tribally operated 638 facility, regardless of health plan enrollment or behavioral health assignment.
3. Developmental Surveillance shall be performed with the PCP at each EPSDT visit.

E. Developmental Screening

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

2. PCP’s shall use Approved Developmental Screening tools. PCPs shall be trained in the use and scoring of the Developmental Screening tools, as indicated by the American Academy of Pediatrics. A list of available training resources may be found in the Arizona Department of Health Services website: www.azdhs.gov/clinicians/training-opportunities/developmental/index.php.

3. The Developmental Screening shall be completed for EPSDT members from birth until three years of age during the nine month, 18 month, and 24 month EPSDT visits.

4. A copy of the Developmental Screening tool shall be kept in the medical record.

5. Use of Approved Developmental Screening tools may be billed separately using CPT-4 code 96110 (Developmental Screening, with interpretation and report, per standardized instrumentation).

6. Other CPT-4 codes, such as: 96111 (Developmental Testing (includes assessment of motor, language, social, adaptive)) are not considered Screening tools and are not separately billable.

7. Only for the nine month, 18 month and 24 month visit when the Developmental Screening tool is used, may the modifier “EP” be added to the 96110. For all claims to be eligible for payment of code 96110: the provider shall have satisfied the training requirements, the claim shall be a nine, 18, or 24-month EPSDT visit, and an Approved Developmental Screening tool shall have been completed (see h. below). In addition, only for these EPSDT visits may the 96110 code be used twice for the same visit when the clinical circumstances warrant more than one tool is used during the visit.

8. Approved Developmental Screening tools include:

   a. The Parent’s Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org. (Age range: Birth to 8 years of age).

   b. Ages and Stages Questionnaire (ASQ) tool which may be obtained from www.agesandstages.com. (Age range: Birth to 5 years of age).

   c. The Modified Checklist for Autism in Toddlers (M-CHAT-r) may be used only as a Screening tool by a primary care provider, for members 15-30 months of age, to screen for autism when medically indicated. (Age range: 15 to 30 months).
F. A comprehensive unclothed physical examination.

G. Immunizations

1. EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules.

2. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier). Combination vaccines are paid as one vaccine.

3. Providers shall be registered as Vaccines for Children (VFC) providers and VFC vaccines shall be used.

4. The Division will cover the Human Papilloma Virus (HPV) vaccine for female and male EPSDT member’s age 11 to 21 years of age and Division members nine and 10 years of age if the member is deemed to be in a high-risk situation. For those members, whose HPV schedule is not completed by age 22 years, completion of the schedule will be covered when determined to be medically necessary.

H. Laboratory tests including blood lead Screening

1. Laboratory including blood lead Screening assessment and blood lead testing appropriate to age and risk, anemia testing and Diagnostic testing for sickle cell trait.

2. EPSDT covers blood lead Screening for all members at 12 months and 24 months of age and for those members between the ages of 24 and 72 months 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 parental concerns. Additional Screening for children under six year of age is based on the child’s risk as determined by either the member’s residential zip code or presence of other known risk-factors.

3. Payment for laboratory services that are not separately billable and considered part of the payment made for the EPSDT visit include but are not limited to: 99000, 36415, 36416, 36400, 36406 and 36410. In addition, payment for all laboratory services shall be in accordance with limitations or exclusions specified in Contractor’s contract with the providers.

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

J. Oral Health Screening

A. 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.
B. Application of fluoride varnish may be billed separately from the EPSDT visit using CPT Code 99188.

C. Fluoride varnish is limited in a primary care provider’s office to once every six months, during an EPSDT visit for children who have reached six months of age with at least one tooth erupted, with recurrent applications up to two years of age.

K. Appropriate vision, hearing, and speech Screenings

1. EPSDT covers eye examinations as appropriate to age per the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools.

2. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP’s office during an EPSDT visit, are considered part of the EPSDT visit and are not separately billable services.

3. Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children ages three to six 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. This procedure, although completed during the EPSDT visit, is a separately billable service and is eligible for a one-time only enhanced reimbursement (use 99177-EP on claim form).

4. Automated visual Screening, described by CPT code 99177, is for vision Screening only, and not recommended for or covered when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

5. Vision CPT codes with the EP modifier shall be listed on the claim form in addition to the preventive medicine CPT codes for visit Screening assessment. Except for CPT code 99177, no additional reimbursement is allowed for these codes.

6. 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.

7. Hearing CPT codes with the EP modifier shall be listed on the claim form, in addition to the preventive medicine CPT codes, for a Periodic Hearing Screening assessment. Except for CPT code 99177, no additional reimbursement is allowed for these codes.

L. Tuberculosis (TB) Screening

1. Tuberculin skin testing as appropriate to age and risk.
Sick Visit Performed in Addition to an EPSDT

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

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

B. The “sick visit” is documented on a separate note.

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

History, Exam, and Medical Decision Making components of the separate “sick visit” already performed during an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215). An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management 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.

AdSS Requirements

A. Implement processes to ensure age appropriate Screening and care coordination when member needs are identified.

B. Ensure providers utilize Approved Standard Developmental Screening tools and complete training in the use of these tools, as indicated by the American Academy of Pediatrics. AdSS shall monitor providers and implement interventions for non-compliance.

C. Develop policies and procedures to identify the needs of EPSDT age members, inform members of the availability of EPSDT services, coordinate their care, provide care management, conduct appropriate follow-up, and ensure members receive timely and appropriate treatment.

D. Develop policies and procedures to monitor, evaluate, and improve EPSDT participation.

E. Ensure members receive required health Screenings in compliance with the contract.

F. Ensure that the Bloodspot Newborn Screening Panel hearing and, if indicated, bilirubin Screening tests are conducted, including initial and secondary Screenings.

G. Ensure that providers report blood lead levels equal to or greater than 10 micrograms of lead per deciliter of whole blood to ADHS (A.A.C. R9-4-302). AdSS shall implement protocols for the following:
1. Care coordination for members with elevated blood lead levels (e.g. parents, PCP and ADHS) to ensure timely follow-up and retesting,

2. Case management is required for all children with a level of 10 micrograms per deciliter or greater, or per current CDC recommendations. Case management shall align with CDC’s recommendations for actions based on blood lead level and ADHS recommendations,

3. Appropriate care coordination for an EPSDT child who has an elevated blood lead level and is transitioning to or from another AdSS.

4. Referral of members who lose eligibility to low-cost or no-cost follow-up testing and treatment for those members that have a blood lead test result equal to or greater than ten micrograms of lead per deciliter of whole blood.

H. Ensure that:

1. Each hospital or birthing center screens all newborns using a physiological hearing screening method prior to initial hospital discharge.

2. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening shall be scheduled at the time of the initial discharge and completed between two and six weeks of age.

3. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family shall be referred to the PCP for appropriate assessment, care coordination and referral(s).

4. All infants with confirmed hearing loss receive services before turning six months of age.

I. Implement protocols for care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment, if medically necessary.

J. Employ sufficient numbers of appropriately qualified local personnel to meet the health care needs of members and fulfill Federal and State EPSDT requirements, as well as achieve contractual compliance.

K. Inform all participating PCPs about EPSDT requirements and monitor compliance with the requirements. This shall include informing PCPs of Federal, State, AHCCCS, and Division requirements for EPSDT and updates of new information as it becomes available, and ensuring PCPs providing care to children are trained to use implemented Developmental Screening tools. This shall also include a process to monitor the utilization of Approved Developmental Screening tools.

L. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the AdSS. This information shall include:

1. The benefits of preventive health care.

2. Information that an EPSDT visit is a Well Child visit.
Division of Developmental Disabilities  
Medical Policy Manual  
Chapter 400  
Medical Policy for Maternal and Child Health  

3. A complete description of the services available as described in this section.

4. Information on how to obtain these services and assistance with scheduling appointments.

5. Availability of care management assistance in coordinating EPSDT covered services.

6. A statement that there is no copayment or other charge for EPSDT Screening and resultant services.

7. A statement that assistance with medically necessary transportation and scheduling appointments is available to obtain EPSDT services.

M. Conduct written and other member educational outreach related to immunizations, available community resources (e.g. WIC, AzEIP, CRS, Behavioral Health, Head Start), dangers of lead exposure and recommended/mandatory testing, childhood obesity and prevention measures, age appropriate risk prevention efforts (addressing injury and suicide prevention, bullying, violence, and sexual behavior and development), education on importance of utilizing primary care provider in place of ER visits for non-emergent concerns, recommended periodicity schedule, and other Contractor selected topics at a minimum of once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic shall be covered during the 12-month period. EPSDT related outreach material, shall include a statement informing members that an EPSDT visits is synonymous to a Well Child visit.

N. Provide EPSDT information accordance with the requirements.

O. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AzEIP, and Head Start.

P. Develop and implement processes to ensure the identification of members needing care management services and the availability of care management assistance in coordinating EPSDT covered services.

Q. Participate in community and/or quality initiatives, to promote and support best local practices and quality care.

R. Attend EPSDT related meetings when required by the Division.

S. Coordinate with other entities when the AdSS determines a member has third party coverage.

T. Develop, implement, and maintain a procedure for ensuring timeliness and care coordination of re-screening and treatment for all conditions identified, including behavioral health services, because of examination, Screening, and diagnosis. Treatment, if required, shall occur on a timely basis, generally initiating services no longer than six months beyond the request for Screening services, unless stated otherwise in this Policy.
U. Develop, implement, and maintain a process to provide appropriate follow-up care for members who have abnormal blood lead test results.

V. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules, Attachment A) by all contracted providers.

W. Develop and implement a process for monitoring that providers use the most current EPSDT Periodicity Schedule at every EPSDT visit and that all age appropriate Screenings and services are conducted during each visit.

X. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. Processes other than mailings shall be pre-approved by the Division. This procedure shall include:

1. Notification to members or responsible parties regarding due dates of each EPSDT visit. If an EPSDT visit has not taken place, a second written notice shall be sent.

2. Notification to members or responsible parties regarding due dates of biannual (one visit every six months) dental visits. If a dental visit has not taken place, a second notice shall be sent.

Y. Develop and implement processes to reduce no-show appointment rates for EPSDT services.

Z. Provide targeted outreach to those members who did not show for appointments.

AA. Encourage providers to schedule the next EPSDT Screening at the current office visit, particularly for children 24 months of age and younger.

BB. Ensure providers enroll and re-enroll annually with the VFC program.

1. AdSS shall not utilize Division funding to purchase vaccines covered through the VFC program for members younger than 19 years of age.

2. AdSS shall ensure providers document each EPSDT age member’s immunizations in the Arizona State Immunization Information System (ASIIS) registry. In addition, AdSS shall ensure providers maintain the ASIIS immunization records of each EPSDT member in ASIIS and monitor provider’s compliance with immunization registry reporting requirements and act to improve reporting when issues are identified.

CC. Submit the EPSDT and Adult Monitoring Report to the Division as specified in Contract describing the activities of the quarter and the progress made in reaching the established goals of the plan. The Report shall include documentation of monitoring and evaluation of EPSDT requirements, and implementation of improvement processes. The Report shall include results of ongoing monitoring of performance rates, in a format that will facilitate comparison of rates to identify possible need for interventions to improve or sustain rates. The report shall also identify the established goals. Refer to AMPM Appendix A for DDD report template and requirements/ instructions.
DD. Participate in an annual review of EPSDT requirements conducted by the Division, including but not limited to; results of on-site visits to providers and medical record audits.

EE. Include language in PCP contracts that requires PCPs to:

1. Provide EPSDT services for all assigned members from birth up to 21 years of age. Services shall be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.

2. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements.

3. Implement protocols to ensure that health problems are diagnosed and treated Early, before they become more complex and the treatment more costly (including follow-up related to blood lead Screening and tuberculosis Screening).

4. Have a process for to assisting members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure that members receive appropriate support services.

5. Implement protocols for coordinating care and services with the appropriate state agencies for EPSDT members, and ensure that members are referred to support services, as well as other community-based resources to support good health outcomes.

6. Refer eligible members to Head Start and the special supplemental nutrition program for WIC, for WIC approved formula and support services. Ensure that medically necessary nutritional supplements are covered.

7. Utilize the criteria specified in this Policy when requesting medically necessary nutritional supplements.

8. Coordinate with the Division’s Arizona Early Intervention Program (AzEIP) for children 0-3 years of age.

9. Require providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member’s AzEIP enrollment.

FF. Provide education and assistance with referrals of eligible members to the special supplemental nutrition program for WIC, for WIC approved formula and support services, and ensure medically necessary nutritional supplements are covered.

GG. Provide education and assist with referrals of eligible members to Head Start to ensure eligible members receive appropriate EPSDT services to optimize child health and development.

HH. Coordinate with behavioral health services agencies and providers to ensure continuity of care for members who are receiving or are eligible to receive behavioral health services. Behavioral health services are delivered in accordance with
guidelines that incorporate evidence-based “best practices. AdSS must implement 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for EPSDT age members.

II. Develop guidelines for use by the PCP in providing the following:

1. Information necessary to obtain PA for commercial oral nutritional supplements.

2. Encouragement and assistance to the parent/guardian in weaning the member from the necessity for supplemental nutritional feedings.

3. Education and training, if the member’s parent/guardian elects to prepare the member’s food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member.

JJ. Implement protocols for transitioning a child who is receiving nutritional therapy, to or from another AdSS or another service program (e.g. WIC).

KK. Implement a process for verifying medical necessity of nutritional therapy through the receipt of supporting medical documentation dated within three months of the request, prior to giving initial or ongoing authorizations for nutritional therapy. Documentation shall include clinical notes or other supporting documentation from the member’s PCP, specialty provider, or registered dietitian, including a detailed history and thorough physical assessment that provides evidence of member meeting all the required criteria.

**AdSS Requirements for the EPSDT Plan and Evaluation**

AdSS shall have a written EPSDT Plan and Evaluation that addresses minimum requirements as specified above as well as the objectives of the EPSDT program that are focused on achieving requirements. It shall also incorporate monitoring and evaluation activities for these minimum requirements. The EPSDT Plan and Evaluation shall be submitted as specified in Contract and is subject to Division approval. The EPSDT Plan and Evaluation shall contain, at a minimum, the following:

A. **EPSDT Narrative Plan**

A written description of all planned activities to address the minimum requirements for EPSDT services, as specified above, including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral health problems for Division members under the age of 21. The narrative description shall also include activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate treatment is received in a timely manner.

B. **EPSDT Plan Evaluation**

An evaluation of the previous year’s Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.
C. EPSDT Plan that includes:

1. Specific measurable objectives. These objectives shall be based on AHCCCS established Minimum Performance Standards. In cases where AHCCCS Minimum Performance Standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts will be used (e.g. National Committee on Quality Assurance, Healthy People 2020 standards). Contractors may also develop their own specific measurable goals and objectives aimed at enhancing the EPSDT program when Minimum Performance Standards have been met. Objectives shall include a focus toward blood lead testing and follow-up for abnormal blood lead test levels identified, childhood obesity, care coordination efforts, and member utilization.

2. Strategies and specific measurable interventions to accomplish objectives (e.g. member outreach, provider education and provider compliance with mandatory components of the EPSDT program).

3. Targeted implementation and completion dates of Plan activities.

4. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective.

5. Identification and implementation of new interventions, continuation of, or modification to existing interventions, based on quarterly analysis of the previous year’s Plan Evaluation.

D. All relevant current EPSDT policies and procedures shall be submitted as separate attachments.

Provider Requirements

EPSDT services shall be provided according to community standards of practice and Division rules and policies including the AHCCCS EPSDT and Dental Periodicity Schedules.

- 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 for managed care members and to the Division for AIHP members, regarding (Prior Authorization) PA requirements.

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

A. Immunizations

1. All appropriate immunizations shall be provided according to the Advisory Committee on Immunization Practices Recommended Schedule.
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/guardian/designated representative’s decision not to utilize EPSDT services or receive immunizations.

2. Providers shall coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program in the delivery of immunization services.

B. Blood Lead Screening

1. 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.

2. Anticipatory guidance to provide an environment safe from lead, shall still be included as part of each EPSDT visit from six to 72 months of age.

3. 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.

C. Organ and Tissue Transplantation Services

Refer to AMPM Policy 310-DD I for information regarding AHCCCS-covered transplants.

D. Metabolic Medical Foods

If a Division 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 AMPM Policy 310-GG.

E. Nutritional Therapy

1. The Division 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.

2. PA is required from the AdSS or Tribal ALTCS Case Manager or The Division for AIHP members for Commercial Oral Supplemental Nutrition, unless the member is also currently receiving nutrition through Enteral Nutrition or TPN Therapy.

a. 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. The PCP or specialty
provider shall use the approved form to obtain authorization from the AdSS or Tribal ALTCS Case Manager or the Division for AIHP members.

i. Below criteria must be met when assessing the medical necessity of providing commercial oral nutritional supplements:

- The member has been diagnosed with a chronic disease or condition, or
- The member is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis or per evidence-based guidance as issued by the American Academy of Pediatrics, and
- There are no alternatives for adequate nutrition.

OR

ii. At least two of the following criteria have been met for the basis of establishing medical necessity:

- The member 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,
- The member has reached a plateau in growth and/or nutritional status for more than six months, or more than three months if member is an infant less than one year of age,
- The member has already demonstrated a medically significant decline in weight within the three-month period prior to the assessment.
- The member can consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

iii. Additionally, the following requirements shall be met:

- The member has been evaluated and treated for medical conditions that may cause problems with growth (e.g. feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems), and
- The member has had a trial of higher caloric foods, pureed foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. If it is determined through clinical documentation and other supporting evidence that a
A trial of higher caloric foods would be detrimental to the member’s overall health, the provider may submit 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 PA request.

iv. Supporting documentation shall accompany Attachment B. This documentation shall demonstrate that the member meets all the required criteria and includes:

- **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 three months of the request, providing a detailed history and thorough physical assessment demonstrating evidence of member meeting all the required criteria, as indicated on Attachment B. The physical assessment shall 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 to boost caloric intake and/or change food consistencies that have proven unsuccessful in resolving the nutritional concern identified, as well as member adherence to the prescribed dietary plan/alternatives attempted.

- **Ongoing Requests**
  - Subsequent submissions shall include a clinical note or other supporting documentation dated within three months of the request that includes the member’s overall response to supplemental therapy and justification for continued supplement use. This shall 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).
v. Members receiving nutritional therapy shall 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 parent/guardian in weaning the member from supplemental nutritional feedings should be included, when appropriate. When requesting initial or ongoing PA for commercial oral nutritional supplements, providers shall ensure the following:

- Documents are submitted with the completed Attachment B to support all the necessary requirements for Commercial Oral Nutritional Supplements as detailed above.
- If the member's parent/guardian elects to prepare the member's food, education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member is provided.
- Ongoing monitoring is conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and determine necessary adjustments to the prescribed amount of supplement are appropriate based on the member’s weight loss/gain.
- Documentation demonstrating encouragement and assistance provided to the parent/guardian in weaning the member from the necessity for supplemental nutritional feedings, when appropriate.

F. 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.

G. Cochlear and Osseointegrated Implantation

1. 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 postlingual. The Division 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:

a. 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.

b. 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.

c. No known contraindications to surgery.

d. Demonstrated age appropriate cognitive ability to use auditory clues.

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

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

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

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

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

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

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

f. Surgical implantation and related services,

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

h. 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.
i. Cochlear implantation requires PA from the Contractor Medical Director, or from the AHCCCS Medical Director or designee for FFS members.

3. Osseointegrated implants (Bone Anchored Hearing Aid [BAHA])

Division 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, or from the Division Medical Director or designee for AIHP members. Maintenance of the Osseointegrated implants is the same as described above for cochlear implants.

H. Conscious Sedation

The Division covers conscious sedation for members receiving EPSDT services.

I. Behavioral Health Services

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

J. Religious Non-Medical Health Care Institution Services

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

K. Care Management Services

The Division 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.

L. Chiropractic Services
The Division 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.

M. Personal Care Services

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

N. Incontinence Briefs

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

1. The member is over three years and under 21 years of age.
2. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder.
3. The PCP or attending physician has issued a prescription ordering the incontinence briefs.
4. 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.
5. The member obtains incontinence briefs from vendors within the Contractor’s network.
6. PA has been obtained as required by the Division, AdSS, or AdSS designee. 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:
   a. The member is over three years and under 21 years of age.
   b. The member has a disability that causes incontinence of bladder and/or bowel.
   c. 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 Contractor.
   d. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
7. The Division shall provide incontinence briefs for members who are between 3 and 21 years of age who are:
a. Group home residents that do not qualify for Medicaid (ALTCS or targeted).

b. Group home residents that qualify for Medicaid (ALTCS) and have been denied incontinence briefs by the assigned health plan and other medical insurance coverage (e.g., Medicare), if applicable.

8. Incontinence briefs will not be covered by Children’s Rehabilitative Services (CRS).

9. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

10. If a member is eligible for AIHP members, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

11. Any exceptions to this policy section must have the approval of the Assistant Director.

12. For information regarding incontinence briefs for members over the age of 21 see the Division Medical Policy Manual, 310-P, Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services.)

O. Medically Necessary Therapies

The Division 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. For children identified by the PCP as needing Early intervention services, AdSS are required to provide services in the natural environment whenever possible.

Claim Forms

Claims for EPSDT services shall be submitted on a CMS (formerly HCFA) 1500 form. Providers shall bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381–99385, 99391–99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in this Policy. Except for those items listed above as separately reimbursable services, no additional reimbursement is allowed. Providers shall use an EP modifier to designate all services related to the EPSDT Visit/Well Child visit, including routine vision and hearing Screenings.

431  ORAL HEALTH CARE (EPSDT-AGE MEMBERS)

EFFECTIVE DATE: November 22, 2017
REFERENCES: 9 A.A.C. 22, Article 2; A.R.S. § 14-5101; AMPM Exhibits 400-1, 400-2C, 430-1 and 431-1

This policy applies to members under 21 years of age eligible for ALTCS (Early Periodic Screening, Diagnosis, and Treatment [EPSDT]). As part of the physical examination, the physician, physician’s assistant, or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but it is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist must be made.

Appointment Standards

Emergent: Within 24 hours of request
Urgent: Within three days of request
Routine: Within 45 days of request

An oral health screening must be part of an EPSDT screening conducted by a Primary Care Provider (PCP). However, it does not substitute for examination through direct referral to a dentist. PCPs must refer members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member’s medical record.

PCPs who have completed the AHCCCS required training may be reimbursed for fluoride varnish applications completed at the EPSDT visits for members who are at least six months of age with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until member’s second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Application of fluoride varnish by the PCP, does not take the place of a dental (oral health) visit.

AHCCCS-recommended training for fluoride varnish application is located on the Smiles for Life oral health website. Refer to Training Module 6, titled Caries Risk Assessment, Fluoride Varnish, and Counseling. Upon completion of the required training, providers must submit a copy of their certificate to each of the contracted health plans in which they participate, as this is required prior to issuing payment for PCP-applied fluoride varnish. This certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

Additional training resources may be found on the Arizona Department of Health Services website.
Dental Home

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

A. Comprehensive oral health care including acute care and preventive services in accordance with AHCCCS Dental Periodicity Schedule

B. Comprehensive assessment for oral diseases and conditions

C. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment

D. Anticipatory guidance about growth and development issues (e.g., teething, digit, pacifier habits)

E. Plan for acute dental trauma

F. Information about proper care of the child’s teeth and gingivae

This includes the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues.

G. Dietary counseling

H. Referrals to dental specialists when care cannot directly be provided within the dental home

Members must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS Dental Periodicity Schedule (AHCCCS Medical Policy Manual [AMPM] Exhibit 431-1). Members must be referred for additional oral health care concerns requiring additional evaluation and/or treatment.

The AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) identifies when routine referrals begin, however, PCPs may refer EPSDT members for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the Administrative Services Subcontractor's (AdSS’s) provider network.
Covered Services

Members receiving EPSDT and Oral Health services through the Regional Behavioral Health Authority (RBHA) are only covered for members 18 to 21 years of age. All members age out of Oral Health & EPSDT services at age 21.

EPSDT covers the following dental services:

A. Emergency dental services including:
   1. Treatment for pain, infection, swelling and/or injury
   2. Extraction of symptomatic (including pain), infected, and non-restorable primary and permanent teeth, and retained primary teeth (extractions are limited to teeth which are symptomatic)
   3. General anesthesia, conscious sedation, or anxiolysis (minimal sedation; members respond normally to verbal commands), when local anesthesia is contraindicated or when management of the member requires it. (See Division Medical Manual, Policy 430, regarding conscious sedation.)

B. Preventive dental services provided as specified in the AHCCCS Dental Periodicity Schedule (Exhibit 431-1), including but not limited to:
   1. Diagnostic services including comprehensive and periodic examinations
      All AdSSs must allow two oral examinations and two oral prophylaxis and fluoride treatments per member per year (one every six months) for members 12 months to 21 years of age
   2. Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry.
      EPSDT covers panorex films as recommended by the American Academy of Pediatric Dentistry, up to three times maximum per provider for children between the ages of three to 20. Further panorex films needed above this limit must be deemed medically necessary through the AdSS’s Prior Authorization (PA) process.
   3. Preventive services, which include:
      a. Oral prophylaxis performed by a dentist or dental hygienist that includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian
      b. Application of topical fluorides
         The use of a prophylaxis paste containing fluoride or fluoride mouth rinses does not meet the AHCCCS standard for fluoride treatment.
c. Dental sealants for first and second molars (every three years up to 15 years of age, with a two-time maximum benefit)

Additional applications must be deemed medically necessary and require Prior Approval (PA) through the AdSS.

d. Space maintainers when posterior primary teeth are lost and when deemed medically necessary through the AdSS’s PA process.

C. All therapeutic dental services, when they are considered medically necessary and cost effective, but they may be subject to PA by the AdSS (or the Division for AIHP members). These services include, but are not limited to:

1. Periodontal procedures, scaling/root planing, curettage, gingivectomy, and osseous surgery

2. Crowns:
   a. When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth, or
   b. Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 to 21 years of age.

3. Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar)

4. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations, unless the member is 18 to 21 years of age and has had endodontic treatment

5. Restorations of anterior teeth for children under the age of five, when medically necessary

Children, five years and over with primary anterior tooth decay should be considered for extraction, if presenting with pain or severely broken down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider.

6. Removable dental prosthetics, including complete dentures and removable partial dentures.

7. Orthodontic services and orthognathic surgery, only when these services are necessary to treat a handicapping malocclusion.

Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan.
developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

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

a. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services

b. Trauma requiring surgical treatment in addition to orthodontic services

c. Skeletal discrepancy involving maxillary and/or mandibular structures.

Services or items furnished solely for cosmetic purposes are excluded from Division and AHCCCS coverage (9 A.A.C. 22, Article 2).

Provider Requirements

Informed consent is a process by which the dental provider advises the member/member’s parent or legal guardian of the diagnosis, proposed treatment, and alternate treatment methods, with associated risks and benefits of each and the associated risks and benefits of not receiving treatment.

Consents for oral health treatment include:

A. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below (this consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment)

B. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy.

In addition, both parties must review and sign a written treatment plan, as described below, with the member’s parent or legal guardian receiving a copy of the complete treatment plan.

All providers must complete the appropriate consents and treatment plans for members eligible for the Division as listed above, in order to provide quality and consistent care in a manner that protects and is easily understood by the member and/or the member’s parent or legal guardian. Consents and treatment plans must be in writing and signed/dated by both the provider and the member, or the member’s parent or legal guardian, if the member is under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101). Providers must maintain completed consents and treatment plans in the member’s chart, and these charts are subject to audit.
The Division (AIHP Members) and AdSS Requirements

The AdSS must:

A. Conduct annual outreach efforts to members receiving oral health care through school-based or mobile unit providers (in or out of network), to:
   1. Ensure members are aware of their dental home provider and contact information.
   2. Let members know when school-based or mobile unit providers are not accessible, they can receive ongoing-access to care through the dental home provider.

B. Conduct written member educational outreach related to dental home, importance of oral health care, dental decay prevention measures, recommended dental periodicity schedule, and other AdSS-selected topics at least once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the 12-month period.

C. Educate providers in the importance of offering continuously accessible, coordinated, family-centered care.

D. Develop processes to:
   1. Ensure members are enrolled into a dental home by one year of age, to allow for an ongoing provision of comprehensive oral health care. This process should allow members the choice of dental providers from within the AdSS’s provider network and provide members instructions on how to select or change a dental home provider. Members not selecting a dental home provider will be automatically assigned a provider by the AdSS.
   2. Connect all members to a dental home before one year of age or upon assignment to the AdSS, informing members of selected or assigned dental home provider contact information and recommended dental visit schedule.
   3. Monitor member participation with the dental home and provide outreach to members who have not completed visits as specified in the AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1).
   4. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Exhibits 430-1 and 431-1). Processes other than mailings must be preapproved by the Division. This procedure must include notification to members or responsible parties regarding due dates of biannual (once every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.
   5. Monitor provider engagement related to scheduling and follow-up of missed appointments, to ensure care consistent with the recommended AHCCCS...
Dental Periodicity Schedule (Exhibit 431-1) for assigned members.

E. Develop and implement processes to reduce no-show appointment rates for dental services.

F. Provide targeted outreach to those members who did not show for appointments.

The AdSS must encourage all providers to schedule the next dental screening at the current office visit, particularly for children 24 months of age and younger.

G. Require the use of the AHCCCS Dental Periodicity Schedules (Exhibit 431-1) by all contracted providers. The AHCCCS Dental Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

**The Division and the Administrative Services Subcontractors Requirements for the Dental Annual Plan**

Each AdSS must have a written Dental Annual Plan that:

- Addresses minimum requirements as specified in this policy
- Addresses the objectives of the AdSS’s program that are focused on achieving Division requirements
- Incorporate monitoring and evaluation activities for these minimum requirements (see AMPM Exhibit 400-2C, Dental Annual Plan Checklist).

The AdSS must submit the Dental Annual Plan no later than December 15th to the Division’s Healthcare Services Clinical Administrator through the Compliance Unit for review and approval (see AMPM Exhibit 400-1, Maternal and Child Health Reporting Requirements).

The written Dental Annual Plan must contain, at a minimum, the following:

A. Dental Narrative Plan – A written narrative description of all planned activities to address the AdSS’s minimum requirements for dental services, as specified in this policy. The narrative description must also include the AdSS activities to identify member needs and coordination of care, as well as follow-up activities to ensure appropriate treatment is received in a timely manner.

B. Dental Work Plan Evaluation – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

C. Dental Work Plan that includes:
   1. Specific measurable objectives

   These objectives must be based on AHCCCS established Minimum Performance Standards as adopted by the Division. In cases where the Minimum Performance Standards have been met, other generally accepted
benchmarks that continue the Contractor’s improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop its own specific measurable goals and objectives aimed at enhancing the Dental program when Minimum Performance Standards have been met.

2. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education, and provider compliance with mandatory components of the Dental program)

3. Targeted implementation and completion dates of work plan activities

4. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective

5. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation

6. Relevant policies and procedures, referenced in the Dental Annual Plan, submitted as separate attachments.
510 PRIMARY CARE PROVIDERS

EFFECTIVE DATE: May 13, 2016

The Division contracts with health plans and delegates the responsibility of implementing this policy. The Division provides oversight and monitoring of delegated duties.
520 MEMBER TRANSITIONS

EFFECTIVE DATE: April 1, 2016

The Division identifies and facilitates coordination of care for all members during changes or transitions between the Division and other AHCCCS Contractors. The Division receives a daily roster (notification) from AHCCCS which includes a list of members that are being disenrolled from the Division or enrolled with the Division. The Division receives the notification prior to the effective date. The Division uses this notification to identify members and to assist with the transition. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition.

A. Medical conditions or circumstances such as:
   1. Pregnancy (especially women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date)
   2. Major organ or tissue transplantation services which are in process
   3. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other facilities, and/or
   4. Significant medical conditions (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing specialist care and appointments.

B. Members who are in treatment such as:
   1. Chemotherapy and/or radiation therapy, or
   2. Dialysis.

C. Members with ongoing needs such as:
   1. Durable medical equipment including ventilators and other respiratory assistance equipment
   2. Home health services
   3. Medically necessary transportation on a scheduled basis
   4. Prescription medications, and/or
   5. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.
D. Members who at the time of their transition have received prior authorization or approval for:

1. Scheduled elective surgery(ies)
2. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits
3. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period
4. Appointments with a specialist located out of the Contractor service area, and
5. Nursing facility admission.

**Transitions to EPD Contractors**

A. The Division initiates a transition to an EPD Contractor via a Member Change Report indicating the member is no longer eligible for the Division.

B. Upon notification, the Division provides relevant information to the receiving EPD Contractor.

C. The Enrollment Transition Information (ETI) form is transmitted by the Division’s Transition Coordinator for all Division members.

D. The Division is responsible for covering the member’s care resulting from the lack of ETI transmission to the EPD Contractor.

E. The Division provides medical records and notifies members, subcontractors or other providers.

**Transition from EPD Contractor to DDD**

A. Upon notification, the Division should anticipate an ETI from the EPD Contractor.

B. The EPD Contractor provides medical records and will notify members, subcontractors or other providers.

C. The Division provides new members with handbooks and emergency numbers,

D. The Division follows up as appropriate for the needs identified on the ETI form.

**Transition from DDD to Acute Care AHCCCS Contractor**

A. When AHCCCS determines a member is determined to no longer need long term care through ALTCS or the ALTCS-Transitional program, and the member is determined eligible for acute care enrollment, he/she will be transitioned to an
Acute Care AHCCCS Contractor.

B. Upon notification, the Division provides relevant information to the receiving Acute Care AHCCCS Contractor.

C. The Enrollment Transition Information (ETI) form is transmitted by the Division’s Transition Coordinator for all Division members.
530 MEMBER TRANSFERS BETWEEN FACILITIES

REVISION DATE: 11/22/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.R.S. § 36-2909(B), 42 CFR 422.113, 42 CFR 438.114

Transfers Following Emergency Hospitalization

A. Transfers initiated by the Administrative Services Subcontractors (AdSSs) of the Division of Developmental Disabilities (Division) between inpatient hospital facilities may be made when all of the following conditions are present:

1. The attending emergency physician, or the provider actually treating the member, determines that the member is sufficiently stabilized for transfer and will remain stable for the period of time required for the distance to be traveled. Such determination is binding on the AdSS responsible for coverage and payment. The AdSSs must comply with Medicaid Managed Care guidelines regarding the coordination of post stabilization care (42 CFR 438.114, 42 CFR 422.113).

2. The receiving physician agrees to the member transfer.

3. Transportation orders are prepared specifying the type of transport, training level of the transport crew, and level of life support.

4. A transfer summary accompanies the member.

B. Transfer to a lesser level of care facility (e.g. Tertiary to Secondary or Primary, or Secondary to Primary Hospital, or transfer to a Skilled Nursing Facility) may be made, when one or more of the following criteria are met:

1. Member's condition does not require full acute hospital capabilities, or

2. Member's condition has stabilized or reached a plateau and will not benefit further from intensive intervention in the transferring facility, and

3. The receiving physician agrees to a member transfer, and

4. Transportation orders are prepared specifying the type of transport, training level of the transport crew and level of life support, and

5. A transfer summary accompanies the member.

C. For transfers initiated by the AdSSs, the attending emergency physician or the attending provider treating the member and the AdSSs Medical Director or designee is responsible for determining whether a particular case meets criteria established in policy. The Division Medical Director in the event of a request for a decision on the transfer of a particular member, the Division will apply the criteria listed in this subsection and A.R.S. 36-2020(B)
## Neonate Transfers Between Acute Care Centers

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

<table>
<thead>
<tr>
<th>LEVEL OF CARE FROM</th>
<th>TO</th>
<th>TRANSFER CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY</td>
<td>SECONDARY</td>
<td>1. The nursing and medical staff of the sending hospital cannot provide:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. The level of care needed to manage the infant beyond stabilization to transport, or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. The required diagnostic evaluation and consultation services needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Transport orders are prepared which specify the type of transport, the training level of the transport crew and the level of life support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. A transfer summary accompanies the infant.</td>
</tr>
<tr>
<td>TERTIARY</td>
<td>SECONDARY</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>PRIMARY</td>
<td>Same as below</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL OF CARE FROM</th>
<th>TO</th>
<th>TRANSFER CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>TERTIARY (RARE)</td>
<td>SECONDARY</td>
<td>1. The sending and receiving neonatalogists (and surgeons, if involved) have spoken and have agreed that the transfer is safe.</td>
</tr>
<tr>
<td></td>
<td>PRIMARY</td>
<td>2. The infant is expected to remain stable, considering the period of time required for the distance to be covered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Transport orders are prepared which specify the type of transport, training level of the transport crew, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. A transfer summary accompanies the infant.</td>
</tr>
<tr>
<td>SECONDARY</td>
<td>PRIMARY</td>
<td>Same as above</td>
</tr>
</tbody>
</table>
540 OTHER CARE COORDINATION ISSUES

REVISION DATE: 7/15/2016, 7/3/2015, 10/1/2015, 10/1/2014
EFFECTIVE DATE: July 3, 1993
REFERENCES: A.R.S. §§ 8-546, 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915 (k).

Acute Medical Care

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member. Each subcontracted health plan has an identified liaison to assist with the coordination of care for Division members enrolled through the Arizona Long Term Care System (ALTCS) program.

The Support Coordinator will:

A. Contact the health plan liaison when a member has a concern related to medical services received or needed from the subcontracted health plan; and,

B. Contact HCS when there are issues that cannot be resolved with the liaisons.

Children’s Rehabilitative Services

The Support Coordinator, along with Health Care Services (HCS), ensures coordination of care for each member receiving medical and behavioral health services from Children’s Rehabilitative Services (CRS).

The Support Coordinator will:

A. Contact the CRS liaison when a member has a concern related to medical or behavioral health services received or needed from CRS; and,

B. Contact HCS when there are issues that cannot be resolved with the liaison.

Behavioral Health

When the Planning Document indicates a need for behavioral health services, the Support Coordinator shall initiate and coordinate such services with the Regional Behavioral Health Authority (RBHA). Additional information is available on the Arizona Division of Health Services/Division of Behavioral Health Services (ADHS/DBHS) website for each RBHA Provider Manual.

A. Qualified Behavioral Health Professional Consult (QBHP)

The Support Coordinator shall complete an initial consultation and quarterly consultations thereafter with the qualified behavioral health professional for all members receiving/needing behavioral health services. Quarterly consultations are not required for members who are stable on psychotropic medications and are not receiving any other behavioral health services.
B. Behavioral Health Treatment Plan (From RBHA Provider)

The Behavioral Health Treatment Plan from the RBHA Provider becomes part of the Division’s Planning Document. The Support Coordinator must include outcomes relevant to a Behavioral Health Treatment Plan on the Division’s Planning Document.

C. Child and Family Teams

The Child and Family Team (CFT) is a group of people that include, at a minimum, the child and the family, a behavioral health representative, the Support Coordinator, and any members important in the child's life who are identified and invited to participate by the child and family. The size, scope, and intensity of involvement of the team members are determined by the CFT outcomes, with oversight by the behavioral health representative.

Residential Placements

At the time of placement, the Support Coordinator is responsible for the following:

A. If a member's behaviors pose a danger to residents or staff, the Division will share this information with the parents/guardians of other residents in the home. The agency director, designee, or Division staff will only provide non-personally identifiable information to the guardian.

B. For a member currently in placement or using out-of-home respite and potentially at risk, the Support Coordinator along with the Individual Support Plan (ISP) team will identify the appropriate person to inform the family of the risk.

In cases of emergency placement, the checklists capturing potential safety concerns for everyone in the home must be available to the guardian/family of the member moving in.

Department of Child Safety

The Support Coordinator is responsible for coordinating services with the Department of Child Safety (DCS) Case Manager when a child eligible for Division services is in the custody of DCS.

Department of Economic Security Vocational Rehabilitation

The Support Coordinator/Employment Specialist is responsible for submitting and coordinating referrals to DES Vocational Rehabilitation for employment related services.

Arizona Department of Education/Local Education Agency

The Division shall coordinate services with the Arizona Department of Education Local Education Agency (LEA) under three distinct circumstances:

A. When the Division makes an out-of-home placement for educational purposes (A.R.S. §15-765, www.azleg.gov);
B. When the Division makes an out-of-home placement of a member receiving public education for other than educational purposes; and,

C. When a child receiving early intervention services (day treatment and training) from the Division reaches ages two years six months and two years nine months, in order to plan for preschool transition.

Residential Placement for Educational Reasons (A.R.S.§15-765)

A.R.S. § 15-765 allows for residential placements for children for educational reasons. It is not intended to provide long term or permanent residential placements for children. These placements should be for a limited period of time and only for the purpose of accomplishing specific educational goals that promote the child's ability to benefit from a special education program in a less restrictive environment. A.R.S. § 15-765

www.azleg.state.az.us/arizonarevisedstatutes.asp requires that residential placement be made for educational reasons only and not for other issues, such as family matters.

In the event the child may need some level of intervention beyond what is available through the Local Education Agency, a representative from the school should collaborate with the family or legal guardian to identify resources available to the child. This may include services covered by either private insurance or the Arizona Health Care Cost Containment System (AHCCCS) behavioral health benefits. If the child is currently not enrolled in AHCCCS but may be eligible through Title XIX/XXI (KidsCare), the Public Education Agency should assist the family in the enrollment process.

When an out-of-home placement is considered, priority should be given to placement in the home school district so the child can maintain placement, transition into the district when specific behavioral, or meet educational goals. Exceptions may exist for children with unusually complex educational needs that cannot be met in the home district, for example, in remote areas of the State. However, these reasons must be clearly documented before the placement is approved.

When the Individual Education Program (IEP) indicates that out-of-home placement for educational purposes may be necessary, the Support Coordinator shall immediately notify the District Program Manager for involvement in the placement process. If placement is to be made out of the Division District where the child resides, the Support Coordinator/originating District Program Manager must contact the District Program Manager in the receiving District in order to facilitate appropriate placement and services.

When requesting residential services for educational reasons through the Division, the following documentation must be provided by the requesting school district to the Support Coordinator. Copies of this documentation shall be placed in the case file. This information is then forwarded to the District Program Manager (DPM) and Central Office.

A. A letter of request for services.

B. Parental signature for consent for evaluation and services.

C. A copy of the Individual Education Program (IEP) that includes:
1. Documentation of least restrictive environment considerations, including the specific reasons why the child cannot be educated in a less restrictive environment;

2. Specific services requested, such as residential placement;

3. Length of time for the placement. For example, six months, one school year; and,

4. The exit criteria (goals which when accomplished will indicate that the child is ready to return home or to the home school district).

A. If the member is being placed outside the state and is eligible for the ALTCS, the AHCCCS must approve the placement in advance.

Incomplete documentation of the educational reasons for requesting residential placement will result in a delay. The Division Central Office may also deny the request.

Following approval and placement in an out-of-home setting for educational purposes, the need for placement shall be reviewed every 30 days after placement by the respective planning processes (Individual Education Program/Individualized Family Services Plan/Person Centered Plan meetings). The results of the review shall be documented in the progress notes. Requests for continuation of the placement must be submitted to the Division Central Office for approval by June 15 of each year. Requests for continued placement shall contain the same information and be submitted in the same manner as required for initial placements.

During the 30-day reviews, all parties shall consider progress according to the goals and objectives of the treatment plan and the Individual Educational Program (IEP) exit criteria. Each review shall also include a discussion surrounding the type of educational and behavioral health supports that would be needed to return the child to a less restrictive placement.

Anticipated transitional supports shall be discussed during the 30-day reviews. The Local Education Agency (LEA) and the Regional Behavioral Health Authority (RHBA) shall both strive to ensure that the necessary educational and Title XIX/XXI behavioral health supports shall be available to the child and family at time of discharge.

Any proposed change in a residential placement for educational reasons must be made through the IEP review process. Changes in placement must be consistent with the goals of the child's IEP and recommended by the team. Placements may not be changed for reasons other than those related to educational purposes. When a child's parents move to a new school district, the District that placed the child must notify the new school District of the placement arrangements.

The new District has the responsibility to review the appropriateness of the placement and use the IEP process to make any recommended changes.
When a child is promoted to a high school district, the District that placed the child must treat the promotion as a change of placement and must include the high school District in the IEP review process.

When the team determines that a child needs Extended School Year Services, no change in the residential placement may be made unless specified in the IEP.

**Transition to the Community**

A. When the child’s treatment goals and the IEP exit criteria have been met, the Division, LEA, RBHA, family or legal guardian and residential provider shall collaborate on the necessary planning for transition to a less restrictive setting. At that time, the IEP shall be revised and the treatment plan updated.

B. The Division, LEA, RBHA and family or legal guardian shall coordinate with the residential facility provider to schedule a discharge date.

C. The Division, LEA and the RBHA shall ensure the agreed upon educational and Title XIX/XXI behavioral health supports are in place for the child and family upon discharge.

Post-discharge, the Division, the LEA and the RBHA shall continue to monitor the child’s status in the less restrictive placement. Communication between the Division, the LEA and the RBHA shall continue in order to monitor and support the child’s successful integration in the new setting.

**Coordination of Care Between The Division And The School System**

In addition to the review and annual due dates for the Planning Documents, the Support Coordinator is responsible for ensuring the overall provision of care in coordination of care with other agencies for each member, including educational services. It is important that the Support Coordinators and Support Coordinator Supervisors understand the appropriate ways to coordinate care with a local school system.

It is also important to develop 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. The development of these relationships before serious concerns occur will assist in resolving issues in a more collaborative and timely manner.

The Support Coordinator should work with the family to identify the dates and times for meeting with the school, and participate in the development of the IEP. Coordinating the efforts of the education plan with the Division’s Planning Documents can ensure these plans complement each other and provide better care for the member. If the family does not remember to invite the Division staff to the IEP meeting, the school representative should be invited to the Division’s Planning Meeting.

When the Division identifies an educational need, the Support Coordinator will take the following steps:

A. Discuss identified need with the family;
B. Within five working days of obtaining the family’s agreement, contact the local schoolteacher and/or principal to inquire about the identified educational need;

C. Contact the District Program Administrator/District Program Manager within two working days of contacting the school to request support with their counterpart in the local school district if the teacher and/or principle have not responded;

D. Contact the Division’s Central Office within two weeks to request support in coordination with the Special Education Division of the Arizona Department of Education when there has not been a response from the local school district;

E. As appropriate, raise the general issue(s) at the Arizona Department of Education (ADDE) through Central Office; and,

F. Follow up with the member or the representative regarding whether or not the need has been/was met.

**Discharge Planning**

Discharge planning is a systematic process for the transition of a member from one health care setting to another or the transition of a medically involved member from one residential placement to another. The key to successful discharge planning is communication between member, family/caregiver and health care team. Depending on the specific needs of the member, the following people may participate in the discharge planning process:

A. Member/family/caregiver;

B. Primary care provider/specialist;

C. Discharge Coordinator/Social Worker/Quality Assurance Nurse;

D. Utilization Review Nurse (hospital, Division or Health plan);

E. The Division Discharge Planning Coordinator;

F. The Division Support Coordinator; and;

G. Other Planning Team members, as necessary.

In order to ensure that Support Coordinators and District Nurses are aware of hospitalizations of ALTCS eligible members, the Medical Services Representative will e-mail the Support Coordinator and District Nurse identified in Focus when notified of an admission. It is the responsibility of the Support Coordinator to notify the Division’s District Nurse or Discharge Planning Coordinator of transfers of medically-involved members, or the hospitalization of a non-ALTCS eligible member.

The discharge planning process is applicable in health care settings, and in the transfer of a medically involved member from one Child Developmental Home, Adult Developmental Home, Group Home, and Intermediate Care Facility for Individuals with an
Intellectual Disability or Nursing Facility to another. The process will generally include the following activities:

A. Complete a Division Discharge Plan Assessment, e.g., nursing assessment;

B. Review of discharge orders written by doctor;

C. Ensure that the member/family/caregiver has received proper training to carry out the discharge orders;

D. Ensure that all necessary equipment and supplies have been ordered and will be available when needed;

E. Ensure that transportation arrangements have been made;

F. Reinstate applicable service(s) that may have been interrupted, or initiate services now determined needed (update Planning Documents);

G. The District Nurse or Discharge Planning Coordinator will complete a Utilization Review Nursing Worksheet – Health Care Services, and send copies to the Support Coordinator and Health Care Services (HCS); and,

H. Notification and/or signatures as required on the Utilization Review Nursing Worksheet – HCS form:

1. Health Care Services Representative (District Nurse and/or Discharge Planning Coordinator);

2. District Program Manager or designee (to be notified about all changes of placement);

3. Medical Director (to be notified by HCS of level of care changes); and,

4. The Division Assistant Director/designee (signature also required for placement in a planning document).

**Members with Medical Needs**

Members are considered to be medically involved when they require two or more hours per day of skilled nursing care. Thorough discharge planning for people who are medically involved ensures continuity of a members’ services when the member is moving from one setting to another. Placement and services should be appropriate and established prior to the member being discharged.

The Support Coordinator, District Nurse, and/or the Discharge Planning Coordinator will work together to initiate the discharge planning process. Their communication can include a Planning Document. Convening a Planning Team meeting is at the discretion of any member.

The following procedures shall be implemented for all members who are medically involved:
A. The District Nurse will verify hospitalization notification and/or transfer intentions with the Support Coordinator;

B. The District Nurse or Discharge Planning Coordinator shall follow the hospitalization and keep the Support Coordinator updated on the member’s condition and the concerns expressed by the member/family/caregiver; and,

C. A Planning Team meeting should be called prior to discharge for complex cases. The hospital discharge planner is considered the lead in this meeting, and should assemble the family/caregiver, attending physician, primary care provider (if possible), social services, the Support Coordinator and Division Nurse, and the health plan utilization review nurse. Other disciplines may be included, particularly if their role influences the member’s discharge status/planning (i.e., Department of Child Safety or Adult Protective Services).

D. If placement is an issue:
   1. A nursing assessment will be updated/completed, to assess the nursing/medical needs of the member and identify the appropriate type of facility/residence.
   2. If behavioral health is a need, referral to the Regional Behavioral Health Authority (RBHA) should be made by the Support Coordinator to initiate assessment and their participation in the discharge planning process.
   3. Based on the Planning Documents, the Support Coordinator will work with the appropriate staff to arrange for the facility/residence which will provide for the identified needs.

E. If the Division is expected to pay for a Planning Document placement, a thorough review is required, including HCS, before any admission is made. All placements in Planning Document(s) must have the approval of the Assistant Director. These facilities are restrictive environments, therefore, placement is temporary and transitional, occurring only after the following alternative options have been eliminated:
   1. In-home supports;
   2. Individually Designed Living Arrangement; and,
   3. Community based placements, e.g.; Group Home; Child Developmental Home (CDH); or Adult Developmental Home (ADH).

See Division Medical Policy Manual for more information on Planning Document.

A. For those members who are returning to a Planning Document, the District Nurse or Discharge Planning Coordinator shall participate in the planning process. The entire planning process shall be completed before the discharge/transfer is made.
B. In the absence of a Planning Meeting, the District Nurse and/or Discharge Planning Coordinator will coordinate the discharge orders, caregiver training, equipment/supplies, home health care, and transportation.

C. The Division Nurse or Discharge Planning Coordinator shall complete a *Utilization Review Nursing Worksheet* –upon discharge, and send copies to the Support Coordinator and HCS.

D. The Discharge Plan shall take precedence over any Planning Document objectives that are in conflict. If there is a conflict, a new Planning Document shall be developed as soon as possible. The member/responsible person, primary care provider, or any other attending physician involved shall resolve disagreements. The medical records and a summary of the disagreement may be sent to the Discharge Planning Coordinator to be reviewed. The Division’s Medical Director may be contacted to review the case and assist in the resolution of the disagreement.

E. The member’s primary care provider shall be given the opportunity to participate in the discharge planning and review the completed Planning Document.

**Nurse Consultation to Determine Medical Needs**

The District Nurse or Discharge Planning Coordinator may be contacted directly by the Support Coordinator to review a member’s hospitalization or transfer plans to determine if medical discharge planning is needed. A *Utilization Review Nursing Worksheet* should be completed by the District Nurse or Discharge Planning Coordinator and submitted with appropriate documentation to HCS and the Support Coordinator indicating if skilled nursing needs have been identified.

**Members Without Medical Needs**

For non-medically involved members who are being discharged from a hospital or skilled nursing facility, the following procedures shall be implemented:

A. The Support Coordinator shall assess for medical needs prior to discharge. If needed the District Nurse or Discharge Planning Coordinator will complete a Nursing Assessment - HCS to plan and recommend an appropriate level of care;

B. If the member is non-medically involved, the Support Coordinator will:
   1. Ensure that training of caregivers has taken place;
   2. Assess for and authorize in-home supports as appropriate;
   3. Make arrangements for equipment, supplies, medications, etc. through appropriate systems; and,
   4. Ensure that follow-up instructions are in place.

C. In those situations where a residential setting will change, the Planning Document process shall be an essential part of discharge planning.
**Foster Care Discharge Planning**

For all members in foster care, the following discharge planning procedures shall be implemented:

A. The Support Coordinator, District Nurse or Discharge Planning Coordinator will assess for medical needs prior to hospital discharge. If medical needs are present, the nurse will complete a Utilization Review Nursing Worksheet – HCS, and coordinate a plan of care, training for caregivers, and equipment and supply needs. A Nursing Assessment - HCS will be updated/completed to determine home based nursing services and/or placement needs.

B. The District Nurse or Discharge Planning Coordinator must be notified:
   1. Prior to any foster child being admitted to or discharged from a planning document or Nursing Facility (NF).
   2. Prior to any foster child that is medically involved, receiving home based nursing services, or being considered for a change in placement.

C. The Planning Team must be notified prior to this change of placement. The District Nurse or Discharge Planning Coordinator will complete the Utilization Review Nursing Worksheet – HCS, and coordinate plan of care, training, and equipment and supply needs. The District Nurse or Discharge Planning Coordinator will notify HCS of changes in placement. The Support Coordinator will notify the District. Specific to a planning document admission, the personal authorization of the Assistant Director (or designee) is required.

D. Children in foster care whose cases have been transferred from DCS to the Division may also require the participation of court appointed special advocates, attorneys, guardian ad litems, or other professionals from the juvenile court.

**Discharge/Transition of Members with Severe Behavioral Challenges**

When a member with severe behavioral health challenges is placed into a psychiatric hospital setting, the Support Coordinator will begin discharge planning immediately and District Personnel will attend a hospital staffing within 72 hours. Support Coordinators shall, if possible, attend all subsequent hospital staffings. Prior to discharge, the Support Coordinator will:

A. Involve staff responsible for contracting with Provider Agencies as soon as possible;

B. Begin the appropriate Planning Process; and,

C. Ensure that staff from the behavioral health system is invited to all planning sessions.

Use of the Discharge/Transition Checklist for Individuals with High Risk Behavioral Challenges is mandated when planning discharge from an inpatient setting for members with severe behavioral challenges. The form can also be used when someone with behavioral challenges moves from one setting to another. The form is intended to provide
reminders to the team about important areas to consider and should be used to plan for the discharge/move.

The Emergency Contact Plan is intended to record very basic information about the person that would be helpful to others coming in to assist in a crisis situation, such as crisis mobile team members or police officers. The form should be completed at the discharge/transition-planning meeting and updated as necessary. The representative from the behavioral health system should assist in filling out the form and the same information should, if possible, be on file with the Regional Behavioral Health Authority (RBHA). The Emergency Contact Plan should be kept in an easily accessible place in the setting, but it should never be posted.

The Emergency Contact Plan does not take the place of the Behavior Plan. Begin development of the behavior plan prior to discharge, so that the person is discharged with at least a rough draft of the plan that eventually gets submitted to the Program Review Committee. This initial plan may be called a “crisis plan.” It should have information about precursors/antecedents and creative strategies for preventing challenging behaviors. It should give staff ideas for teaching replacement behaviors, and it should let staff know whom to call when a crisis occurs.
541 COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division as delineated within policy.

The Division is required to develop and maintain collaborative relationships with other government entities that deliver services to members and their families, ensure access to services, and coordinate care with consistent quality.

Appropriate authorizations to release information must be obtained prior to releasing information.

Definitions

A. Adult Recovery Team (ART) - 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’s guardian/designated representative (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the enrolled 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 members identified by the enrolled member.

B. Child and Family Team (CFT) - A defined group of individuals that includes, at a minimum, the child and his or her family, the assigned Support Coordinator, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD), which includes AzEIP. 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 Planning Document and can therefore expand and contract as necessary to be successful on behalf of the child.

C. Rapid Response - A process in which, a behavioral health service provider is dispatched within 72 hours, to assess a child’s immediate behavioral health needs, and refer for further assessments through the behavioral health system when a child first enters into DCS custody.

D. Service Plan (Behavioral Health) - A complete written description of all covered behavioral health services and other informal supports that includes individualized goals, family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.
E. **State Placing Agency** - The Department of Juvenile Corrections, Department of Economic Security, Department of Child Safety, the Arizona Health Care Cost Containment System or the Administrative Office of the Court. (A.R.S. §15-1181(12)).

F. **Team Decision Making (TDM)** - When an emergency removal of a child has occurred or the removal of a child is being considered, a TDM Meeting is held. The purpose of the meeting is to discuss the child’s safety and where they will live.

**Policy**

The Division must develop policies, protocols, and procedures that describe how member care will be coordinated and managed with other governmental entities. The Division is responsible for ensuring collaboration with government agencies, including but not limited to involvement with the member’s Planning Team.

The Division must ensure that all required protocols and agreements with State agencies are delineated in provider manuals. The Division must develop mechanisms and processes to identify barriers to timely services for members served by other governmental entities and work collaboratively to remove barriers to care and to resolve any quality of care concerns.

A. **Arizona Department of Child Safety (DCS)**

The Division is required to work in collaboration with DCS as outlined below:

1. **General Requirements:**
   a. Coordination of the development of the Service Plan with the DCS case plan to avoid redundancies and/or inconsistencies;
   b. Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings;
   c. 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;
   d. 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 CFT;
   e. Attend team meetings such as Team Decision Making (TDM) providing input about the child and family’s behavioral health needs. When it is possible, TDM and CFT meetings should be combined;
   f. Coordinate necessary services to stabilize in-home and out-of-home
placements provided by DCS;

g. Coordinate provision of behavioral health services in support of family reunification and/or other permanency plans identified by DCS;

h. Coordinate activities and service delivery that supports the child and family Plans and facilitates adherence to established timeframes (see Division Operations Manual Policy 417 and AHCCCS Behavioral Health System Practice Tools: Transition to Adulthood, Unique Behavioral Health Services for Needs of Children, Youth and Families involved with DCS, and Child and Family Team; and

i. Coordination activities should include coordination with the adult service providers rendering services to adult family members.

2. Rapid Response Process:

   The Division must consider the removal of a child from home to the protective custody of the DCS to be an urgent behavioral health situation. Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. The Rapid Response process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself. If the Division receives notification from DCS of the physical removal of a child, the Division must contact the AdSS to initiate the Rapid Response Process. See AdSS Medical Manual 541 – Coordination of Children’s Care with Other Government Agencies.


1. The Division must ensure that behavioral health providers coordinate with parents/families/caregivers referred through the Arizona Families F.I.R.S.T. (AFF) Program (hereafter referred to as the AFF Program) and the Support Coordinator participate in the family’s Planning Team to coordinate services for the family and temporary caregivers.

2. The AFF Program provides expedited access to substance use treatment for parents/families/caregivers referred by DCS and the ADES/Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with DCS.

3. Substance use disorder treatment for families involved with DCS must be family centered, provide for sufficient support services and must be provided in a timely manner to promote permanency for children, stability for families, to protect the health and safety of abused and/or neglected children and promote economic security for families.
C. Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities

1. The Division is required to work in collaboration with the ADE and assist with resources and referral linkages for children with behavioral health needs.

2. The Division must ensure that behavioral health providers collaborate with schools and help a child achieve success in school as follows:
   a. Work with the school and share information to the extent permitted by law and authorized by the child’s parent or legal guardian. Refer to Division Medical Manual Policy 550;
   b. For children who receive special education services, include information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning process (see Division Medical Manual Policy 300). The Division must invite the Behavioral health providers to IEP meetings to partner in the implementation of behavioral health interventions;
   c. For children in the custody of DCS, the Support Coordinator must communicate and involve the DCS Specialist with the development of the IEP;
   d. Invite teachers and other school staff to participate in the CFT if agreed to by the child and legal guardian.
   e. Understand the IEP requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004;
   f. Support accommodations for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973; and.
   g. Ensure that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

D. Courts and Corrections

1. The Division must collaborate and coordinate care for members involved with:
   a. Arizona Department of Corrections (ADOC),
   b. Arizona Department of Juvenile Corrections (ADJC),
   c. Administrative Offices of the Court (AOC), or
   d. County Jails System.
2. The Division must collaborate with courts or correctional agencies to coordinate member care as outlined in AHCCCS AMPM Policy 1020 and as follows:

   a. Work in collaboration with the appropriate staff involved with the member;

   b. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with the member’s/guardian’s/designated representatives’ approval;

   c. Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan; and

   d. Ensure that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member’s release.
550 MEMBER RECORDS AND CONFIDENTIALITY

REVISION DATE: 11/17/2017
EFFECTIVE DATE: May 13, 2016
REFERENCES: A.A.C. R9-22-501 et seq; 42 CFR 431.300 et seq

All AHCCCS providers and Administrative Service Subcontractors (AdSS) must protect member information in accordance with federal and state laws, rules, Division of Developmental Disabilities (Division) and AHCCCS policies, and contracts.

Consistent with R9-22-501 et seq, AHCCCS, contractors, providers, and non-contracted providers must safeguard the privacy of records and information about members who request or receive services from the Division and the AdSS.

Information from, or copies of, medical records may be released only to authorized individuals, and processes must be in place to ensure that unauthorized individuals cannot gain access to, or alter, medical records.

Original and/or copies of medical records must be released only in accordance with federal or state laws or court orders. AdSS and the AdSS providers must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.
570 RESERVED
610  AHCCCS PROVIDER QUALIFICATIONS

EFFECTIVE DATE: November 17, 2017
REFERENCES: AHCCCS Medical Policy Manual Exhibit 610-1

All providers of services that are covered by the Division of Developmental Disabilities must:

A. Register with AHCCCS, which requires signing the Provider Participation Agreement or Group Biller Participation Agreement that includes all federal and state requirements as applicable.

B. Comply with all federal, state, and local laws, rules, regulations, executive orders, and agency policies governing performance of duties under the contract.

C. Sign and return attestations, found on the Provider Registration section of the AHCCCS website, that apply to their individual practices or facilities.

D. Meet AHCCCS requirements for professional licensure, certification, or registration, including current Medicare certification.

E. Complete all applicable registration forms.

Institutional and other designated providers are required to submit an enrollment fee (see AHCCCS Medical Policy Manual Exhibit 610-1).

Specific provider types require an AHCCCS Office of the Inspector General (AHCCCS-OIG) site visit prior to enrollment, and they are subject to unannounced post enrollment site visits (see AHCCCS Medical Policy Manual Exhibit 610-1).

AHCCCS Provider Registration Materials

AHCCCS-OIG Provider Registration materials are available on the AHCCCS web site. On the AHCCCS website, click on the “Plans/Providers” tab. In the resulting screen, click on the “New Providers” link and, in the resulting dropdown menu, click on the “Provider Reenrollment” link. The forms can be completed on the AHCCCS website, but they must be submitted by fax or mail.

AHCCCS Provider Types

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician) established by AHCCCS. The AHCCCS-OIG “Provider Registration” section on the AHCCCS website will help providers to identify the most appropriate provider type, based on the provider’s license/certification and other documentation.

Refer to the AHCCCS website for additional information regarding provider registration requests.
640 ADVANCE DIRECTIVES

EFFECTIVE DATE: November 17, 2017
REFERENCES: A.R.S. § 36-3231; 42 CFR 489.102; 42 U.S.C. 1396

The Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities must ensure their providers (e.g., hospitals, nursing facilities, hospice providers, home health agencies) comply with federal and state laws regarding advance directives for members who are adults. An Advance Directive is a document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

A. At a minimum, providers must:
   A. Maintain written policies for 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.
   B. Provide written information to members regarding the provider’s policies concerning advance directives, including any conscientious objections.
   C. Document in the member’s medical record whether or not the member has been provided the information, and whether an advance directive has been executed.
   D. Prevent discrimination against a member because of his or her decision to execute or not execute an advance directive, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive.
   E. Provide to members, and when the member is incapacitated or unable to receive information, the member’s family or surrogate as defined in A.R.S. 36-3231, written information regarding advance directives as delineated in 42 CFR 489.102(e), concerning:
      a. The member’s rights, regarding advance directives under Arizona State law
      b. The AdSS’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
      c. A description of the applicable state law and information regarding the implementation of these rights
      d. The member’s right to file complaints directly with the Division or AHCCCS
e. Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of conscience. This statement, at a minimum, should:

i. Clarify institution-wide conscientious objections and those of individual physicians

ii. Identify state legal authority permitting such objections

iii. Describe the range of medical conditions or procedures affected by the conscience objection.

B. The provider is not relieved of its obligation to provide the above information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

C. The provider must also provide the above information to an individual upon each admission to a hospital or nursing facility and each time the individual comes under the care of a home health agency.

D. Providers must provide a copy of a member’s executed advance directive, or documentation of refusal, to the member’s Primary Care Provider for inclusion in the member’s medical record; and, provide education to staff on issues concerning advance directives.
680-C PRE-ADMISSION SCREENING AND RESIDENT REVIEW

REVISION DATES: 9/25/19, 4/1/14  
IMPLEMENTATION DATE: 7/31/93  

PURPOSE: This Policy applies to AHCCCS registered nursing facilities contracted with the Department of Economic Security/Division of Developmental Disabilities (Division). This policy outlines Federal and State mandates for Pre-Admission Screening and Resident Review (PASRR) requirements for nursing facilities who facilitate and deliver services to any individual being considered for nursing facility admission regardless of payor source as delineated in 42 CFR 483.100 – 438.138.

DEFINITIONS

**Determination:** The outcome of the Level II evaluation which ensures the nursing facility placement is, or continues to be, appropriate, and that services provided to individuals with a mental illness, intellectual disability, or related condition meet the individual’s needs, including the need for specialized services.

**Inter-facility Transfers:** Occurs when an individual is transferred from one nursing facility to another nursing facility, with or without an intervening hospital stay. Inter-facility transfers are subject to resident review rather than preadmission screening.

**Readmission:** A return to the facility following a temporary absence for hospitalization or for therapeutic leave.

**Resident Review:** A subsequent Level II evaluation and determination for existing nursing facility residents, triggered whenever an individual undergoes a significant change in status and that change has a substantial impact on their functioning as it relates to their mental illness/intellectual disability status.

**Significant Change:** A major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident’s health status, and requires interdisciplinary review or revision of the care plan, or both (42 CFR 483.20).

**Specialized Services:** Services provided to individuals with mental illness/intellectual disability or with a related condition residing in a nursing facility. These services exceed those typically provided by a nursing facility under its daily or per diem rate and address the individualized needs related to an individual’s mental illness, intellectual disability, or related condition, as identified through the PASRR Level II Evaluation.

**Treatment Plan:** A written plan of services and therapeutic interventions based on a complete assessment of a member’s developmental and health status, strengths and needs.
that are designed and periodically updated by the multi-specialty, interdisciplinary team.

**Nursing Facility Requirements**

A. AHCCCS registered nursing facilities are required to verify that a Level I PASRR Screening has been conducted, in order to identify Mental Illness (MI) and/or an Intellectual Disability (ID), prior to initial admission of individuals to a Medicaid certified or dually certified for Medicaid/Medicare nursing facility.

B. The PASRR screening consists of a two-stage identification and evaluation process and is conducted to assure appropriate placement and treatment for those individuals identified with MI and/or ID.

1. PASRR Level I screenings are used to determine whether the individual has a diagnosis or other presenting evidence that suggests the potential for MI and/or ID. Refer to Attachment A in the AHCCCS Medical Policy Manual for a copy of the PASRR Level I Screening tool.

2. PASRR Level II evaluations are conducted to further evaluate and determine whether the individual has MI/ID. It also determines whether the individual needs the level of care provided in a nursing facility and/or needs Specialized Services as defined in this Policy for MI or ID.

   a. Level II evaluations for individuals suspected to have ID are conducted by the Division. An Intergovernmental Agreement between AHCCCS and DES is in place to initiate the Level II process. PASRR Level II Determinations for individuals with ID shall be completed within nine business days of the referral, and

   b. Level II evaluations for individuals suspected to have MI are coordinated by AHCCCS and performed by a designated entity. Attachment B in the AHCCCS Medical Policy Manual provides a copy of the Level II Psychiatric Evaluation form to be used when screening an individual for MI and Attachment C in the AHCCCS Medical Policy Manual provides a copy of the invoice to be used for reimbursement.

   i. PASRR Level II Determinations for individuals with MI shall be completed within five business days of the referral.

   ii. Determinations may be conveyed verbally to nursing facilities and to the individual, but shall be confirmed in writing.

3. The PASRR Level I Screening tool shall be completed by an individual involved in the PASRR process, such as a hospital discharge planner, case manager, nursing facility staff, social worker, or other qualified health professional; however, it is ultimately the responsibility of the nursing facility to assure that the PASRR Level I is completed prior to admission to the nursing facility.
4. It is the responsibility of the nursing facility, or in some cases the Division, to make referrals for a Level II PASRR if determined necessary. The nursing facility or the ALTCS Contractor/Tribal ALTCS Program shall contact the AHCCCS PASRR Coordinator for a Level II evaluation of MI at PASRRProgram@azahcccs.gov. The Division PASRR Coordinator shall be contacted for Level II PASRR evaluations for individuals with ID. When submitting the PASRR Level I Screening tool the following documentation shall also be included:

   a. Hospital or facility face sheet/demographic sheet,
   b. History and examination findings (H & P),
   c. Current medication list,
   d. MPOA/guardian documentation and information (if applicable),
   e. Current nursing/physician progress notes, and
   f. Any recent consults and/or evaluations.

5. The outcome of the Level II PASRR will determine action to be taken by the nursing facility. If the individual requires nursing facility services, he/she may be admitted to the nursing facility. The nursing facility shall also ensure that any specialized services recommended in the Level II PASRR documentation are available and coordinated by the facility. If the outcome of the Level II PASRR determines the individual does not require nursing facility services or Specialized Services, no admission shall take place; however, ALTCS enrolled members are appropriate for a nursing level of care as determined by the ALTCS Pre-Admission Screening (PAS) tool for medical eligibility. Therefore, ALTCS members may still be appropriate for nursing facility placement despite the outcome of the Level II evaluation. If an ALTCS member is determined to need Specialized Services and is admitted to a nursing facility, the nursing facility shall coordinate with the member’s Support Coordinator to arrange for the required services.

6. A new PASRR Level I Screening is not required for readmission to the nursing facility when an inter-facility transfer occurs. All PASRR screening information shall accompany the readmitted or transferred individual.

7. A request for a Level II Evaluation is not required under the following circumstances:

   a. When it is determined that an individual has a primary diagnosis of dementia and a secondary diagnosis of mental illness or intellectual disability;
b. For individuals requiring admission to a nursing facility for a convalescent period, or respite care (not to exceed 30 consecutive days). If it is later determined that the admission will last longer than 30 consecutive days, a new PASRR Level I Screening must be completed within 40 calendar days of the admission date to the nursing facility; or

c. When an individual meets one or more of the following criteria as a result of a terminal or severe illness:

i. An individual has been diagnosed with a terminal illness and has a life expectancy of less than six months (records supporting the terminal state must be present), and there is not a current risk to self or others and behaviors/symptoms are stable; and/or

ii. An individual has been diagnosed with a severe illness, including but not limited to brain-stem dysfunction, progressed ALS, progressed Huntington’s disease, in coma state, is ventilator dependent, etc., of such severity that the individual would be unable to participate in a program of specialized care associated with his/her MI and/or ID or related condition.

Specialized Services

A. For individuals determined to have ID, the Specialized Services as specified by the Division, combined with services provided by the nursing facility or other service providers, results in the implementation of an individualized Treatment Plan that:

1. Allows the acquisition of skills necessary for the individual to function as independently as possible, and

2. Prevents or decreases regression or loss of the individual’s current optimal level of functioning.

B. For individuals determined to have MI, the Specialized Services, combined with services provided by the nursing facility, results in the continuous and aggressive implementation of an individualized plan of care that:

1. Is developed and supervised by an interdisciplinary team composed of a physician, qualified behavioral health professionals and other professionals;

2. Prescribes specific therapies and services for the treatment of individuals experiencing an acute episode of mental illness which requires intervention by trained behavioral health personnel; and

3. Is directed toward diagnosing and reducing the resident’s behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the
intensity of behavioral health services to below the level of Specialized Services at the earliest possible time.

**Resident Review**

A. Nursing facilities are required to request Resident Reviews for individuals experiencing a significant change in condition as outlined in Section 1919(e)(7)(B)(iii) of the Social Security Act. Nursing facilities shall submit an amended Level I Screening to AHCCCS or the Division, as applicable, within 14 calendar days after the facility determines, or should have determined, through the Minimum Data Set assessment, that there has been a significant change in the resident's physical or mental condition (42 CFR 483.20). The amended Level I Screening indicating a change in the individual's status shall include the same documentation as required when submitting an initial Level I Screening. The submitted documentation will be reviewed by AHCCCS or the Division, as applicable, to determine if another PASRR Level II evaluation is needed.

B. Resident Reviews shall also be requested upon any evidence of possible, but previously unrecognized or unreported, MI, ID, or related condition.

**Request for Hearing**

A. An individual can request a hearing when he or she believes the State has made an erroneous determination with regard to the pre-admission and resident review requirements of 42 CFR Part 438, Subpart C. The AHCCCS rules for the administrative dispute resolution process are delineated in 9 A.A.C. 34.

B. Individuals determined to have a serious mental illness have the option to choose between the appeal process for individuals determined to have a serious mental illness (ACOM Policy 444 and 446, and A.A.C. R9-21-401) or the standard Title XIX appeal process (42 CFR Part 438 Subpart F).
700 School Based Claiming For Medicaid

REVISION DATE: 9/15/2014  
EFFECTIVE DATE: June 30, 1994

The School Based Claiming Program through Arizona Health Care Cost Containment System (AHCCCS) covers both school-age children who are Medicaid Long Term Care eligible, and members supported by the Division’s Targeted Support Coordination. The member must be at least three years of age but younger than 22 years of age, and have been determined by the school to be eligible for special education and related services. (See AHCCCS Medical Policy Manual Chapter 700.)
810  UTILIZATION MANAGEMENT OVERVIEW

EFFECTIVE DATE:  May 13, 2016

The Division contracts with health plans and delegates the responsibility of implementing this policy. The Division provides oversight and monitoring of delegated duties.
QUALITY MANAGEMENT / PERFORMANCE IMPROVEMENT PROGRAM
ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: May 13, 2016
REFERENCES: ACOM 900:910

A. The Division’s written Quality Management/Performance Improvement (QM/PI) Plan addresses the proposed methodology to meet or exceed the standards and requirements in the Arizona Health Care Cost Containment System (AHCCCS) Contractor Operations Manual chapter 900:910 and the contractual requirements between the Division and AHCCCS.

B. The QM/PI Plan describes how program activities will improve the quality of care, service delivery, and satisfaction for members.

C. The QM/PI Plan, and any subsequent modifications are submitted to the AHCCCS/Division of Health Care Management/ Clinical Quality Management (DHCM/CQM) for review and approval prior to implementation.

D. The QM/PI Plan includes, at a minimum, in paginated detail, the following components:
   1. QM/PI Program Administrative Oversight,
   2. QM/PI Committee,
   3. Peer Review,
   4. The QM/PI Staffing,
   5. Delegated Entities,
   6. Health Information System Policies and Procedures,
   7. Annual Work Plan,
   8. Annual QM/PI Program Evaluation,
   9. QM/PI Documentation,

E. Quality Management and Performance Improvement (QM/PI) activities include:
   1. Policies and Procedures,
   2. Studies and Performance Improvement Plans,
   3. Reports,
   4. Processes/Desktop Procedures,
5. Standards,

6. Worksheets,

7. Meeting Minutes,

8. Corrective Action Plans (CAPs), and

9. Other information and data appropriate to support changes made to the scope of the QM/PI Plan or Program.
920 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM SCOPE

REVISION DATE: 8/1/2018, 7/15/2016
EFFECTIVE DATE: May 27, 2016
REFERENCES: AMPM 1600, AHCCCS contract, 42 CFR 438.208

QM/PI Program Components

The QM/PI (Quality Management/Performance Improvement) Program Components include:

A. A detailed, written set of specific measurable objectives that demonstrates how the Division’s QM/PI Program meets established goals and complies with all components of this Chapter

B. A work plan to support the objectives including:
   1. A description of all planned goals and objectives for both clinical care and other covered services
   2. Targeted implementation and completion dates for quality management measurable objectives, activities and performance improvement projects
   3. Methodologies to accomplish measurable goals and objectives
   4. The inclusion of measurable behavioral health goals and objectives
   5. Staff positions responsible and accountable for established goals and objectives
   6. Detailed policies and procedures implementing all components and requirements of this Policy

C. A requirement to conduct a new member health risk assessment or a “best effort” attempt has been made to conduct an initial health risk assessment including follow up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment

   Each attempt is documented. The Division uses the results of health assessments to identify individuals at risk for and/or with special health care needs and to coordinate care (42 CFR 438.208).

D. Requirements to ensure continuity of care and integration of services, through Policies and Procedures, such that:
   1. Each member has the choice to select or have a Primary Care Provider (PCP) assigned to them who is formally designated as having primary responsibility for coordinating the member’s overall health care, including coordination with the behavioral health medical professional.
   2. All services provided by the Division or its subcontractors are coordinated with specific documentation of these processes.
3. Covered services are coordinated with community and social services so that they are generally available through contracted or non-contracted providers.

4. Policies specifying services are coordinated by the Division’s Health Care Services Unit and sub-contractors.

5. Communication of clinical information amongst providers is timely and confidential, as required by the Arizona Health Care Cost Containment System (AHCCCS).

E. Oversight of implementation of measures to ensure members:

1. Are informed of specific health care needs that require follow-up

2. Receive, training in self-care and other measures they may take to promote their own health, as appropriate

3. Are informed of their responsibility to comply with ordered treatments or regimens.

F. Maintenance of records and documentation as required under state and federal law.

**QM/PI Program Monitoring and Evaluation Activities**

The Division’s QM/PI Program includes a comprehensive evaluation of activities used by the Division, and demonstrates how these activities improve the quality of services and the continuum of care in all services sites. Monitoring and evaluation activities include:

A. Using data from monitoring showing trends in quality of care issues to select and develop performance improvement projects

B. Reporting all incidents of abuse, neglect, exploitation, and unexpected deaths to AHCCCS Clinical Quality Management Unit under established timelines

C. Reporting identified quality of care, reportable incidents and/or service trends to the AHCCCS Clinical Quality Management Unit immediately upon identification of the trend, including trend specifications such as providers, facilities, services, and allegation types

D. Tracking and reporting Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) to the AHCCCS Clinical Quality Management Unit on a quarterly basis using the established AHCCCS format

E. Incorporating the ADHS licensure and certification reports and other publicly reported data, as applicable

F. Reviewing quality of care trend reports and incorporating the reports into the QM/PI evaluation
G. Ensuring the health and safety of members in placement settings or service sites that are found to have survey deficiencies that may impact the health and safety of members.

The Division actively participates in both individual and coordinated efforts to improve the quality of care by taking appropriate and collaborative action regarding:

1. Placement settings or service sites that have been identified through the Licensure Survey process or other mechanisms as having an immediate jeopardy situation or have had multiple survey or complaint investigations resulting in a finding of non-compliance with licensure requirements.

2. Facilities, placement settings, or service sites that have been identified by AHCCCS as an Immediate Care Need.

3. Meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service sites are in compliance with ADHS Licensure and/or AHCCCS requirements.

4. Scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status or have serious identified or suspected deficiencies that may affect health and safety of members (Immediate Care Needs).

5. Assisting in the identification of technical assistance resources focused on achieving and sustaining licensure compliance.

6. Monitoring placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.
a. The following services and service sites will be monitored at a minimum annually by the Division, or its sub-contractor, and will include the following:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>SERVICE SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Behavioral Health Therapeutic Home Care</td>
<td>• Behavioral Health Outpatient Clinics</td>
</tr>
<tr>
<td>Services</td>
<td>• Behavioral Health Therapeutic Home</td>
</tr>
<tr>
<td>• Behavioral Management</td>
<td>(Adults and Children)</td>
</tr>
<tr>
<td>• Behavioral Health Personal Assistance</td>
<td>• Independent Clinic</td>
</tr>
<tr>
<td>• Family Support</td>
<td>• Federally Qualified Health Center</td>
</tr>
<tr>
<td>• Peer Support</td>
<td>• Community Mental Health Center</td>
</tr>
<tr>
<td>• Case Management Services</td>
<td>• Community/Rural Health Clinic (or Center)</td>
</tr>
<tr>
<td>• Emergency/Crisis Behavioral Health Services</td>
<td>• Crisis Service Provider</td>
</tr>
<tr>
<td>• Emergency Transportation</td>
<td>• Community Service Agency</td>
</tr>
<tr>
<td>• Evaluation and Screening (initial and</td>
<td>• Hospital (if it includes a distinct</td>
</tr>
<tr>
<td>ongoing assessment)</td>
<td>behavioral health or detoxification unit)</td>
</tr>
<tr>
<td>• Group Therapy and Counseling</td>
<td>• Inpatient Behavioral Health Facility</td>
</tr>
<tr>
<td>• Individual Therapy and Counseling</td>
<td>• Behavioral Health Residential Facility</td>
</tr>
<tr>
<td>• Family Therapy and Counseling</td>
<td>• Residential Treatment Center</td>
</tr>
<tr>
<td>• Marriage/Family Counseling</td>
<td>• Psychiatric Hospital</td>
</tr>
<tr>
<td>• Substance Abuse Treatment</td>
<td>• Substance Abuse Transitional Center</td>
</tr>
<tr>
<td>• Inpatient Hospital</td>
<td>• Unclassified Facility</td>
</tr>
<tr>
<td>• Inpatient Psychiatric Facilities (resident</td>
<td>• Integrated Behavioral Health and Medical</td>
</tr>
<tr>
<td>treatment centers and sub-acute facilities)</td>
<td>Facility</td>
</tr>
<tr>
<td>• Institutions for Mental Diseases</td>
<td>• Individual Respite Homes</td>
</tr>
<tr>
<td>• Laboratory and Radiology Services</td>
<td></td>
</tr>
<tr>
<td>• Non-emergency Transportation</td>
<td></td>
</tr>
<tr>
<td>• Nursing</td>
<td></td>
</tr>
<tr>
<td>• Opioid Agonist Treatment</td>
<td></td>
</tr>
<tr>
<td>• Partial Care (supervised day program,</td>
<td></td>
</tr>
<tr>
<td>therapeutic day program and medical day</td>
<td></td>
</tr>
<tr>
<td>program)</td>
<td></td>
</tr>
<tr>
<td>• Psychosocial Rehabilitation (living skills</td>
<td></td>
</tr>
<tr>
<td>training, health promotion and supported</td>
<td></td>
</tr>
<tr>
<td>employment)</td>
<td></td>
</tr>
<tr>
<td>• Psychotropic Medication</td>
<td></td>
</tr>
</tbody>
</table>
b. The following services and service sites will be monitored at a minimum every three years by the Division, or its sub-contractor, and will include the following:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>SERVICE SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ancillary</td>
<td>Ambulatory Facilities</td>
</tr>
<tr>
<td>Dental</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Emergency</td>
<td>Nursing Facilities</td>
</tr>
<tr>
<td>Early Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Individual Respite Homes</td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
</tr>
<tr>
<td>Obstetric</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Prevention and Wellness</td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
</tr>
<tr>
<td>Specialty Care</td>
<td></td>
</tr>
<tr>
<td>Other (e.g. Durable Medical Equipment (DME)/Medical Supplies, Home Health Services, Therapies, Transportation, etc.)</td>
<td></td>
</tr>
</tbody>
</table>
c. The following services and service sites will be monitored at a minimum every three years (unless otherwise noted) by the Division, or its sub-contractor, and will include the following:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>SERVICE SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health Care*</td>
<td>Assisted Living Centers*</td>
</tr>
<tr>
<td>Ancillary</td>
<td>Assisted Living Homes*</td>
</tr>
<tr>
<td>Attendant Care*</td>
<td>Ambulatory Facilities</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Behavioral Health Facilities</td>
</tr>
<tr>
<td>Dental</td>
<td>Developmentally Disabled (DD)Group Homes*</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)/ Medical Supplies</td>
<td>Developmental Homes*</td>
</tr>
<tr>
<td>Emergency</td>
<td>Hospice*</td>
</tr>
<tr>
<td>Emergency Alert</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Environmental Modifications</td>
<td>Institution for Mental Diseases*</td>
</tr>
<tr>
<td>Early Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Intermediate Care Facility for Persons with Intellectual Disabilities*</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Nursing Facilities*</td>
</tr>
<tr>
<td>Habilitation Services (as applicable)</td>
<td>Own Home*</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Residential Treatment Centers*</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Traumatic Brain Injury Facilities*</td>
</tr>
<tr>
<td>Homemaker*</td>
<td>Individual Respite Homes*</td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Medical/Acute Care</td>
<td></td>
</tr>
<tr>
<td>Obstetric</td>
<td></td>
</tr>
<tr>
<td>Personal Care Services* †</td>
<td></td>
</tr>
<tr>
<td>Directed Care Services*††</td>
<td></td>
</tr>
<tr>
<td>Prevention and Wellness</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
</tr>
<tr>
<td>Respite Care</td>
<td></td>
</tr>
<tr>
<td>Specialty Care</td>
<td></td>
</tr>
<tr>
<td>Therapies (Occupational Therapy [OT], Physical Therapy [PT], Speech Therapy [ST])</td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
</tr>
</tbody>
</table>

*These services must be reviewed annually.
†Defined in ARS §36-401(36)
‡‡Defined in ARS §36-401(15)
d. The Division monitors Attendant Care, Homemaker services, Respite services, and Habilitation services on an annual basis. When deficiencies or potential deficiencies are identified, they are addressed from a member and system perspective.

e. The Division submits monitoring results to AHCCCS Clinical Quality Management annually by December 15. Additionally, an agreed-upon tool is used for:

i. General monitoring, to include the verification of:
   - The written documentation of timeliness
   - The implementation of contingency plans
   - Customer/Member satisfaction information
   - The effectiveness of service provision
   - Mandatory documents, in the services file or service site personnel file, including documentation of:
     - Cardio Pulmonary Resuscitation (CPR) training
     - First Aid training
     - Skills or competencies to provide care
     - Evidence that the agency contacted at least three references, one of which must be a former employer. Results of the contacts are documented in the employee's personnel record.

ii. Specific monitoring of Direct Care Services (Attendant Care/Homemaker services), to include verification of:
   - Mandated written agreement between the member and/or member representative and the Direct Care Worker (DCW) that defines the responsibilities of each
   - Evaluation of the appropriateness of allowing the member’s immediate relatives to provide attendant care
   - DCWs competencies to provide care including training, testing, verifying and sharing testing records of DCWs
   - Compliance with continuing education standards
   - Incorporation of testing results into monitoring tools for organizational providers that are and are not Approved DCW Training and Testing Programs
   - Timeliness and content of supervisory visitations.
f. The Division:
   i. Monitors that the Arizona Long Term Care System services a member receives aligns with those documented in the member's service plan and are appropriate, and
   ii. Uses the National Core Indicator Survey to assess the experience of members receiving long term care services.

**Implementation of Actions to Improve Care**

A. If problems are identified, the Division may develop and monitor a corrective action plan required by AHCCCS and may require the development and monitoring of a corrective action plan by its service providers. The CAP addresses the following:

1. Specified specific problem(s) requiring the corrective action. Examples include:
   a. Abuse, neglect, and exploitation
   b. Healthcare acquired conditions
   c. Unexpected death
   d. Isolated systemic issues
   e. Trends
   f. Health and safety issues, Immediate Jeopardy and Immediate Care Need situations
   g. Lack of coordination
   h. Inappropriate authorizations for specific ongoing care needs,
   i. High profile/media events
   j. Other examples as identified by the Division.

2. All determinations regarding quality issues that are referred for peer review will be made only by the Peer Review Committee chaired by the Chief Medical Officer. Per the ruling of the Peer Review Committee to refer a decision for review, the person(s) or body (e.g., board) will be responsible for making the final determinations regarding quality issues.

3. Type(s) of action(s) to be taken, including:
   a. Education/training/technical assistance
   b. Follow-up monitoring and evaluation of improvement
   c. Changes in processes, organizational structures, forms
Quality Management/Performance Improvement Program

4. Method(s) for internal dissemination of findings and resulting corrective action plans to appropriate staff and/or network providers, and documentation of assessment of the effectiveness of actions taken

5. Method(s) for dissemination of pertinent information to AHCCCS Administration and/or regulatory boards and agencies (e.g., Arizona Department of Health Services, Arizona Medical Board, Arizona Board of Pharmacy, Arizona State Board of Nursing).

B. The Division maintains documentation confirming implementation of corrective action.

d. Informal counseling
e. Termination of affiliation, suspension or limitation of the provider (if an adverse action is taken with a provider the Division reports the adverse action to the AHCCCS Clinical Quality Management Unit within one business day)
f. Referrals to regulatory agencies
g. Other actions as determined by the Division.
Credentialing and Recredentialing Processes

EFFECTIVE DATE: May 3, 2016

Credentialing and Recredentialing System

The Division of Developmental Disabilities (Division) maintains a system for credentialing and recredentialing providers.

The Division delegates a portion of the required responsibilities of credentialing/ recredentialing to subcontractors.

A. The Division or its subcontractors conducts and documents credentialing and recredentialing for all providers, including those employed by an organizational provider contracted with the Division for care and services to members. Credentialing and recredentialing is completed for the following provider types:

1. Physicians (Medical Doctor [MD])
2. Doctor of Osteopathic Medicine (DO)
3. Doctor of Podiatric Medicine (DPM)
4. Nurse practitioners
5. Physician Assistants
6. Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers
7. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD])
8. Affiliated Practice Dental Hygienists
9. Psychologists
10. Optometrist
11. Certified Registered Nurse Anesthetist
12. Occupational Therapist
13. Speech and Language Pathologist
14. Physical Therapists
15. Independent behavioral health professionals who contract directly with the Division, including:
   a. Licensed Clinical Social Worker (LCSW)
b. Licensed Professional Counselor (LPC)

c. Licensed Marriage/Family Therapist (LMFT)

d. Licensed Independent Substance Abuse Counselor (LISAC)

16. Board Certified Behavioral Analysts (BCBAs)

17. Any non-contracted provider that is rendering services and sees 50 or more members per contract year

18. Covering or substitute oral health providers that provide care and services to members while providing coverage or acting as a substitute during an absence of the contracted provider. Covering or substitute oral health providers must indicate on the claim form that they are the rendering provider of the care of service.

B. The Division or it subcontractors ensure:

1. The credentialing and recredentialing processes do not discriminate against a provider who serves high-risk populations or who specializes in the treatment of costly conditions.

2. There is compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid or that employ individuals or entities that are excluded from participation.

C. The Division delegates a portion of the required responsibilities of credentialing/recredentialing to subcontractors.

1. The Division retains the right to approve, suspend, or terminate any provider credentialed by a subcontractor.

2. The Division is responsible for making an independent decision regarding any provider approved through a delegated credentialing process into its network.

D. The Division or its subcontractor’s Chief Medical Officer (CMO), or in the absence of the CMO, another designated physician:

1. Acts as the Chair of the Credentialing Committee

2. Implements the decisions made by the Credentialing Committee

3. Oversees the credentialing process.

E. The Division ensures the use of participating Arizona Medicaid network providers in making credentialing decisions through participation in the Credentialing Committee.

F. The Division or its subcontractor maintains an individual electronic or hard copy credentialing/recredentialing file for each credentialed provider in accordance
with AHCCCS policy.

G. Credentialed providers are included in the claims payment system within 30 calendar days of Credentialing Committee approval.

H. Credentialed providers must be entered/loaded into the claims payment system with an effective date of no later than the date the provider was approved by the Credentialing Committee or the contract effective date, whichever is later.

I. For Locum Tenens, the Division or its subcontractor verifies the status of the physician with the Arizona Medical Board and national databases.

**Initial Credentialing**

The Division or its subcontractors use the Arizona Health Plan Association’s Credential Verification Organization (CVO) as part of the credentialing process. The initial credentialing of physicians, other licensed health care providers, behavioral health providers, and BCBAs follow AHCCCS policy.

The Division or its subcontractor ensures network providers can ensure physical access, accommodations, and accessible equipment for members with physical and mental disabilities. Accommodations are reasonable and providers ensure culturally competent communications with members. The Division or its subcontractor ensures that providers can communicate, in a culturally competent manner, in the preferred language of those with limited-English-proficient members, diverse cultural and ethnic backgrounds, and disabilities, and regardless of gender, sexual orientation, or gender identity.

The Division or its subcontractor ensures that initial credentialing will include:

A. A written application to be completed, signed and dated by the provider that attests to the following elements:
   1. Reasons for any inability to perform the essential functions of the position, with or without accommodation,
   2. Lack of present illegal drug use,
   3. History of loss of license and/or felony convictions,
   4. History of loss or limitation of privileges or disciplinary action,
   5. Current malpractice insurance coverage,
   6. Attestation by the applicant of the correctness and completeness of the application (a copy of the signed attestation must be included in the provider's credentialing file), and
   7. Minimum five year work history or total work history if less than five years.

B. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification, if a prescriber.

C. Verification from primary sources of:
1. Licensure or certification,
2. Board certification, if applicable, or highest level of credentials attained.

**Temporary/Provisional Credentialing**

The Division or its subcontractor maintains procedures to address temporary or provisional credentials, when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-Alike Center, as well as hospital employed physicians (when appropriate), are credentialed using the temporary or provisional credentialing process, even if the provider does not specifically request their application be processed as temporary or provisional.

The Division or its subcontractors follow AHCCCS policy when granting temporary or provisional credentialing to:

A. Providers needed in medically underserved areas
B. Providers joining an existing, contracted oral health provider group
C. Covering or substitute providers providing services to members during a provider’s absence from the practice.

The Division or its subcontractor renders a decision regarding temporary or provisional credentialing in 14 calendar days from receipt of a completed application.

If a covering or substitute provider is used and is approved through the temporary/provisional credentialing process, the Division or its subcontractor ensures that its system allows payments to the covering/substitute provider. Covering or substitute providers also meet the requirements set forth in AHCCCS policy.

A. For consideration of temporary or provisional credentialing, at a minimum, a provider completes a signed application that includes:
   1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
   2. Lack of present illegal drug use
   3. History of loss of license and/or felony convictions
   4. History of loss or limitation of privileges or disciplinary action
   5. Current malpractice insurance coverage
   6. Attestation by the applicant of the correctness and completeness of the application. A copy of the most current signed attestation will be included in the provider’s credentialing file.

B. The applicant furnishes:
1. Work history for the past five years, or total work history if less than five years

2. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.

C. The Division or its subcontractor conducts primary verification of the following licensure or certification (a print out of license from the applicable Board’s official website denoting that the license is active with no restrictions is acceptable).

1. Board certification, if applicable, or the highest level of credential attained, and

2. National Provider Data Bank (NPDB) query, including:
   a. Minimum five year history of professional liability claims resulting in a judgment or settlement
   b. Disciplinary status with regulatory board or agency
   c. State sanctions or limitations of licenses
   d. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

D. The Division’s or its subcontractor’s CMO reviews the information obtained and determines whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and Credentialing Committee review, as outlined in this policy, is completed.

**Recredentialing Individual Providers**

A. The Division or its subcontractors use the Arizona Health Plan Association’s CVO as part of its credentialing process. Recredentialing of physicians and other licensed or certified health care providers:

1. Occurs at least every three (3) years

2. Includes an update of information obtained during the initial credentialing process

3. Verifies continuing education requirements are met, if applicable

4. Includes a process for monitoring health care providers specific information, including:

   a. Member concerns, which include grievances (complaints)

   b. Utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)

   c. Performance improvement and monitoring (e.g.,
quality of care issues (including trend data). If an adverse action is taken with a provider, including non-renewal of a contract, the Division reports the adverse action and includes the reason for the adverse action to the AHCCCS Clinical Quality Management Unit within one business day.

d. Results of medical record review audits, if applicable

e. Pay for performance and value-driven health care data/outcomes, if applicable

g. Evidence that the provider’s policies and procedures meet AHCCCS requirements

B. Timely approval (or denial) by the Division’s Credentialing Committee occurs within 90 days of recredentialing being initiated.

Initial Credentialing of Organizational Providers

A. The Division or its subcontractors ensures the organizational provider has established policies and procedures that meet AHCCCS and Division requirements, as a prerequisite to contracting with an organizational provider. The requirements described in this section are met for all organizational providers in its network, including, but not limited to:

1. Hospitals
2. Home health agencies
3. Attendant care agencies
4. Habilitation providers
5. Group homes
6. Nursing facilities
7. Dialysis centers
8. Dental and medical schools
9. Freestanding surgical centers
10. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
11. State or local public health clinics
12. Community/Rural Health Clinics (or Centers)
13. Air transportation
14. Non-emergency transportation vendor
15. Laboratories
16. Pharmacies
17. Respite homes/Providers
18. Adult/Child Developmental Homes
19. Day/Employment Homes
20. Therapies
21. Behavioral health facilities, including but not limited to:
   a. Independent Clinics
   b. FQHCs
   c. FQHC look-alikes
   d. Community Mental Health Centers
   e. Level 1 Sub-Acute Facility
   f. Level 1 Sub-Acute Intermediate Care Facility
   g. Level 1 Residential Treatment Center (secure and non-secure)
   h. Community Service Agency
   i. Crisis Services Provider/Agency
   j. Behavioral Health Residential Facility
   k. Behavioral Health Outpatient Clinic
   l. Integrated Clinic
   m. Rural Substance Abuse Transitional Agency
   n. Behavioral Health Therapeutic Home
   o. Respite homes/providers
   p. Specialized Assisted Living Centers
   q. Specialized Assisted Living Homes.

B. Prior to contracting with an organizational provider, the Division or its subcontractors:
1. Confirms the provider has met all the state and federal licensing and
regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement)

2. Confirms the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement), when applicable

3. Conducts an onsite quality assessment. The Division uses assessment criteria for each type of unaccredited organizational provider with which it contracts, that includes, at minimum, confirmation that the organizational provider has:
   a. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers listed in this policy
   b. Liability insurance
   c. Business license
   d. CMS certification or state licensure review/audit within the past three years of the credentialing date

   If this criterion is met and documentation supports provider passed inspection and meets Division or subcontractors standards, an on-site visit can be waived.
   e. In addition, for Community Service Agencies:
      i. A signed relationship agreement with the contractor whose members they are serving
      ii. An approved application with the contractor
      iii. A signed contract with a Regional Behavioral Health Authority - contracted network provider or with contractor directly as applicable.
      iv. A description of the services provided that matches the services approved on the Title XIX Certificate
      v. Fire inspection reports
      vi. Occupancy permits
      vii. Tuberculosis testing
      viii. CPR certification
      ix. First Aid certification
      x. Respite providers provide and maintain consistently a
signed agreement with an Outpatient Treatment Center.

4. Reviews and approves the organizational provider through the Division’s or its subcontractor’s Credentialing Committee.

5. For transportation vendors, reviews a maintenance schedule for vehicles used to transport AHCCCS members and the availability of age-appropriate car seats when transporting children.

Reassessment of Organizational Providers

A. The Division or its subcontractors reassess organizational providers at least every three years. The reassessment includes the following information, which must be current:

1. Confirmation the organizational providers remain in good standing with state and federal bodies, and, if applicable, are reviewed and approved by an accrediting body, by validating the organizational provider:
   a. Is licensed to operate in the state, and is in compliance with any other state or federal requirements as applicable
   b. Is reviewed and approved by an appropriate accrediting body.

   If an organizational provider is not accredited or surveyed and licensed by the state, an on-site review is conducted.

2. Review of:
   a. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review is be documented) and, if applicable, review of the online “Hospital Compare” or “Nursing Home Compare”
   b. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications
   c. Supervision of staff and required documentation of direct supervision/clinical oversight as required, including, if applicable, review of a valid sample of clinical/member charts
   d. Most recent audit results of the organizational provider
   e. Confirmation that the service delivery address is correct
   f. Verification that staff meet the credentialing requirements.

3. Evaluation of organizational provider-specific information, such as but not limited to the following:
   a. Member concerns which include grievances (complaints)
   b. Utilization management information
c. Performance improvement and monitoring
d. Quality of care issues
e. Onsite assessment.

4. The Division’s Credentialing Committee reviews and approves all credentialing decisions.

5. The Division reviews and monitors other types of organizational providers in accordance with their contract.

**Notification Requirements - Suspensions and Terminations**

The Division or its subcontractors must report within one business day issues/quality deficiencies that result in a provider’s suspension or termination from the network to the AHCCCS Clinical Quality Management Unit. If the deficiency is determined to have criminal implications, including allegations of abuse or neglect, the Division promptly notifies a law enforcement agency, and Adult Protective Services or the Department of Child Safety. In addition, the Division or its subcontractors have processes in place to report providers to licensing, certification agencies and other regulatory entities, such as medical, nursing boards, etc. when there are allegations of misconduct, prescribing concerns, etc.

The Division or its subcontractors report to the AHCCCS Clinical Quality Management Unit all credentialing, provisional credentialing, recredentialing, and organizational credentialing denials that are based on quality-related issues or concerns.

A. The Division or its subcontractor indicates in its notification to AHCCCS the reason for the denial decision and when restrictions are placed on the provider’s contract, such as denials or restrictions which are the result of licensure issues, quality of care concerns, excluded providers, alleged fraud, and waste or abuse. The Division or its subcontractors:

1. Maintains documentation of implementation of the procedures
2. Has an appeal process for instances in when restrictions are placed on the provider’s contract based on issues of quality of care and/or service
3. Informs the provider of the Quality Management (QM) dispute process through the QM Department
4. Notifies the AHCCCS Clinical Quality Management (CQM) within one business day for all reported events.

**Notification Requirements - Final Adverse Actions**

A. Within one business day, the Division or its subcontractors reports to the AHCCCS Clinical Quality Management Unit in writing, any final adverse action for any reason, taken against a health care provider, supplier/vendor, or practitioner.
B. A final adverse action includes:

1. Civil judgments in federal or state court related to the delivery of a health care item or service

2. Federal or state criminal convictions related to the delivery of a health care item or service, and

3. Actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
   a. Formal or official actions, such as restriction, revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation,
   b. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such federal or state agency that is publicly available information,
   c. Exclusion from participation in federal or state health care programs as specified in current statute, and
   d. Any other adjudicated actions or decisions as necessary.

4. Any adverse credentialing, provisional credentialing, recredentialing, or organizational credentialing decision made based on quality-related issues/concerns or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the Division’s or its subcontractors network, provider termination, provider suspension or an action that limits or restricts a provider.

C. A final adverse action does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made.

D. The Division or its subcontractors submits to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):

1. Within 30 calendar days from the date the final adverse action was taken or the date when the Division or its subcontractors became aware of the final adverse action, or

2. By the close of the Division’s or its subcontractors next monthly reporting cycle, whichever is later.

E. The Division or its subcontractors immediately notifies the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the AHCCCS Program, including allegations of fraud, waste or abuse that were resolved internally but involved AHCCCS funds. The Division or its
subcontractors also reports to AHCCCS, as specified in Attachment F3, Contractor Chart of Deliverables, any credentialing denials issued by the CVO including, but not limited to, those that are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. AHCCCS-OIG conducts a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. The Division or its subcontractors reports, within one business day, the following:

1. The name and Tax Identification Number (TIN) (as defined in section 7701(A)(41) of the Internal Revenue Code of 1986[1121])
2. The name (if known) of any heath care entity with which the health care provider, supplier, or practitioner is affiliated or associated
3. The nature of the final adverse action and whether such action is on appeal
4. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information determined by regulation, for appropriate interpretation of information reported under this section. The date the final adverse action was taken, its effective date and duration of the action
5. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, and
6. Documentation that the following sites have been queried; any provider that is found to be on any of the lists below may be terminated and the identity of the provider is disclosed to AHCCCS/OIG immediately:
   a. The System of Award Management (SAM)/www.sam.gov, formerly known as the Excluded Parties List System (EPLS)
   b. The Social Security Administration’s Death Master File
   c. The National Plan and Provider Enumeration System (NPPES)
   d. The List of Excluded Individuals (LEIE)
   e. Any other databases directed by AHCCCS or CMS.

Teaching Physicians and Teaching Dentists

A. AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist. In limited circumstances when specific criteria are met, medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

B. The teaching physicians and teaching dentists must be an AHCCCS registered provider and must be credentialed by the AHCCCS Contractors in accordance with AHCCCS policy as set forth in this Policy.
Credentialing Timeliness

The Division or its subcontractors processes credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing, the number of complete applications processed (approved/denied) during the time period per category is divided by the number of complete applications that were received during the time period per category.

The timeliness standards for approvals/denials, expressed as a percentage of total received, is shown below.

<table>
<thead>
<tr>
<th>Type of Credentialing</th>
<th>Timeframe</th>
<th>Completion Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provisional</td>
<td>14 days</td>
<td>100%</td>
</tr>
<tr>
<td>Initial</td>
<td>90 days</td>
<td>100%</td>
</tr>
<tr>
<td>Organizational</td>
<td>90 days</td>
<td>100%</td>
</tr>
<tr>
<td>Credentialing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Load Times</td>
<td>30 Days</td>
<td>90%</td>
</tr>
</tbody>
</table>

(Thickness between credentialing Committee approval and loading into claims system.)
960 TRACKING AND TRENDING OF MEMBER AND PROVIDER ISSUES

EFFECTIVE DATE: May 20, 2016

Documentation Related to Quality of Care Concerns

As a part of the Division’s process for reviewing and evaluating member and provider issues, there are written procedures regarding the receipt, initial and ongoing processing of these matters that include the following:

A. Documenting each issue raised, when and from whom it was received, and the projected time frame for resolution.

B. Determining promptly whether the issue is to be resolved through the Division’s established:
   1. Quality management process,
   2. Grievance and appeals process,
   3. Process for making initial determinations on coverage and payment issues, or
   4. Process for resolving disputed initial determinations.

C. Acknowledging receipt of the issue and explaining to the member or provider the process that will be followed to resolve his or her issue through written correspondence.

D. Assisting the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.

E. Ensuring confidentiality of all member information.

F. Informing the member or provider of all applicable mechanisms for resolving the issue external to the Division’s processes.

G. Documenting all processes (including detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance or appeal, including but not limited to:
   1. Corrective action plan(s) or action(s) taken to resolve the concern,
   2. Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives,
   3. New policies and/or procedures,
   4. Follow-up with the member that includes, but is not limited to:
      a. Assistance as needed to ensure that the immediate health care needs
are met,

b. Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns, and

c. Referral to the Division’s compliance department and/or AHCCCS Office of the Inspector General.

**Process of Evaluation and Resolution of Quality of Care and Service Concerns**

The quality of care concern include documentation of identification, research, evaluation, intervention, resolution and trending of member and provider issues. Resolution includes both member and system interventions when appropriate. The quality of care/service concern process is a stand-alone process completed through the quality management unit with assistance from other units when necessary. The process is not combined with other Division meetings or processes. Other units outside of the Quality Management unit do not have the authority to solely conduct quality of care investigations but may provide subject matter expertise throughout the investigative process.

A. The Division maintains procedures that address analysis the quality of care issues through:

1. Identification of the quality of care issues,

2. Initial assessment of the severity of the quality of care issue,

3. Prioritization of action(s) needed to resolve immediate care needs when appropriate,

4. Review of trend reports obtained from the Division’s quality of care concern data to determine possible trends related to the provider(s), including organizational providers involved in the allegation(s) severity and substantiation,

5. Research, including, but not limited to:

   a. A review of the log of the events,

   b. Documentation of conversations,

   c. Medical records review, and

   d. Mortality review.

6. Quantitative analysis which may include root cause analyses when needed, and
7. Interviews of members, direct care staff, and witnesses to a reportable event; when applicable and appropriate.

B. Onsite visits are conducted by the Division’s Quality Management staff when:
   1. There are identified health and safety concerns,
   2. Immediate jeopardy,
   3. Other situations as determined by Division administration, or
   4. At the request of AHCCCS.

Subject matter experts outside the Quality Management unit may participate in the onsite visit but may not take the place of Quality Management staff during reviews.

C. The Division participates in efforts to prevent, detect and remediate all critical issues including those that are self-identified, or when notified by AHCCCS of issues.

D. The Division does not delegate quality of care investigation processes or onsite quality of care issues.

E. The Division maintains a process to assure that action is taken when needed by:
   1. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring,
   2. Determining, implementing, and documenting appropriate interventions,
   3. Monitoring and documenting the success of the interventions,
   4. Incorporating interventions into the organizations Quality Management (QM) program if successful, or
   5. Implementing new interventions/approaches when necessary.

F. The Division maintains a process to ensure resolution of the issue. Member and system resolutions may occur independently from one another.

G. The Division maintains a process to determine the level of severity of the quality of care issue.

H. The Division maintains a process to confirm referral and/or reporting of issues to the appropriate regulatory agency including:
   1. The Department of Child Safety,
   2. Adult Protective Services,
3. Arizona Department of Health Services (AZDHS),
4. The Attorney General’s Office,
5. Law Enforcement,
6. AHCCCS, and/or
7. Other entities as necessary.

Initial reporting may be made verbally, but must be followed by a written report within one business day.

I. The Division maintains a process to refer the issues to the Division’s Peer Review Committee when appropriate. Referral to the Peer Review Committee is not a substitute for implementing interventions aimed at individual and systemic quality improvement.

J. If an adverse action is taken with a provider for any reason including those related to quality of care concern, the Division must report the adverse action to the AHCCCS Clinical Quality Management Unit within 24 hours of the determination to take an adverse action as well as to the National Practitioner Data Bank when needed.

K. The Division maintains a process to determine the level of substantiation of the quality of care or service issue.

L. The Division maintains a process to provide written notification to the appropriate regulatory/licensing Board or Agency and AHCCCS when a health care professional/s organizational provider or other provider’s affiliation with its network is suspended or terminated for any reason, including those related to quality of care issues.

M. The Division maintains a process to document the criteria and process for closure of the review or investigation including:

1. A description of the problems, including new allegations identified during the investigation/review process, and the substantiation and severity level for each allegation as well as the case overall.

2. Written response or summary of the documents received from referrals made to outside agencies such as accrediting bodies, or Medical Examiner.

N. The Division notifies AHCCCS CQM and takes appropriate action with the provider including suspension or corrective action plans and referrals to appropriate regulatory Boards including the Pharmacy Board when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to check the CSPMP, to coordinate care with other prescribers, refer for substance use treatment or pain management. The case finding are presented to the Division’s Peer Review Committee for discussion and review.
Requests for Copies of Death Certificates

As part of the quality of care investigative process, the Division will request copies of member death certificates from the ADHS Office of Vital Statistics. The following process is followed:

A. The Division sends a letter, on Division letterhead, providing one or two names of employees who are authorized to make the request for a copy of the death certificate.

B. Only those individual(s) listed on the letter are eligible to apply/request a copy of the death certificate.

C. The letter must include original ink signatures and is mailed to:

   1. Arizona Department of Health Records
      Office of Vital Records
      Office Chief
      P.O Box 3887
      Phoenix, Arizona 85030

D. The Division notifies the AZDHS Office of Vital Statistics in writing of any termination of employment of those listed on the original letter. Included in the notification should be the name of the replacement managerial or supervisory staff person. These changes should be mailed to:

   1. Operations Section Manager
      Arizona Department of Health Services
      Office of Vital Records
      P.O Box 3887
      Phoenix, Arizona 85030

E. The following information will be included on requests for death certificates:

   1. The decedents’ s (member’s) name,

   2. Date of death,

   3. Purpose of request (i.e. quality of care investigation process), and

   4. Signature of the authorized employee

   Documentation showing that the decedent was a member of the Division (copy of an eligibility screen with the Division’s name, members name and date of eligibility is acceptable)

F. All requests for death certificates are sent to:

   1. Arizona Department of Health Records
Tracking and Trending of Quality of Care Issues

A. The Division maintains a system to document, track, trend and evaluate complaints and allegations received from members and providers or as requested by AHCCCS, inclusive of quality care, quality of service and immediate care need issues.

B. The information from the quality of care concern data is analyzed and evaluated to determine any trends related to the quality of care or service in the Division’s service delivery system or provider network. The Division incorporates trending of quality of care issues in determining systemic interventions for quality improvement.

C. The Division documents quality tracking and trending information as well as documentation that the information was submitted, reviewed and considered for action by the Division’s Quality Committee and Chief Medical Officer, as Chairman of the Quality Management Committee.

D. Quality tracking and trending information from all closed quality of care issues within the reporting quarter is submitted to AHCCCS/Division of Health Care Management/Clinical Quality Management (AHCCCS/DHCM/CQM) utilizing the Quarterly Quality Management Report template provided by AHCCCS. The report is due 60 days after the end of each quarter and includes the following reporting elements:

1. Types and number/percentages of substantiated quality of care issues,
2. Intervention implemented to resolve and prevent similar incidents, and
3. Resolution status of “substantiated”, “unsubstantiated” and “unable to substantiate” quality of care issues.

E. If significant negative trends are noted, the Division considers developing performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process.

F. The Division subcontracts to AHCCCS CQM all pertinent information regarding an incident of abuse, neglect exploitation, unexpected death (including all unexpected transplant deaths), and other critical incidents as determined by the Division or AHCCCS as soon as the Division is aware of the incident, and no later than 24 hours after receiving a credible report. Pertinent information must not be limited to autopsy results, and must include a broad review of all issues and possible areas of concern. Delays in receipt of autopsy results shall not result in delays of the Division’s investigation of a quality of care concern. Delayed autopsy results shall be used by the Division to confirm the resolution of the quality of care concern.
G. The Division ensures member health record are available and accessible to authorized staff and to appropriate State and Federal authorities, or their delegates, involved in accessing quality of care/service or investigating member or provider quality of care concerns, complaints, allegation of abuse, neglect exploitation, serious incidents, grievances, Provider Preventable Conditions and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility complies with Federal and State confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPPA) and C.F.R. 431.300 et seq.

H. Information related to coverage and payment issues is maintained for at least five years following resolution of the issue, and is made available to the member, provider and/or AHCCCS authorized staff upon request.

**Provider-Preventable Conditions**

A. Payments are prohibited for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).

1. If an HCAC or OPPC is identified, the Division conducts a quality of care investigation, and

2. Reports the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

The term HCAC and OPPC are defined as follows:

Health Care Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program which occurs in any inpatient hospital setting and is not present on admission. (Refer to the current CMS list of Hospital-Acquired Conditions).

Other Provider Preventable Conditions (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

A. Surgery on the wrong member,

B. Wrong surgery on a member, and

C. Wrong site surgery.
Performance Measures are reported to Arizona Health Care Cost Containment System (AHCCCS) Clinical Quality Management on a quarterly basis. The Division of Developmental Disabilities (Division) evaluates performance based on sub-categories of populations when reasonable to do such.

**Quality Management Performance Measure Requirements**

The Division complies with AHCCCS quality management requirements to improve performance in all AHCCCS established performance measures. The Division applies the correct performance measure methodologies, including the Center for Medicare and Medicaid Services (CMS) methodology, for its internal monitoring of performance measure results. The Division provides oversight sufficient to ensure compliance with all AHCCCS requirements when performance measure activities fall under delegated duties.

A. The Division:

1. Achieves at least the Minimum Performance Standards (MPS) established by AHCCCS for each measure, based on the rate calculated by AHCCCS or,

2. Develops an evidence-based Corrective Action Plan (CAP) for each measure not meeting the MPS to bring performance up to at least the minimum level established by AHCCCS.

3. Receives AHCCCS approval prior to implementation. Each CAP will minimally include the components set forth by AHCCCS.

4. Monitors and reports to AHCCCS the status of and any discrepancies identified in encounters submitted to and received by AHCCCS including paid, denied, and pended encounters for purposes of Performance Measure monitoring. The Division monitors encounter submissions by its subcontractors.

5. Shows demonstrable improvement from year to year, which is sustained over time, in order to meet goals for performance established by AHCCCS.

6. Complies with national performance measures and levels that may be identified and developed by the CMS in consultation with AHCCCS.

a. The Division Quality Management/Performance Improvement Program internally measures and reports to AHCCCS its performance on contractually mandated performance measures, using standardized methodology established or adopted by AHCCCS.

b. The Division uses the results of the AHCCCS contractual performance measure in evaluating its quality assessment and performance improvement program.
c. The Division shows demonstrable and sustained improvement toward meeting AHCCCS Performance Standards.

7. The Division collects data used to measure performance as required by AHCCCS. The Division submits specific documentation as requested by AHCCCS to verify that indicator criteria were met.
980 PERFORMANCE IMPROVEMENT PROJECTS

REVISION DATE: 11/17/2017
EFFECTIVE DATE: May 13, 2016

Overview

The Division participates in Performance Improvement Projects (PIPs) selected by AHCCCS in accordance with standardized methodology. The Division of Developmental Disabilities (Division) also selects and designs additional PIPs specific to needs identified through internal monitoring of trends and data. Topics take into account comprehensive aspects of enrollee needs, care, and services for a broad spectrum of members or a focused subset of the population. The Division considers all populations and services covered when selecting PIPs.

The Division participates in performance measures and performance improvement projects that are mandated by Centers for Medicare and Medicaid Services (CMS) in consultation with AHCCCS, other states, and other stakeholders. The Division conducts oversight sufficient to confirm that AHCCCS mandated PIPs are implemented appropriately meeting all requirements when such projects fall under delegated duties.

Performance Improvement Projects (PIPs) Design

A. PIPs are designed, through ongoing measurement and intervention, to achieve:

1. Demonstrable improvement, sustained over time, in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction

2. Correction of significant systemic problems

3. Clinical focus topics may include:
   a. Primary, secondary, and/or tertiary prevention of acute conditions
   b. Primary, secondary, and/or tertiary prevention of chronic conditions
   c. Care of acute conditions
   d. Care of chronic conditions
   e. High-risk services
   f. Continuity and coordination of care.

4. Non-clinical focus topics that may include:
   a. Availability, accessibility, and adequacy of the Division’s service delivery system
   b. Cultural competency of services
c. Interpersonal aspects of care (i.e., quality of provider/member encounters)
d. Appeals, grievances, and other complaints.

B. PIP methodologies are developed according to current statute, AHCCCS requirements, and community practice inclusive of quality assessment and performance improvement programs for Medicaid managed care organizations.

**Data Collection Methodology**

Assessment of the Division’s performance on the selected measures is based on systematic, ongoing collection and analysis of the most accurate, valid and reliable data, as collected and analyzed by AHCCCS. The Division collects all or some of the data used to measure performance when needed. The Division ensures inter-rater reliability if more than one person is collecting and entering data. The Division maintains specific documentation to verify that indicator criteria were met.

**Measurement of Demonstrable Improvement**

The Division initiates interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Improvement is evidenced in repeated measurements of the indicators specified for each PIP undertaken.

A. The Division strives to meet or exceed established benchmark levels of performance.

B. The Division defines demonstrated improvement as improvement that:

1. Meets or exceeds the AHCCCS overall average for the baseline measurement, if its baseline rate was below the average and the increase is statistically significant.

2. Shows a statistically significant increase, if its baseline rate was at or above the AHCCCS overall average for the baseline measurement, or

3. Is the highest performing (benchmark) plan in any re-measurement and maintains or improves its rate in a successive measurement.

C. The Division defines sustained improvement as improvement that demonstrates that the Division:

1. Maintains or increases the improvements in performance for at least one year after the improvement in performance is initially achieved.

2. Demonstrates how the improvement can be reasonably attributed to the interventions undertaken.
Performance Improvement Projects (PIPs) Timeframes

A. The Division initiates mandated PIPs on a date established by AHCCCS. Baseline data is collected and analyzed at the beginning of the PIP for the AHCCCS determined timeframes.

B. During the initial year of a mandated PIP, the Division implements interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served.

C. The Division uses any baseline data provided by AHCCCS in determining optimal interventions.

D. The Division uses a Plan-Do-Study-Act (PDSA) cycle to test changes (interventions) quickly and refine them as necessary. The rapid cycle improvement process is implemented in as short a time frame as practical based on the PIP topic.

E. The Division’s participation in the mandated PIP will continue until demonstration of significant improvement is sustained for at least one year.

F. Annually, the Division reports to AHCCCS its interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements.
1000  CHAPTER OVERVIEW

REVISION DATE: 11/22/2017
EFFECTIVE DATE:  May 13, 2016
REFERENCES: 9 A.A.C. 34, 42 CFR 438.210

The standards and requirements included in this Chapter are applicable to the Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSSs). If requirements of this Chapter conflict with specific contract language, the AHCCCS medical contract with the Division will take precedence.

At least annually, the Medical Management (MM) Unit will conduct reviews of each AdSS’s compliance with the requirements of this Chapter. The Division’s MM Unit is located within the Division’s Health Care Services.

The Chapter provides the necessary information to the Division and its AdSS to ensure compliance with federal, state, and AHCCCS requirements to medical management activities.

Monitoring

The Division monitors AHCCCS acute services, for the Division’s members, with the following processes:

A. Contracts with acute health plan

B. Operational Reviews with each Division contracted health plan

C. Quarterly compliance meetings with each Division contracted health plan

D. Annual Medical Management (MM) plans that include narratives, evaluations, completed work plans from the previous year and new work plans for the current year

E. Quarterly AHCCCS deliverables (includes EPSDT reports) oversight for Division members

F. Division contracted health plan quarterly Utilization Management (UM) reports

G. The Division’s Medical Management and Medical Director meetings to discuss data analysis, interventions, and Corrective Action Plans (CAPs). Informal clarification may occur as well as defined CAPs coordinated through the compliance units of the Division and the AdSSs.

H. Provider manual and member handbook oversight

I. Health Care Services Procedures.
Definitions

The Division’s words and phrases in this Chapter have the following meanings, unless the context explicitly requires another meaning. Refer to AHCCCS Policy for other applicable definitions.

A. **Assess or Evaluate** - to study or examine methodically and in detail, typically for purposes of explanation and interpretation.

B. **Authorization Request (Expedited)** - under 42 CFR 438.210, a request for which a provider indicates the Division determines that using the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function. The Division must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires no later than three working days following the receipt of the authorization request, with a possible extension of up to 14 days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member’s best interest.

C. **Authorization Request (Standard)** - under 42 CFR 438.210, a request for which a the Division must provide a decision as expeditiously as the member’s health condition requires, but not later than 14 calendar days following the receipt of the authorization request, with a possible extension of up to 14 calendar days if the member or provider requests an extension or if the Division justifies a need for additional information and the delay is in the member’s best interest.

D. **Care Management** – a group of activities performed by the Contractor to identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Distinct from case management, care management does not include day-to-day duties of service delivery.

E. **Case Management** – a collaborative process that 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.

F. **Catastrophic Reinsurance** - stop-loss mechanism to provide the Division with partial reimbursement for specified service costs incurred by a member. This risk-sharing program is available when the provisions delineated in the Reinsurance Processing Manual, Medical Policy Manual, and contract are met.

G. **Concurrent Review** - process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care. The Division reviewers assess the appropriate use of resources, Level of Care (LOC) and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care.
H. **Continuous Health Care Improvement** - integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

1. Identifying and proactively monitoring high-risk populations
2. Assisting members and providers in adhering to identified evidence-based guidelines
3. Promoting care coordination
4. Increasing and monitoring member self-management
5. Optimizing member safety.

I. **Delegated Entity** - qualified organization, agency, or provider that holds a subcontract to perform delegated management/administrative functions or responsibilities for the Division.

J. **Disease Management** - an integrated approach to health care delivery that seeks to improve health outcomes and reduce health care costs by:

1. Identifying and proactively monitoring high-risk populations
2. Assisting members and providers in adhering to identified evidence-based guidelines
3. Promoting care coordination
4. Increasing and monitoring member self-management
5. Optimizing member safety.

K. **Goal** - desired result the Division envisions, plans, and commits to achieve within a proposed timeframe.

L. **Grievance** - expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships, such as rudeness of a provider or employee, or failure to respect the member’s rights. Grievances do not include “Action(s)” as defined in 9 A.A.C. 34.

M. **Measurable** - a gauge to determine definitively whether a goal has been met or progress has been made.

N. **Medical Management (MM)** - integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve the desired health outcomes, across the continuum of care (from prevention to end of life care).

O. **Methodology** - planned process, steps, activities, or actions taken by the Division to achieve a goal or objective or to progress toward a positive outcome.
P. Monitoring – process of auditing, observing, evaluating, analyzing and conducting follow-up activities, and documenting results.

Q. Retrospective Review - process of determining the medical necessity of a treatment/service post-delivery of care.

R. Utilization Management - applies to a Division process to evaluate and approve or deny health care services, procedures, or settings based on medical necessity, appropriateness, efficacy, and efficiency. Utilization management also includes processes for prior authorization, concurrent review, retrospective review, and case management.
1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 C.F.R. § 438.210(b)(3), A.R.S. 36-2907(B), A.A.C. R9-22-201 et seq. (Article 2)

Medical Management Plan

The Division develops a written Medical Management (MM) Plan that describes the methodology to meet or exceed the standards and requirements of contract. The Division submits the MM Plan, and any subsequent modifications, to the Arizona Health Care Cost Containment System (AHCCCS) Medical Management (MM) for review and approval prior to implementation. At a minimum, the MM Plan describes, in detail, the MM program and how program activities assure appropriate management of medical care service delivery for enrolled members. MM Plan components include:

A. A description of the Division’s administrative structure for oversight of its MM program, including the role and responsibilities of:
   1. The governing or policy-making body
   2. The MM committee
   3. The Executive Management
   4. MM program staff.

B. An organizational chart that delineates the reporting channels for MM activities and the relationship to the Medical Director and Executive Management

C. Documentation that the governing or policy-making body has reviewed and approved the Plan

D. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out MM program functions

E. The Division’s specific MM goals and measurable objectives as required by AHCCCS Policy

F. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to members in compliance with State and Federal regulations:
   1. MM Utilization Data Analysis and Data Management
   2. Concurrent Review
   3. Discharge Planning
   4. Prior Authorization
   5. Inter-Rater Reliability
6. Retrospective Review
7. Clinical Practice Guidelines
8. New Medical Technologies and New Uses of Existing Technologies
9. Case Management/Care Coordination
10. Disease/Chronic Care Management
11. Drug Utilization Review

G. The Division’s method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with AHCCCS Policy

H. A description of how delegated activities are integrated into the overall MM program and the methodologies for oversight and accountability of all delegated functions, as required by AHCCCS Policy

I. Documentation of input into the medical coverage policies from the Division or providers and members

J. A summary of the changes made to the Division’s list of services requiring prior authorization and the rationale for those changes.

**MM Work Plan**

The Division develops a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the MM program requirements outlined in AHCCCS Policy. The work plan:

A. Is submitted in an acceptable format or in the template provided by the MM Unit

B. Supports the MM Plan goals and objectives

C. Includes goals that are quantifiable and reasonably attainable

D. Includes specific actions for improvement

E. Incorporates a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to AHCCCS Policy for details related to PDSA methodologies.
**MM Evaluation**

An annual narrative evaluation of the effectiveness of the previous year’s MM strategies and activities is submitted to AHCCCS MM after being reviewed and approved by the Division governing or policy-making body; the evaluation includes:

A. A summary of the MM activities performed throughout the year with:
   1. The title/name of each activity
   2. The desired goal and/or objective(s) related to each activity
   3. The staff positions involved in the activities
   4. Trends identified and the resulting actions implemented for improvement
   5. The rationale for actions taken or changes made
   6. A statement describing whether the goals/objectives were met.

B. Review, evaluation and approval by the MM Committee of any changes to the MM Plan

C. Necessary follow-up with targeted timelines for revisions made to the MM Plan.

The MM Plan and MM Evaluation may be combined or written separately, as long as required components are addressed and easily located.

Refer to AHCCCS Policy for reporting requirements and timelines.

**MM Administrative Oversight**

A. The Division ensures ongoing communication and collaboration between the Division MM program and the other functional areas of the Division (e.g., quality management, member and provider services).

B. The Division has an identifiable and structured MM Committee that is responsible for MM functions and responsibilities, or if the MM Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that MM issues and topics are presented, discussed and acted upon.

1. At a minimum, the membership includes:
   a. The Medical Director or appointed designee as the chairperson of the MM Committee
   b. The MM Manager
   c. Representation from the functional areas within the Division
   d. Representation of contracted or affiliated providers.
2. The Medical Director, as chairperson for the MM Committee, or his/her designee, is responsible for the implementation of the MM Plan and has substantial involvement in the assessment and improvement of MM activities.

3. The MM Committee ensures that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or MM Committee sign-in sheets with requirements noted).

4. The frequency of MM Committee meetings is sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the MM Committee meets quarterly.

5. MM Committee meeting minutes include the data reported to the MM Committee, and analysis and recommendations made by the MM Committee. Data, including utilization data, may be attached to the MM Committee meeting minutes as separate documents if the documents are noted in the MM Committee meeting minutes. Recommendations made by the MM Committee are discussed at subsequent MM Committee meetings. The MM Committee reviews the MM program objectives and policies annually and updates them as necessary to ensure:

a. The MM responsibilities are clearly documented for each MM function/activity

b. Division staff, administrative services sub-contractors and providers are informed of the most current MM requirements, policies and procedures in a timely fashion in order to allow for implementation that does not adversely impact the members or provider community

c. The providers are informed of information related to their performance (e.g., provider profiling data)

d. The MM policies and procedures, and any subsequent modifications to them, are available upon request by the AHCCCS MM Unit.

C. The MM Program is staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities.

1. Staff qualifications for education, experience and training are developed for each MM position.

2. The grievance process is part of the new hire and annual staff training. including, but not limited to:

a. What constitutes a grievance

b. How to report a grievance

c. The role of the quality management staff in grievance resolution.

3. A current organizational chart is maintained to show reporting channels and responsibilities for the MM program.
D. The Division maintains records that document MM activities, and make the information available to AHCCCS MM Unit upon request. The required documentation includes, but is not limited to:

1. Policies and procedures
2. Reports
3. Practice guidelines
4. Standards for authorization decisions
5. Documentation resulting from clinical reviews (e.g. notes related to concurrent review, retrospective review, and prior authorization)
6. Meeting minutes including analyses, conclusions, and actions required with completion dates
7. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the MM program such as inter-rater-reliability
8. Other information and data deemed appropriate to support changes made to the scope of the MM Plan.

E. The Division has written policies and procedures pertaining to:

1. Information/data received from providers is accurate, timely, and complete.
2. Reported data is reviewed for accuracy, completeness, logic and consistency, and that the review and evaluation processes used are clearly documented.
3. All member and provider information protected by Federal and State law is kept confidential.
4. Informing appropriate parties of the MM requirements and updates, utilization data reports, and profiling results.
5. Identification of provider trends and subsequent necessary corrective action
6. Quarterly evaluations and trending of subcontracted health plan internal appeal overturn rates
7. Quarterly evaluations of the timeliness of service request decisions
8. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.
The Division has processes that ensure:

1. Per 42 C.F.R. 438.210(b)(3), Qualified health care professionals, with appropriate clinical expertise in treating the enrollee’s condition or disease, render decisions to:
   a. Deny an authorization request based on medical necessity.
   b. Authorize a request in an amount, duration, or scope that is less than requested.
   c. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. 36-2907(B) and AHCCCS Administrative Code (A.A.C.) R9-22-201 et seq. (Article 2), as specified in section F.4.a (below) of this policy.

2. Per 42 C.F.R. 438.406(a)(3), Qualified health care professionals, with appropriate clinical expertise in treating the members’ condition or disease, and who have not been involved in any previous level of decision making, render decisions regarding:
   a. Appeals involving denials based on medical necessity
   b. Grievances regarding denial of expedited resolution of an appeal
   c. Grievances and appeals involving clinical issues.

3. Prompt notifications to the requesting provider and the member or member’s authorized representative or Medical Power of Attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice includes information as specified in the AHCCCS Contractor Operations Manual (ACOM).

4. For purposes of this section:
   a. The following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and nonskilled services within their scope of practice: physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor. Decision making includes determinations involving excluded or limited services under A.R.S. 36-2907 and A.A.C. R9-22-201 et seq. (Article 2).
b. In addition to those providers listed above, the following health care professionals have the appropriate clinical expertise to render decisions for non-skilled Home and Community Based Service (HCBS) such as attendant care, personal care, homemaker, habilitation, and non-nursing respite care:

i. Arizona Long Term Care System (ALTCS) case management staff when the individual is a:
   - Registered Nurse,
   - Licensed Practical Nurse,
   - Degreed social worker, or
   - An individual with a bachelor’s or master’s degree in a related field.

ii. Support Coordination ALTCS case management staff with a minimum of two consecutive years of experience in providing case management services to persons who are elderly and/or persons with physical or developmental disabilities, when the staff individual does not have a degree or a license.

5. Consistent application of standards and clinical criteria, and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action is developed and implemented for staff who fail to meet the inter-rater reliability standards.

G. The Division maintains a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program. Data elements include but are not limited to:

1. Member demographics
2. Provider characteristics
3. Services provided to members
4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

H. The Division oversees and maintains accountability for all functions or responsibilities that are delegated to other entities. Documentation is kept that demonstrates:

1. A written agreement specifies the delegated activities and reporting responsibilities of the entity to the subcontracted health plan and include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.

2. The Division evaluates the entity’s ability to perform the delegated activities prior to executing a written agreement for delegation.
3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed.

I. The Division ensures:

1. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.

2. Providers are not prohibited from advocating on behalf of members within the service provision process.
1030 REPORTING REQUIREMENTS

EFFECTIVE DATE: November 22, 2017

Reports and Due Dates

The Administrative Services Subcontractors of the Division of Developmental Disabilities (Division) must submit data reports to the Division within the timeframe indicated in the Contract, Exhibit C Deliverables and Amendments.

The Division submits data reports to AHCCCS within the timeframe indicated in the AHCCCS Contract.
Outreach, Engagement, Re-engagement, and Closure for Behavioral Health

Overview

The Division develops and implements outreach, engagement, reengagement, and closure activities. The Division develops and makes available to providers its policies and procedures regarding outreach, engagement, reengagement, and closure, including any additional information specific to their operations.

Outreach includes activities designed to inform individuals of behavioral health services availability and to engage or refer those individuals who may need services. The activities described within this section are essential elements of clinical practice. Outreach to vulnerable populations, establishing an inviting and non-threatening environment, and re-establishing contact with persons who have become temporarily disconnected from services are critical to the success of any therapeutic relationship.

Community Outreach

The Division provides and participates in community outreach activities to inform members of the benefits and availability of behavioral health services and how to access them. Outreach activities conducted by the Division may include the following:

A. Participation in local health fairs or health promotion activities.
B. Involvement with local schools
C. Involvement with outreach activities for military veterans, such as Arizona Veterans Stand Down Coalition events.
D. Development of outreach programs and activities for first responders (i.e. police, fire, EMT).
E. Regular contact with AHCCCS Contractor behavioral health coordinators and primary care providers.
F. Development of outreach programs to members experiencing homelessness.
G. Development of outreach programs to persons who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues, or are underserved.
H. Publication and distribution of informational materials.
I. Liaison activities with local, county, and tribal jails, prisons, county detention facilities, and local and county Department of Child Safety (DCS) offices and programs.
J. Regular interaction with agencies that have contact with substance abusing pregnant women/teenagers.
K. Development and implementation of outreach programs to identify members with co-
    morbid medical and behavioral health disorders and those who have been determined
to have Serious Mental Illness (SMI) within the Contractor’s geographic service area.
Including persons who reside in jails, homeless shelters, county detention facilities or
other settings.

L. Provision of information to behavioral health advocacy organizations.

M. Development and coordination of outreach programs to Native American tribes in
    Arizona to provide services for tribal members.

**Engagement**

The Support Coordinator must ensure active engagement by providers in the treatment
planning process with the following:

A. The member and/or member’s legal guardian

B. The member’s family or significant others, if applicable and amenable to the person

C. Other agencies or providers, as applicable

D. For persons with a SMI who are receiving Special Assistance (see AHCCCS AMPM Policy
   320-R), the person (guardian, family member, advocate or other) designated to
   provide Special Assistance.

**Reengagement**

The Support Coordinator takes the lead in the coordination with the Regional Behavioral
Health Authorities (RBHA) to ensure reengagement attempts are made with members who
have withdrawn from participation in the treatment process prior to the successful completion
of treatment, refused services or failed to appear for a scheduled service based on a clinical
assessment of need. All attempts to re-engage members must be documented in the
member’s file.

A. If attempts to engage the member are unsuccessful, the Support Coordinator must
    ensure further attempts are made to re-engage the member. Further attempts must
    include at a minimum: contacting the member or member’s responsible person face-
to-face, and contacting natural supports for whom the member has given permission to
    contact. All attempts to re-engage members must be clearly documented in the
    member’s case file.

B. If face-to-face contact with the member is successful and the member appears to be a
danger to self, danger to others, persistently, and acutely disabled or gravely disabled,
the Support Coordinator must determine whether it is appropriate to engage the
person to seek inpatient care voluntarily. If the member declines voluntary admission,
the Support Coordinator must initiate the pre-petition screening or petition for
treatment process described in AMPM Policy 320-U.

**Follow-up After Significant and/or Critical Events**

Discharge planning must begin upon notification that the member has been hospitalized. The
Support Coordinator must ensure activities are documented in the member’s case file and
follow-up activities are conducted to maintain engagement within the following timeframes.
A. Discharged from inpatient services, in accordance with the discharge plan and within seven days of the member’s release to ensure member stabilization, medication adherence, and to avoid re-hospitalization.

B. Involved in a behavioral health crisis within timeframes based upon the member’s clinical needs, but no later than seven days.

C. Refusing prescribed psychotropic medications within timeframes based upon the member’s clinical needs and individual history.
1200 OVERVIEW

REVISION DATE: 6/10/2016, 7/3/2015
EFFECTIVE DATE: June 30, 1994
REFERENCES: A.R.S. §§ 36, 32-1, 36-2939(B)(1), 36-591(G); A.A.C. R6-6-901 - R6-6-910; C.F.R. §§ 42, and, 42-456.1.

The following section contains information about services available either through the Arizona Long Term Care System (ALTCS) or the State only funded programs administered by the Division. Each eligible member will receive services in accordance with documented needs and availability of State funds.

The Arizona Long Term Care System (ALTCS) provides funding for certain services based upon assessed needs and medical necessity. ALTCS does not provide day care or educational services. Transitional Waiver services include all Home and Community Based Services under ALTCS and supported employment. The Transitional Waiver is a program for members who were eligible for the Arizona Long Term Care System and have improved either medically, functionally or both to the extent that they are no longer at risk of institutionalization at a nursing facility or Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) level of care. The Transitional Waiver does not cover institutional services in excess of 90 days.

Based on assessed need, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) drives what services, types and amounts of support a member may receive. The person with a disability may request the Planning Team to help them identify what their needs are, the best ways to meet those needs and what the primary caregiver(s) is willing and able to do. Often a person’s services needs may be met through natural supports (such as relatives, friends, places of worship and local community resources). A contracted service provider may also be used. Though funding for services through ALTCS is not intended to replace what families currently provide, under certain circumstances parents or family members may be paid to provide services that support home and community living.

Although the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan planning documents processes identifies needed services, members who are eligible for ALTCS shall receive information regarding their right to receive services as authorized.

Members who are eligible for ALTCS shall also receive information regarding the appropriate Division staff to contact if services are not provided as scheduled. The Support Coordinator must assess with the member their needs, the risk to the member if a gap in services were to occur and develop a contingency plan in the event of a services gap. These needs and risk factors are determined at the time of the initial and quarterly (90 day review) assessments. The Support Coordinator shall also explain the guidelines regarding the Divisions process (including a time estimate) for providing services when there is a service gap. The Division tracks and trends these gaps in services per the Arizona Health Care Cost Containment Systems (AHCCCS) contract requirements. The Division also submits a semi-annual report and other necessary reports to the AHCCCS summarizing trends, services gaps, and related grievances.
Primary care givers are not required to be in the home during the delivery of services unless one of the following situations exists:

A. The primary care giver provides "skilled care" and the service being provided is non-skilled care. In this case, the primary care giver would need to perform any "skilled care" that the provider is not certified/licensed to do.

B. The intent of the service as documented on the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) is to facilitate the primary care giver's ability to work with the member. As an example, the service is intended to directly train the family in learning how to respond to behavior problems.

Each person must be evaluated on a member basis to determine medical necessity as well as the cost effective level of care that will achieve the desired results. Only nurses or respiratory therapists can provide skilled care. For example, skilled care includes Jejunum tube insertion, catheter replacement, respiratory treatment such as small volume nebulizers suctioning, tracheostomy care.

Guidelines for services and evaluation criteria are found in the Service Approval Matrix (Prior Authorization). This information is available on the Division's website. https://www.azdes.gov/main.aspx?menu=96&id=2470

The source information regarding each service is found in one of the following documents:

C. A.R.S. §36. www.azleg.gov/ArizonaRevisedStatutes.asp; or,
D. The Division Service Specifications.
1210    INSTITUTIONAL SERVICES AND SETTINGS

EFFECTIVE DATE: June 30, 1994

The Division of Developmental Disabilities (Division) covers medically necessary institutional services provided in an Arizona Health Care Cost Containment System (AHCCCS) registered long term care facility for members who are eligible for the Arizona Long Term Care System (ALTCS).

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities. ALTCS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual. The Division uses an acuity tool to determine the level of institutional placement prior to placement.

Members who are eligible for the ALTCS transitional program are not eligible for Nursing Facility (NF) services or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) services exceeding 90 continuous days per admission.

**Nursing Facility**

**Service Description and Goals (Nursing Facility)**

This service provides skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care or direct daily care from a physician.

The goal of this service is to provide care that meets and enhances the medical, physical, and emotional needs of members residing in Nursing Facilities (NF).

**Service Settings (Nursing Facility)**

NFs must be Medicare and Medicaid certified and licensed by the Arizona Department of Health Services in accordance with 42 CFR 440.155 and 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis. For the purposes of reimbursement by ALTCS funding, the facility must be Medicare/ Medicaid certified.

**Service/Provider Requirements (Nursing Facility)**

The provider must demonstrate the following before the service is authorized:

A. The NF must be licensed and certified by the appropriate Arizona state agencies.
B. The NF must comply with all applicable federal and state laws relating to professional conditions, standards, and NF requirements, including the conditions set forth in the 42 CFR 483 et seq.

C. The NF must also comply with all health, safety, and physical plant requirements established by federal and state laws.

D. The portion of the facility in which the member will be placed must be registered with AHCCCS.

Admission Criteria (Nursing Facility)

A. The NF service may be considered appropriate for a member if the member is in need of skilled nursing care on a 24-hour basis but does not require hospital care or direct daily care from a physician and is ordered by, and provided under, the direction of a physician, pursuant to 42 CFR 440.40.

B. Pursuant to 42 CFR 409.31-35 and 440.155, the member requires:
   1. The skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists
   2. Daily skilled services that can only be provided in an NF, on an inpatient basis
   3. Skilled services because of special medical complications
   4. Services that are above the level of room and board.

C. The member must cooperate in a nursing assessment performed by the Division District Utilization Review Nurse prior to NF service being authorized.

D. The Pre-Admission Screening and Resident Review (PASRR) is completed pursuant to 42 CFR 483.100-138 (see Division Medical Policy Manual, Policy 680-C Pre-Admission Screening and Resident Review).

E. Prior to the authorization, the above criteria in this section must be met.

Exclusions (Nursing Facility)

A. The Division will authorize an NF placement only in a licensed and Medicare/Medicaid certified NF.

B. The Division will not pay for placement in an NF without prior authorization pursuant to 42 C.F.R 483.100 et seq. (see Division Medical Policy 680-C Pre-Admission Screening and Resident Review).

C. If the Primary Care Provider (PCP) or the Division District Utilization Review Nurse advises that the NF cannot meet the member’s needs, the member shall be offered a choice of available alternatives, including less restrictive settings and/or Home and Community Based Services (HCBS), as medically necessary.
D. If the Division places an NF on termination status:
   1. No new members will be admitted to the NF.
   2. Members currently residing, or on leave from, the NF may remain or return to the facility and will have a special planning meeting scheduled. The planning meeting must identify contracted residential alternatives that are available to the member.
E. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.
F. The member is in the Transitional Program and requests Long Term Care placement.

Therapeutic Leave and Bed Holds (Nursing Facility)
If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the NF.
A. Therapeutic leave includes leave due to a therapeutic home visit to enhance psychosocial interactions, a trial basis, or as a part of discharge planning, and is limited to 9 days per calendar year.
B. A bed hold includes medically necessary short-term hospitalization and is limited to 12 days per calendar year.

Reassessment for Continued Placement (Nursing Facility)
A. Members residing in an NF must be reassessed by the Division for appropriateness (medical necessity) of placement, whenever a significant change in the physical or mental status of the member occurs (see PASARR section of this policy manual).
B. Physicians must order the continued need for NF placement not less than annually in accordance with 42 CFR 483.114.
C. The member must continue to meet the criteria in the Admission Criteria (Nursing Facility) section of this Policy.

Service Closure (Nursing Facility)
As determined by the PASRR, medical documentation, and the current needs of the member, NF services will be terminated when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met. The discharge shall occur as follows:
A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to update the current Planning Document to include:
   1. The member’s health and abilities
   2. Current medication
   3. Identification of needed Durable Medical Equipment (DME)
4. An updated Service Plan
5. A completed Cost Effectiveness Study (CES) based on anticipated service needs
6. Needed follow up medical appointments.

B. The Planning Team includes the member and/or responsible person, the Division’s Health Care Service (HCS) nurse, the Support Coordinator, and representatives from the NF. The Planning Team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division’s Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member’s previous living arrangement needs to change, the Support Coordinator makes a request for residential services by completing a Placement Profile and submitting it to the Division’s District Network Unit.

D. The member or responsible person, the PCP, attending Physician, and the Division’s Medical Director shall resolve disagreements regarding discharge planning.

E. The Division’s Chief Medical Officer has the final authority as delegated by the Assistant Director.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Service Description (ICF/IID)

ICF/IID provides comprehensive and individualized health care, and habilitative and rehabilitative services, to members to promote functional status and independence for members who need, and are receiving, active treatment services that help the member obtain as much independence as possible.

Service Settings (ICF/IID)

An ICF/IID shall include the Arizona Training Program facilities, a state-owned and operated service center, state-owned or operated community residential settings, and private state-certified facilities that contract with the Department.

Service Provider/Facility Requirements (ICF/IID)

The provider must be state operated or contracted with the Division and demonstrate the following before the service is authorized:

A. The ICF/IID is registered with the Arizona Health Care Cost Containment System (AHCCCS).

B. The ICF/IID must be reviewed and certified annually by the Department of Health Services in accordance with 42 CFR 483.400.

C. The ICF/IID must comply with contract, all applicable federal and state laws, and DES and Division policies and procedures.
Admission Criteria (ICF/IID)

A. The ICF/IID service may be considered appropriate for a member who is in need of, or could benefit from, active treatment.

1. Active treatment includes continuous, aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services that are directed toward:
   a. The acquisition of the behaviors necessary for the member to function with as much self-determination as possible and the ability to live in a more independent setting
   b. The prevention or deceleration of regression or loss of current optimal functional status.

2. Active treatment is provided continuously based on an individual member’s assessed developmental needs that prevent the member from living in a more independent setting.

3. A continuous active treatment program includes interaction, between ICF/IID staff and the member, in which the member receives aggressive and consistent training, treatments, and supports during the normal rhythm of the member’s day, whenever the need arises or an opportunity presents itself, in both formal and informal settings.

4. Examples of active treatment may include:
   a. The application of a specific stimulation technique, to the area of the mouth of an individual with severe physical and medical disabilities, that decelerates the individual’s rate of reliance on tube feedings, and helps the individual retain ability to take food by mouth
   b. Teaching the member to use an adaptive spoon and plate to eat independently
   c. Acquisitions of behaviors for the member to function with as much self-determination and independence as possible
   d. Teaching daily living skills.

5. Examples of what active treatment does not include:
   a. Services to maintain generally independent members who are able to function with little supervision or in the absence of an active treatment program
b. Protective oversight for a member who is not in need of training for developmental deficits (e.g., a court placement to protect the community or the client from the client’s behavior)

Programs to simply maintain a member’s independence are not considered active treatment because the member is not learning to live in a more independent setting. If a member already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support, resources, and services that only an ICF/IID can provide, the member is considered generally independent and not in need of active treatment.

B. Prior to any permanent or temporary admission, the Division will complete a preliminary evaluation. The preliminary evaluation will consider background information as well as currently valid assessments of functional development, behavioral, social, health, and nutritional status and assessed needs that are prohibiting the member from living in a more independent setting and which require intensive specialized supports, services, and supervision that only an ICF/IID can provide.

The Division will review all necessary medical or other documentation to support the need for admission into an ICF/IID. This information may include the Planning Document, Placement Profile and, if the member receives nursing or therapies, the Nursing Assessment and Therapy evaluations/reports. If any additional information (e.g., medical records) is required, the Division’s HCS will contact the Support Coordinator.

C. The Division will determine whether there are alternative placements that are less restrictive and more cost effective than the requested ICF/IID placement. The alternative options shall be discussed with the member and/or their responsible person before a final decision is made by the Division.

D. A Cost Effectiveness Study must be completed prior to admission.

E. A written ICF/IID placement approval from the Assistant Director or the Assistant Director’s Designee is required prior to authorization.

Development and Implementation of the Active Treatment Plan (ICF/IID)

A. Pursuant to 42 CFR 483.440, within 30 days after admission:
   1. A comprehensive functional assessment of the member is completed.
   2. As a result of the comprehensive functional assessment, specific objectives necessary to meet the member’s needs will be identified.
   3. A written active treatment program specific to the member will be designed and implemented.

B. Data documentation of the specific objectives must be in measurable terms.
C. The initial active treatment plan must be reviewed by a Qualified Intellectual Disability Professional/Support Coordinator, the Planning Team, and revised as necessary.

D. During the annual planning meeting the comprehensive functional assessment shall be reviewed for relevancy and updated as needed.

**Exclusions (ICF/IID)**

ICF/IID placements shall not be made when any of the following are true:

A. The member’s needs can be met in a less restrictive and more cost-effective HCBS option.

B. The member does not need active treatment in an ICF/IID.

C. The member has exceeded 90 continuous days of acute services and is enrolled in the Transitional Program.

D. The member is in the Transitional Program and requests Long Term Care placement.

**Therapeutic Leave and Bed Holds (ICF/IID)**

If the member exceeds allowable Therapeutic Leave and bed hold days, the Division will not pay the facility when the member is absent from the ICF/IID.

A. Therapeutic Leave includes leave due to a therapeutic home visit to enhance psychosocial interactions or on a trial basis or as a part of discharge planning and is limited to 9 days per calendar year.

B. A bed hold includes when short-term hospitalization is medically necessary and is limited to 12 days per calendar year.

**Continued Stay Reviews (ICF/IID)**

A. The Division completes “Continued Stay Reviews” pursuant to 42 CFR 456.436 and “Active Treatment Reviews.”

B. The “Continued Stay Reviews” and “Active Treatment Reviews” will be completed at least every six months, and the following will be considered:

1. The member no longer needs, and will not benefit from, continued active treatment in an ICF/IID.

2. The member requires protective oversight only.

3. The member is able to function with little supervision in the absence of an active treatment program.

4. A less restrictive and more cost effective level of service or living situation would meet the needs of the member as determined by the Planning Team.
Service Closure (ICF/IID)

ICF/IID services may be terminated:

A. As determined by the Continued Stay Review
B. As necessary for the member’s welfare and when the needs of the member cannot be met in the ICF/IID
C. When the member has met their outcomes and no longer needs the services provided by the ICF/IID
D. At the request of the member/responsible person
E. When the member is no longer eligible for ALTCS
F. When the criteria in the Admission Criteria (ICF/IID) section in this Policy are no longer met
G. When the ICF/IID is no longer operating and a less restrictive or more cost effective level of service or living situation can meet the needs of the member.

The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a team meeting must occur to update the member’s current Planning Document to include:
   1. The member’s health and abilities
   2. Current medication
   3. Identification of needed Durable Medical Equipment (DME)
   4. An updated Service Plan
   5. A completed Cost Effectiveness Study based on anticipated service needs
   6. Needed follow up medical appointments.

B. The Planning Team shall include the member or responsible person, the Division’s HCS nurse, the Support Coordinator, and representatives from the ICF/IID. The team may also include a Division network representative, the HCBS provider, the PCP, or other representatives as needed per Division’s Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member’s living arrangement needs to change from what it was previously, the Support Coordinator makes the request for residential services by completing a Placement Profile and submitting it to the Division’s District Network Unit.
D. The member or responsible person, the PCP, attending Physician and the Division’s Chief Medical Officer shall resolve disagreements regarding discharge planning and service closure.

E. The Division’s Chief Medical Director shall have the final authority as delegated by the Assistant Director.

**Behavioral Health**

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities.

**Behavioral Health Inpatient Facility**

A Behavioral Health Inpatient Facility is a behavioral health service facility licensed by ADHS, as defined in A.A.C. R9-10-101, to provide a structured treatment setting with 24-hour supervision, on-site medical services, and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services. Some Behavioral Health Inpatient Facilities are IMDs.

**Institution for Mental Disease (IMD)**

Services provided to members eligible for Title XIX (including members who receive behavioral health services through an Integrated/Tribal/Regional Behavioral Health Authority (IRBHA, RBHA, TRBHA) may be reimbursed in any behavioral health setting, regardless of age, as per AHCCCS Medical Policy Manual, Policy 1210.

An IMD is a Medicare-certified hospital, special hospital for psychiatric care, behavioral health facility, or nursing care institution which has more than 16 treatment beds and provides diagnosis, care, and specialized treatment services for mental illness or substance abuse for more than 50% of the members is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Inpatient facilities with more than 16 beds are considered IMDs.

**Inpatient Psychiatric Residential Treatment Center (available to Title XIX members under 21 years of age)**

An Inpatient Psychiatric Residential Treatment Center is a behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A member who turns age 21 and is Tribal ALTCS Title XIX while receiving services in an inpatient psychiatric facility considered to be an IMD may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.

In addition, the following services must be available to members residing in a behavioral health institutional setting, but are not included in the service unit:

A. Speech, physical, and occupational therapies unless required as a part of the per diem for the service unit
B. Medical/acute care services as specified in this Policy Manual.
1230-A ASSISTED LIVING FACILITIES

REVISION DATE: 7/15/2016, 7/3/2015
EFFECTIVE DATE: June 30, 1994

Description

“Assisted Living Center” (Center) means an assisted living facility that provides resident rooms or residential units to eleven or more residents. Assisted Living Centers may be licensed to provide one of three levels of care listed below, as defined by the Arizona Department of Health Services:

A. “Supervisory Care Services” means general supervision, including daily awareness of resident functioning and continuing needs, the ability to intervene in a crisis and assistance in the self-administration of prescribed medications.

B. “Direct Care Services” means programs and services, including personal care services provided to persons who are incapable of recognizing danger, summoning assistance, expressing need or making basic care decisions.

C. “Personal Care Services” means assistance with activities of daily living that can be performed by persons without professional skills or professional training and includes the coordination or provision of intermittent nursing services and the administration of medication and treatments by a nurse who is licensed pursuant to Arizona Revised Statutes Title 32, Chapter 15 or as otherwise provided by law.

“Assisted Living Home” (Home) means a facility that provides resident rooms and services to ten or fewer residents.

Considerations

To ensure the appropriateness of a placement in a facility, the following must be considered and documented:

A. The member is over the age of 60; however, the team can recommend exceptions for approval by the Assistant Director;

B. A nursing home is the only other alternative available or the team feels a facility best meets the needs, desires, and capabilities of the member;

C. Alternate placements were considered and the reason why they were not appropriate. Facility placement cannot be the only placement option considered and cannot be used as an “emergency” placement alternative;

D. The member and/or guardian clearly understand the alternative placement options;

E. The guardian, member, and the Support Coordinator have visited the proposed facility;
F. The member will be placed with a similar age group as the other members living in the facility and not be segregated based on disability;

G. The supports identified in the Individual Support Plan/Person Centered Plan can be provided by the Center;

H. The member must be given the choice to live by with or without a roommate. The Support Coordinator shall document this choice on the Assisted Living Facility/Single Occupancy Form. This form shall be filed with the Planning Document and be reviewed annually. At any time the member may contact their Support Coordinator to revise their choice to live with or without a roommate. When this occurs the Support Coordinator shall update the form;

I. The Support Coordinator and others can monitor the facility at any time. Monitoring by the Support Coordinator, through on-site visits, will be conducted at least every 30 days for the first quarter and every 90 days thereafter; and,

J. The District Program Manager/designee has reviewed the required documentation and concurs the considerations has been met prior to the authorization of services.

**Conditions**

When identifying potential facilities, the following conditions are recommended:

A. Private room (unless the member chooses to have a roommate as noted above);

B. Room includes a private in-room bathroom (unless the member chooses to have a roommate as noted above);

C. Space allows for separation of sleeping and living areas;

D. An inside door lock;

E. Food preparation space;

F. Doorbell or door knocker;

G. Individual mailbox;

H. Variety of on-site and off-site and events from which to choose;

I. Transportation;

J. Indoor and outdoor common areas;

K. Weekly housekeeping service;

L. Weekly laundry service; and,
M. Monthly newsletter or calendar of events.

**Exclusions**

A. Under no circumstance will a facility be used for Respite.

B. The Division provides Adult Developmental Homes in lieu of Adult Foster Care Homes.

C. The Division does not contract with Adult Foster Care Facilities
1230-C ROOM AND BOARD

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Service Description and Goals (Room and Board)

This service provides for a safe and healthy living environment on a 24-hour basis that meets the physical and emotional needs of a member.

Service Settings (Room and Board)

Room and board may be provided in any state operated or contracted community residential setting.

Service Requirements (Room and Board)

Before Room and Board can be authorized, the following requirements must be met:

A. Living arrangements for members served must be identified; and,

B. Nutritional maintenance for members served must be ensured and provided.

Target Population (Room and Board)

All members receiving services in a residential setting may also receive room and board.

Exclusions (Room and Board)

Exclusions to the provision of Room and Board include Home and Community Based Services. Other room and board services excluded are those funded by Arizona Long Term Care System (ALTCS). All other fund sources shall be exhausted prior to funding by the Division.

Service Provision Guidelines (Room and Board)

RESERVED

Provider Types and Requirements (Room and Board)

Designated District staff will ensure all contractual requirements are met before Room and Board is provided.

Service Evaluation (Room and Board)

The provider shall maintain an on-site file that documents appropriate inspections and licenses necessary to operate the home.
Service Closure (Room and Board)

This service shall be terminated when a member moves from a State operated or contracted residential setting.
1240-A ATTENDANT CARE AND HOMEMAKER (DIRECT CARE SERVICES)

EFFECTIVE DATE: June 30, 1994

Attendant Care

Description

This service provides assistance for a member to remain in their home and participate in community activities by attaining or maintaining personal cleanliness, activities of daily living, and safe and sanitary living conditions.

Barring exclusions noted in this section, Attendant Care (ATC) may include the following as determined by the member’s assessed needs:

A. Meal preparation and clean up (e.g., meal planning, preparing foods, special diets, clean-up, and storing foods);

B. Eating and assistance with eating;

C. Bathing (e.g., washing, drying, transferring, adjusting water, and setting up equipment);

D. Dressing and grooming (e.g., selecting clothes, taking off and putting on clothes, fastening braces and splints, oral hygiene, nail care, shaving, and hairstyling);

E. Toileting (e.g., reminders, taking off and putting on clothes and/or undergarments, cleaning of catheter or ostomy bag);

F. Mobility (e.g., physical guidance or assisting with the use of wheelchair);

G. Transferring;

H. Cleaning;

I. Laundry (e.g., putting clothes in washer or dryer, folding clothes, putting away clothes);

J. Shopping (e.g., grocery shopping and picking up medications);

K. Attending to certified service animal needs; and,

L. General supervision for a member who cannot be safely left alone. (See Appendix A, B and C.)

Responsible Person's Participation (Attendant Care)

The member/family is responsible to provide:
A. Needed supplies (e.g., cleaning supplies) or money for supplies. Money must be provided in advance when the Attendant Care provider is expected to shop for food, household supplies, or medications; and,

B. Documentation required for the approval of this service.

Considerations (Attendant Care)

When assessing the need for this service, the following factors will be considered:

A. Due to advancing age, a temporary or permanent documented physical or cognitive/intellectual disability or documentation of other limitation, the parent or guardian cannot meet a child’s basic care needs;

B. Due to the child’s intensive medical, physical, or behavioral challenges, which are a result of the disability, the parent or guardian cannot meet the child’s care needs;

C. The child, due to a medical condition or procedure related to the disability, is unable to attend their school/work/day program, and natural support(s) is/are unavailable to provide care;

D. The adult member is unable to meet specific, basic personal care needs;

E. The adult member lives alone and is temporarily unable to meet basic personal care needs due to a medical condition or illness;

F. The members’ needs are not currently met due to unavailability of service. Attendant Care may be used as an alternative service;

G. The member has medical or physical needs, was living in a Developmental Home, Group Home, Intermediate Care Facility, Nursing Facility, or other out of home placement, and with Attendant Care, the member will be able to return home;

H. When a spouse provides Attendant Care, the total hours of Attendant Care may not exceed 40, regardless of who provides the care. In addition, the member may not receive any similar or like service (i.e., Homemaker). (Habilitation services are not a similar or like service.);

I. Attendant Care services are subject to monitoring and supervision as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy; and,

J. When a family member requests to become the Attendant Care Provider for a member over the age of 18, the Support Coordinator/designee will conduct a personal interview with the member.

Settings (Attendant Care)

Attendant Care Services may only be provided:
A. In the member’s home (unlicensed);

B. In an Independent Developmental Home when there is a specific issue, problem, or concern that is believed to be temporary or short term, and the service is approved by the Assistant Director/designee; and,

C. In the community:
   1. While accompanying the member; or,
   2. While shopping or picking up medications.

Exclusions (Attendant Care)

Exclusions to the authorization of Attendant Care service are indicated below. Exceptions shall be approved by the District Manager.

A. The Attendant Care Service:
   1. Shall not substitute for private pay day care or a school program for children;
   2. Shall not cover before and after school care needs, days when there is no school, half school days, holidays, or summer and winter breaks, or for ‘babysitting’ unless a child meets the criteria for supervision;
   3. Shall not be provided for acute illnesses that prevent the child from attending private daycare or school;
   4. Shall not be provided while the member is hospitalized;
   5. Shall not substitute for Work, Day Program, Transportation, or Habilitation, unless those services are not available to the member;
      a. When used as a substitute, Attendant Care shall be used only until an appropriate service is available; or,
      b. When the appropriate service has been refused, Attendant Care cannot be used as a substitute.
   6. Shall not substitute for Respite;
   7. Shall not be received during the provision of a Division funded Employment or Day Program;
   8. Shall not be used to avoid residential licensing requirements; and,
   9. Shall not be used to take the place of care provided by the natural support system for children.

B. The tasks below are not included as part of the Attendant Care Service:
1. Cleaning up after parties (e.g., family celebrations and holidays);
2. Cleaning up several days of accumulated dishes;
3. Preparing meals for family members;
4. Routine lawn care;
5. Extensive carpet cleaning;
6. Caring for household pets;
7. Cleaning areas of the home not used by the member (e.g., parents’ bedroom or sibling’s bathroom);
8. Skilled medical tasks. (See Appendix D – Skilled Nursing Matrix.); and,
9. Shopping for a child living in the family home.

The Division will not authorize Attendant Care when the only tasks identified are cleaning, shopping and laundry.

**Homemaker (Housekeeping)**

**Service Description and Goals (Homemaker)**

This service provides assistance in the performance of activities related to routine household maintenance at a member’s residence. The goal of this service is to increase or maintain a safe, sanitary, and/or healthy environment for eligible members.

**Service Settings (Homemaker)**

This service would occur in the member's own home or family's home. It would occur outside only when unsafe/unsanitary conditions exist and would occur in the community when purchasing supplies or medicines.

**Service Requirements (Homemaker)**

Before Homemaker can be authorized, the following requirements must be met:

A. Safe and sanitary living conditions shall be maintained only for the member’s personal space or common areas of the home the member shares/uses.

B. Tasks may include:
   1. Dusting;
   2. Cleaning floors;
   3. Cleaning bathrooms;
4. Cleaning windows (if necessary to attain safe or sanitary living conditions);
5. Cleaning oven and refrigerator (if necessary to prepare food safely);
6. Cleaning kitchen;
7. Washing dishes;
8. Changing linens and making beds; and,

A. Washing, drying, and folding the member’s laundry (ironing only if the member’s clothes cannot be worn otherwise).

B. Shopping for and storing household supplies and medicines.

C. Unusual circumstances may require the following tasks be performed:

1. Tasks performed to attain safe living conditions:
   a. Heavy cleaning such as washing walls or ceilings; and,
   b. Yard work such as cleaning the yard and hauling away debris.

2. Assist the member in obtaining and/or caring for basic material needs for water heating and food by:
   a. Hauling water for household use;
   b. Gathering and hauling firewood for household heating or cooking including sawing logs and chopping wood into usable sizes; and,
   c. Caring for livestock used for consumption including feeding, watering and milking.

3. Provide or ensure nutritional maintenance for the member by planning, shopping, storing, and cooking foods for nutritious meals.

Target Population (Homemaker)

Members who are eligible for or are receiving assistance through the Supplemental Payment Program (SPP) will not receive Housekeeping. Members who are not eligible for Arizona Long Term Care Services (ALTCS) should be referred to the SPP. Needs are assessed by the Support Coordinator based upon what is normally expected to be provided by a member and/or his/her caregiver. It is important to remember that housekeeping services are based on “assessed need” and not on a person’s or the family’s stated desires regarding specific services.
Consideration should be made to age appropriate expectations of the member and his/her entire family (what can reasonably be expected of each member based on his/her age). The team should consider the natural supports available and not supplant them. In addition to the guidelines found in this section, there may be a need for the SPP if any of the following are factors:

A. A member is living with his/her family and has intense medical, physical, or behavioral needs; and the family members are unable to care for the member and maintain a safe and sanitary environment;

B. A member is living with his/her family and the family members have their own medical/physical needs that prevent the family members from maintaining a safe and sanitary environment (documentation of the medical/physical needs may be required);

C. A member is living independently and has medical/physical needs that preclude him/her from maintaining/attaining a safe and sanitary environment;

D. A member is living independently and has demonstrated that he/she cannot maintain a safe and sanitary environment. Habilitation should be considered before using Housekeeping so the member’s abilities may be maximized; and,

E. The family is experiencing a crisis that prevents them from maintaining a safe and sanitary environment. The situation would be documented in the member’s progress notes and the service delivery would be of a time-limited nature.

**Exclusions (Homemaker)**

The following exclusions apply to the provision of Homemaker:

A. Homemaker is to be performed only for the members’ areas of the home or common areas of the home used by the member, e.g., parents’ or siblings’ bedrooms or bathrooms would not be cleaned. Other examples of inappropriate use of Homemaker services include:

1. Cleaning up after parties;
2. Cleaning up several days of accumulated dishes;
3. Preparing meals for the whole family; and,
4. Routine lawn care.

B. Homemaker shall not be provided to members residing in group homes, vendor supported developmental homes, skilled nursing facilities, non-state operated Intermediate Care Facilities for Persons with an Intellectual Disability or Level I or Level II Behavioral Health Facilities.

**Service Provision Guidelines (Homemaker)**
Typical utilization of Homemaker would be two to four hours per week. Additionally:

A. The member or family is expected to provide all necessary supplies;

B. This service shall not be provided when the member is hospitalized or otherwise receiving institutional services. The service may only be provided at the end of hospitalization to allow the member to return to a safe and sanitary environment; and,

C. Members residing in Group Homes, Foster Homes or Adult Developmental Homes shall not receive this service.

Utilization of Homemaker will be in accordance with the Service Authorization Matrix.

Provider Types and Requirements (Homemaker)

Designated District staff will ensure all contractual requirements related to Homemaker providers are met before services can be provided. Additionally, all providers of ALTCS must be certified by the Division and registered with AHCCCS prior to service initiation.

Service Evaluation (Homemaker)

The Individual Support Plan/Individualized Family Service Plan/Person Centered Plan review (Plan Review) shall document appropriateness of this service based upon the Support Coordinator’s observation and input from the member, family, and provider.

Service Closure (Homemaker)

This service is no longer appropriate when:

A. The member’s medical, physical or behavioral needs have decreased;

B. The physical/medical needs of the family members have decreased;

C. The family is no longer experiencing crisis;

D. The member no longer resides at home, has moved out of state, or when the member is no longer eligible for ALTCS;

E. The member moves to a residential or institutional setting; or,

F. The family has adequate resources or other support to provide the service.

A Notice of Intended Action must be sent in accordance with the processes defined in of this policy manual.

Other Homemaker Services

A. The amount of Homemaker provided shall be determined based on the home requirements for a safe and sanitary environment. If more than one eligible member resides in the home, payment will not be made twice for cleaning common areas of the home.
B. If the family is receiving supplemental payments for other members in the home, the Support Coordinator shall determine if the Supplemental Payment Program (SPP) is meeting the family's needs.
1240-C   COMMUNITY TRANSITION SERVICES

REVISION DATE:  3/2/2015
EFFECTIVE DATE: June 30, 1994

Description

The Community Transition Service (CTS) assists members eligible for Arizona Long Term Care System (ALTCS) to reintegrate into the community by providing financial assistance to move from an ALTCS setting to their own home or apartment, excluding licensed community settings.

An ALTCS setting includes one of the following:

A. Behavioral Health Level I facility;

B. Institution for Mental Disease;

C. Inpatient Psychiatric Residential Treatment Center (available to members under 21 years of age eligible for Title XIX.);

D. Nursing Facility, including religious non-medical health care institution; and,

E. Intermediate Care Facility (ICF).

The following items can be purchased using CTS funds:

A. Security deposits required to obtain a lease on an apartment or home (refunded deposits are the property of the Division);

B. Essential furnishings (new or gently used including items such as: bed, bedding, towels, table, chairs, window coverings, eating utensils, food preparation items, small electrical appliances);

C. Moving expenses; and,

D. Set up fees or deposits for utility or service access (e.g., telephone, electricity, gas). (Refunded deposits are the property of the Division.)

Considerations

The following factors will be considered when assessing the need for this service:

A. The member has been living in an ALTCS setting a minimum of 60 consecutive days regardless of ALTCS enrollment;

B. The member is within 30 days of being discharged into the community; and,

C. The LTC setting discharge plan identifies needs and assistance for which the member has no other source or support to move.
1. It is not intended to replace items or supports otherwise provided by the Division or community resources.

2. The members’ needs shall be met upon discharge and discharge cannot be delayed in anticipation of receiving services from other sources (e.g., when coordinating with other community sources for the provision of this service).

Exclusions

Community Transition Services are:

A. Not available to members moving from an ALTCS setting to an alternate residential setting such as Assisted Living Facilities, Group, or Developmental Homes;

B. Limited to a one-time authorization (see exception letter C below) of up to $2,000 every five years per member;
   1. The $2,000 includes all applicable administration fees.
   2. The five year timeframe applies regardless of changes in Managed Care Contractors or the member transfers between fee-for-service and managed care.

C. Available 30 days prior to the planned discharge date and remain available for 90 days from the date of discharge from an ALTCS institutional setting. Exceptions to this timeframe for partially expended funds will be determined on a case-by-case basis.

D. Not dispersed to the member, the member’s family, or friends.
   1. Funds are paid directly to the vendor identified by the member or family.
   2. Receipts for all purchases using CTS funds shall be retained for a minimum of five years.
   3. The Support Coordinator will assist the member and family with prioritization of needs and facilitate the purchase of identified goods and services.

The following items cannot be purchased using CTS funds:

A. Cash payments to members or significant others;

B. Rent;

C. Leisure/recreational devices (e.g., television or cable access, internet access, stereo);

D. Aesthetics/decorative items (e.g., picture frames, rugs);

E. Remodeling improvements to any home or apartment; and,
F. Grocery items (e.g., food, personal hygiene, cleaning products).
1240-D  EMERGENCY ALERT SYSTEM

REVISION DATE: 3/2/2015
EFFECTIVE DATE: June 30, 1994

Description

An Emergency Alert System is a monitoring device/system for members who are unable to access assistance in an emergency situation.

Barring exclusions noted in this section, Emergency Alert System may include:

A. One emergency alert system unless a second is medically necessary;
B. The medically necessary accessories for operation;
C. Voice or touch capability; or,
D. Replacement of equipment in cases of loss, irreparable damage, or wear not caused by carelessness or abuse.

Considerations

The following factors will be considered when assessing the need for this service:

A. The member lives alone or is alone for eight or more hours without contact with a service provider, family member, or other support system and cannot call 911 by using a standard phone, portable phone, or cell phone;
B. The member’s community does not have reliable/available emergency assistance on a 24-hour basis;
C. The assessment of the member’s medical and/or functional level documents an acute or chronic medical condition, which is not improving; and,
D. The primary care provider has prescribed the system.

Settings

An Emergency Alert System may only be provided in the member’s own or family home.

Exclusions

An Emergency Alert System shall not be provided:

A. To members living in Group Homes or Child/Adult Developmental Homes; and,
B. When the member no longer meets the target population/service considerations (e.g., the member moves to a Group Home or the member is no longer alone for
eight hours or more). When this occurs, the system and all components must be returned to the Division.
HABILITATION SERVICES

EFFECTIVE DATE: June 30, 1994
REFERENCES: A.A.C. R6-6-903

Habilitation Consultation

A. Service Description and Goals (Habilitation Consultation)

This service assists a member to remain in his/her home or the family/caregiver’s home and to participate in community activities, by providing a variety of behavioral interventions. Habilitation Consultation is a consultative service that is intended to complete an assessment and develop an intervention plan. The plan identifies strategies to strengthen the skills of the member and his/her family/caregivers. The member must be eligible for ALTCS and the family/caregivers must have the ability and interest to participate in this service.

Habilitation Consultation may include:

1. Conducting an assessment of the member’s challenging behavior and/or area of skill deficit
2. Developing an intervention plan derived from the assessment for the family/caregivers, and/or direct care workers to implement with the member to improve the member’s self-help, socialization, and adaptive skills
3. Assisting Planning Teams and family/caregivers, and/or direct care workers in managing the member’s challenging behaviors through a thorough understanding of the purpose and function of a behavior and how that behavior has been reinforced in the past
4. Facilitating implementation of the intervention plan and strategies
5. Modeling the implementation of the intervention plan for the member, family/caregivers, and/or direct care workers, including the teaching of functional alternative or replacement behavior (behavior that serves the same function for that member)
6. Training the family/caregivers, and/or direct care workers in the implementation of the intervention plan and monitoring their fidelity in the use of the treatment interventions as outlined in the intervention plan
7. Assisting the Planning Team in acquiring any needed approvals of the intervention plan by oversight committees, as required per A.A.C. R6-6-903
8. Providing follow-up consultation to revise the intervention plan as needed.

B. Family/Caregivers and Direct Care Workers (Consultation)

This service requires participation in training, provided by the habilitation consultation provider, on the specific activities and techniques developed in the
intervention plan. Training participants may include family/caregivers and direct care workers, based on where the member lives. The Planning Team identifies all participants to receive the training and documents this in the member’s record.

C. Referral Considerations (Habilitation Consultation)

The Planning Team determines the need for a referral for Habilitation Consultation when:

1. There is a deficit in functional living or adaptive skills including, but not limited to social communication skills, daily living skills, and independent living skills, AND

2. One or more of the following considerations apply:
   a. Frequent visits (two or more in the last 6 months) to an emergency department for non-health emergency conditions
   b. Multiple admissions (two or more in the last 6 months) to psychiatric acute care and/or psychiatric facilities
   c. Multiple contacts (two or more in the last 30 days, or an escalation in frequency) with crisis services
   d. Contact with law enforcement related to behavior (one or more in the last 30 days)
   e. Multiple incident reports related to behavior (i.e., physical aggression, self-harm) showing a trend or escalation in the last 30 days
   f. Multiple physical restraints (two or more in the last 30 days)
   g. Behavior outbursts placing any of the following settings at risk:
      i. Family/own home
      ii. Out of home placement
      iii. Day program
      iv. School
      v. Employment
      vi. Any community setting
   h. Behavioral health, home and community based services have been unsuccessful in addressing the needs of the member and/or family to date and behavior intervention planning and assistance is needed to stabilize the behavior and the environment
   i. A consistently and correctly used Behavior Plan has not been successful in addressing the needs of the member.
D. Settings (Habilitation Consultation)

1. This service may be provided in any of the following settings:
   a. The member’s own home or family home
   b. A Group Home
   c. A state-supported or a vendor-supported Developmental Home (child or adult)
   d. A community setting chosen by the member and his/her Planning Team
   e. An Intermediate Care Facility
   f. A Skilled Nursing Facility.

2. This service may be provided for observation and assessment purposes only in the member’s school, during school provided transportation to and from school, and the hospital.

E. Exclusions (Habilitation Consultation)

1. This service cannot be provided when a member is receiving:
   a. Habilitation, Early Childhood Autism Specialized service
   b. Positive Behavioral Support-Consultation service
   c. Positive Behavioral Support service
   d. Comprehensive or focused behavior intervention services from any other funding source
   e. Or residing in a facility identified as an Institute for Mental Disease (IMD).

2. Training on, and implementation of, the specific activities developed in the intervention plan are not to be provided:
   a. In the school setting
   b. During school provided transportation
   c. When the member is hospitalized.

F. Service Authorizations (Habilitation Consultation)

Initial service authorizations cover a six month timeframe and include the following:

1. A maximum of 10 units of Habilitation Consultation Evaluation (billing code HCA) to complete the initial assessment and intervention plan.
2. A maximum of 110 units of Habilitation Consultation, Licensed Psychologist /Behavioral Analyst/BCBA (billing code HCM)/ Habilitation Consultation, Assistant (billing code HCB) for training, modeling implementation, and consultation. Leftover units of HCA may be authorized as HCM/HCB at the request of the Habilitation Consultation provider.

Prior to the end of the six-month authorization period, all progress reports will be reviewed to determine the member’s progress and the continued need for the service. If the service is determined to be medically necessary, based on the review of the data and documentation, a service extension will be authorized for an additional six month period.

No additional hours of HCM/HCB will be authorized in the extension period until the initial authorized units have been exhausted.

Day Treatment and Training

A. Service Description and Goals (Day Treatment and Training)

This service provides specialized sensory-motor, cognitive, communicative, behavioral training, supervision, and as appropriate, counseling, to promote skill development in independent living, self-care, communication and social relationships.

The goals of this service are to:

1. Increase or maintain the self-sufficiency of eligible members.
2. Improve emotional and mental well-being.
3. Enable eligible members to acquire knowledge and skills.
4. Ensure the availability to eligible members of information about, and access to, human services and community resources.
5. Develop positive relationships with, and support for, families.
6. Encourage family and member participation in areas of the program.
7. Ensure that programs optimize the health and physical well-being of the members served.
8. Provide opportunities for members to participate in meaningful integrated community activities.
9. Produce outcomes of increased individual skill development toward outcomes identified in the member’s plan.
10. Assist members in achieving and maintaining a quality of life that promotes the member’s vision of the future.
B. Service Settings (Day Treatment and Training)

1. Children ages birth to 48 months may not be appropriate for this service. Any considerations to provide this service to this age group requires approval from the District Program Manager or designee.

2. This service is not provided in a group home, developmental home (child or adult), hospital, skilled nursing facility, non-state operated Intermediate Care Facility (ICF), or Level I or Level II behavioral health facility.

3. For members under age 18, services are provided in a Qualified Vendor owned/leased setting or a publicly available setting where members participate in a supervised program.

4. For adult members age 18 or above, services are provided in a Qualified Vendor owned or leased setting or a publicly available setting where members participate in a supervised program. The primary use of this setting is the operation of a day program, not as a permanent residence, unless approved by the Division’s District Program Manager or designee.

5. All Day Program settings in a provider’s owned/leased setting require a Life Safety Inspection by the Division’s Office of Licensing Certification and Regulation (OLCR).

C. Service Requirements (Day Treatment and Training)

Before Day Treatment and Training can be authorized, the following requirements must be met:

1. Members between the ages of 16-65 years must be assessed and considered for employment supports and services.

2. The Planning Documents must identify needs and outcomes consistent with the service description and setting.

3. Training and instruction must be pertinent to the present developmental, physical, mental, and/or sensory abilities of the member.

D. Target Population (Day Treatment and Training)

Using the assessment and plan development processes described in this policy manual, the Planning Documents must determine the need for this service according to the following age categories:

1. Age 36 Months - 5 Years of Age

   Generally, children of this age range receive instruction from public schools in accordance with Part B of Public Law 105-17. However, the provision of Day Treatment and Training by the Division may be appropriate, if all of the following conditions are met:

   a. The Planning Document identifies needs above and beyond those...
identified in the Individualized Educational Plan (IEP).

b. The additional hours of Day Treatment and Training are reasonable and normal for the child's age, considering the number of hours the child is participating in pre-school programs and other out-of-home activities.

c. The child's developmental needs can best be met in a group setting.

d. Family and other community resources are not available to meet the need.

e. No other service is more appropriate.

2. Age five - 12 Years of Age

a. Generally, children with developmental disabilities have their instructional needs met by the public school system. Therefore, most children do not need or receive Day Treatment and Training when they are eligible for public education services.

b. For children five to 12 years old, Arizona Health Care Cost Containment System (AHCCCS) does not pay for childcare or Respite as an alternative to Day Treatment and Training services. The Division may consider providing Day Treatment and Training for this age group if all the requirements for the three to five years age group are met and if the child needs to develop appropriate social and behavioral interaction skills and opportunities to integrate with peers who do not have disabilities.

c. If the Division considers Day Treatment and Training services for children five to 12 years of age, habilitation goals and objectives must be established and documented in the Person Centered Plan/Child and Family Team Plan. The Division may also consider providing Day Treatment and Training services, when the member is eligible for an Extended School Year Program. This may indicate a need for Day Treatment and Training to be provided in the summer. Habilitation goals and objectives must also be documented in the respective plans (referenced in "c" of this section) for Day Treatment and Training services for the summer.

3. Age 13 - Graduation from High School (18 - 22 Years of Age)

a. Generally, members with developmental disabilities have their instructional needs met by the public-school system. Therefore, most members do not need or receive Day Treatment and Training when they are eligible for public education services.

b. The Division may consider providing Day Treatment and Training for this age group, if all the requirements for the three to five years’ age group are met.
c. For members of working age, Day Treatment and Training may only be authorized after the individual has been assessed and considered for employment supports and services.

d. The Support Coordinator must determine that community resources are unavailable to meet member needs, especially as related to independent living, communication, and social relationships. If the Division considers Day Treatment and Training for this age group, habilitation goals and objectives must be established and documented in the Individual Support Plan/Person Centered Plan only after consideration of employment supports and services.

4. Adults

a. For members of working age, Day Treatment and Training may only be authorized after the individual has been assessed and considered for employment supports and services.

b. Day Treatment and Training should enable members to increase their range of independent functioning and to refine their personal living skills. The service must be age appropriate.

c. Members participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

B. Exclusions (Day Treatment and Training)

The provision of Day Treatment and Training cannot:

1. Substitute for Respite or day care

2. Be used in place of regular educational programs as provided under Public Law 105-17 (www.gpoaccess.gov/plaws/)

3. Be used to provide other related services that have been determined in the IEP to be educationally necessary

4. Be used when another service, such as an employment service, is more appropriate

5. Include wage-related activities that would entitle the member to wages.

C. Service Provision Guidelines (Day Treatment and Training)

Use of Day Treatment and Training is in accordance with the Individual Support Plan/Person Centered Plan (Planning Documents).

D. Provider Types and Requirements (Day Treatment and Training)

1. Designated District staff ensure that all contractual requirements related to Day Treatment and Training providers are met before services can be
provided.

2. All providers of Arizona Long Term Care Services (ALTCS) must be certified by the Department and registered with Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

E. Service Evaluation (Day Treatment and Training)

1. The Support Coordinator must continually assess the quality of services provided to members with developmental disabilities.

2. Written Progress Reports
   a. The provider must submit a written progress report on Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents) outcomes, as required by the Division’s Provider Manual Progress Reporting Requirement, to the Support Coordinator. The report must address the presence or absence of measurable progress toward the member's goals and outcomes.
   b. Each month, the Support Coordinator must review these reports for progress toward outcomes. If there is no progress in the time period specified, the member with his/her Individual Support Plan/Individualized Family Services Plan/Person-Centered Plan (Planning Team) must reassess the outcomes and determine the ongoing appropriateness of the service or outcome.

3. The Support Coordinator must review the Planning Documents as noted in the Division Operations Manual Policy 2003, Planning Documents.

4. The provider must maintain a monthly activity schedule based on the goals and preferences of the persons supported.

5. The program must furnish materials, supplies, and equipment used to deliver Day Treatment and Training that meet the needs of the member and are age appropriate.

F. Service Closure (Day Treatment and Training)

Service closure occurs in any of the following situations:

1. Based on the member’s progress, the Planning Documents determine that goals have been met.

2. The member/responsible person declines the service.

3. The member moves out of state.

4. The member transitions to another age/skill appropriate service or program, or the member/responsible person/family can now meet the needs the service addressed, as identified in the Planning Documents.
**Employment Supports and Services**

A. Employment First Principles

1. The Division supports Employment First Principles, Policy and Practice which include the following:

2. Competitive integrated employment is the preferred daily service and outcome for all working age Arizonans who have disabilities.

3. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.

4. Employment First encompasses the belief that competitive integrated employment should be the primary day service and outcome for working age youth and adults with disabilities.

5. It supports an overarching goal that eligible persons with disabilities will have access to integrated work settings most appropriate for them, including the supports necessary to help them succeed in the workplace.

6. Employment First does not mean employment only and does not deny individual choice.

7. Employment First does not eliminate service options currently available but is intended to increase employment opportunities.

8. Employment Services are provided according to this policy and Arizona’s Employment First Strategic Plan and MOU, which can be found at the Employment First website.

B. Service Description and Settings (Employment Supports and Services)

These services provide opportunities for employment, using several models to support members in a variety of job related settings. The Division supports Employment First policy and practice, which means that employment should be the preferred daytime activity for members of working age.

1. Individual Supported Employment provides job coaching support, at a competitive job site, with the employed member and/or employer. Individuals receiving Individual Supported Employment work with people without disabilities and earn wages at the same rate as others in the community doing the same work. This service helps ensure that the member maintains employment and may also include job search services, if these services are not available through Vocational Rehabilitation Services. Individual Supported Employment cannot be provided in a group supported employment setting.

Members receiving this service must be paid by the employer. Individual Supported Employment is a time-limited service, which must be provided on a member basis, and can be used for members who are self-employed.
2. Group Supported Employment is a service that provides members with an on-site, supervised, paid work environment in an integrated community setting. Settings may include enclaves, work crews, and other integrated work sites.

3. Center Based Employment is a service that provides a controlled, protected and supervised work environment. This service is provided in a Qualified Vendor-owned or leased setting where the majority of the members have disabilities and are supervised by paid staff. If certain criteria are met, the member may be paid a sub-minimum wage. The service goal is to provide members with gainful, productive, and remunerative work.

4. Career Preparation and Readiness is a service that provides assistance to eligible individuals to obtain competitive and/or integrated employment. This service provides Division members currently participating in Center-Based Employment with the services and supports to assist them in making a progressive move into competitive and/or integrated employment.

5. Employment Support Aide services provide members with one-to-one supports needed to enable them to remain in their employment. These supports may include personal care services, behavioral intervention, and/or “job follow along” supports, and they may be provided in any of the above service settings, as well as a stand-alone service.

6. Split programming may be appropriate for members who desire to participate in multiple employment supports and services. Providers bill these services hourly and base them on team agreement and assessed need. Split programming is designed to fulfill the needs and desires of the members. Members participating in Day Treatment and Training may also participate in Employment Supports and Services as part of a meaningful day.

C. Transition to Employment (Employment Supports and Services)

Transition to Employment is a service that provides:

1. Training in the meaning, value and demands of work and in the development of positive attitudes toward work

2. Individualized instruction, training, and supports to promote skill development for integrated and competitive employment.

3. Opportunities for members to engage in job shadowing and job exploration. This service provides no pay to the member.

D. Transportation Services (Employment Supports and Services)

Transportation, to and from work, may be available to members receiving Employment Supports and Services, when such transportation is not available from community resources or natural supports.
E. Target Populations (Employment Supports and Services)

1. Target populations are members who may benefit from Employment Supports and Services. All members of working age should be involved in employment or employment-related activities unless otherwise determined unable to work as determined by the Planning Team (Individual Support Plan/Person Centered Plan team).

2. The Individual Support Plan/Person Centered Plan meetings and monthly progress reports from providers may be used to identify the need for Employment Supports and Services. Participation in Individual Education Plan meetings/School-to-Work Transition Planning meetings, and the member’s verbalized interest in employment may also identify the member’s need for employment services.

3. Beginning no later than age 14, the member, with his/her Planning Team (Individual Support Plan/Person Centered Plan team), should identify the member’s desired future, employment goals, and skills and abilities. The Planning Team must include a description regarding the level of support needed and documentation of these needs (including transportation) on the Individual Support Plan/Person Centered Plan.

4. Employment Supports and Services are available to:
   a. Members who are eligible for ALTCS, based on assessed need
   b. State-funded-only members based on assessed need and availability of funding.

F. Rehabilitation Services Administration/Vocational Rehabilitation Referral Process (Employment Supports and Services)

The Division works in collaboration with the Rehabilitation Services Administration/Vocational Rehabilitation to coordinate the provision of employment services.

1. When the Planning Team determines that a member may be interested in competitive employment or can benefit from employment-related service, the Support Coordinator will document this in the ISP and will complete a Referral to Vocational Rehabilitation (DDD 1328-A FORFF) to Employment Services Specialist.

2. The Employment Program Specialist reviews the referral packet for completeness and appropriateness and determines whether the completed packet will be sent to Rehabilitation Services Administration/Vocational Rehabilitation Program.

G. Authorization (Employment Supports and Services)

1. The Support Coordinator adds the appropriate code to the Service Plan and submits the authorization request to the Employment Services Specialist.
2. The Employment Services Specialist reviews and approves the authorization for services.

3. The Qualified Vendor is informed in writing of service authorization and may only provide the services that have been authorized by the Division. Any change in services requires a new written authorization.

H. Service Changes (Employment Supports and Services)

Any change in Employment Supports and Service, including changes from one employment service to another or from an employment service to a different day service, requires Planning Team agreement, an updated ISP and new authorization for services.

I. Tracking and Reporting (Employment Supports and Services)

1. The Qualified Vendor must submit individualized quarterly progress reports to the Support Coordinator. The Support Coordinator ensures that Qualified Vendors submit required reports and address reported concerns.

2. If concerns cannot be resolved, the Support Coordinator contacts the District Employment Program Specialists.

3. The Qualified Vendor submits a report on Division forms every six months to the Employment Program Specialist.

J. Monitoring and Technical Support (Employment Supports and Services)

At a minimum, the District Employment Program Specialist performs:

1. An annual on-site Quality Assurance Review of all Qualified Vendors who provide Employment Supports and Services

2. A review of the Qualified Vendors' "six month" reports, on-site visits, and technical support as needed.

**Hourly and Daily Habilitation**

A. Description (Hourly and Daily Habilitation)

This service provides learning opportunities designed to help a member develop skills and independence.

1. Barring exclusions noted in this section, based on member and family priorities, Habilitation may be provided to:

   a. Increase or maintain:

      i. Independence and socialization skills

      ii. Safety and community skills

      iii. Member’s health and safety.
b. Provide training in:
   i. Essential activities required to meet personal and physical needs
   ii. Alternative and/or adaptive communication skills
   iii. Self-help/living skills.

c. Develop the member's support system to reduce the need for paid services.

d. Help family members learn how to teach the member a new skill.

2. When this service is authorized for a member with nursing needs, all assessed medically necessary services and supports are provided.

B. Considerations (Hourly and Daily Habilitation)

The following are considered, when assessing the need for this service:

1. Existing community support systems have been exhausted and no other service is available

2. The member's documented needs cannot be met by the member's support system, employment program, or day program

3. Habilitation can support therapy home program strategies.

C. Settings (Hourly and Daily Habilitation)

Habilitation Services may be provided:

1. Hourly or daily in the member's own home

2. Hourly in the home the member shares with the family

3. Hourly in a Department of Child Safety licensed foster home

4. Hourly in other community settings (e.g., a Habilitation provider can assist a child in participating in a private pay day care/after school program)

5. Daily in a Group Home


D. Exclusions (Hourly and Daily Habilitation)

Exclusions to the authorization of Habilitation services include, but are not limited to, the following scenarios. Habilitation cannot:

1. Substitute for Respite or day care
2. Be used in place of regular educational programs as provided under Public Law 108-446 IDEA Part B

3. Substitute for funded or private pay day programs

4. Be used when another service is more appropriate

5. Be authorized when Daily Habilitation is authorized

6. Be provided in a:
   a. Private or public school during school hours or during transit to schools
   b. Provider’s residence unless the residence is also the home of the member receiving the service
   c. Qualified Vendor owned or leased service site.
   d. Vendor-supported Child Development Homes or Adult Developmental Homes, unless the following are met:
      i. There is a specific issue, problem, or concern that is believed to be temporary or short term.
      ii. The Planning Document outlines specific, time limited goals/outcomes regarding the service to be provided.
      iii. Progress reports validate continuing the service.

**Habilitation Early Childhood Autism Specialized**

Description (Habilitation Early Childhood Autism Specialized)

This service provides various interventions, to maximize the independence and functioning of young children diagnosed with, or at risk of, Autism/Autism Spectrum Disorder per Division eligibility requirements. Service interventions address special developmental skills, behavior intervention, and sensorimotor development in order to prepare the child for entry into a full-time academic program. This service is designed to teach and strengthen the skills of the parent(s)/caregiver(s) through participation when this service is provided.

This service may be a combination of Habilitation Doctoral or Masters (Early Childhood-Master-ECM) and Habilitation Bachelors (Early Childhood-Bachelor, ECB). It is authorized concurrently with Habilitation Hourly (Early Childhood Hourly, ECH) and must be provided to one child at a time, with the participation of the child’s parent(s)/caregiver(s). The ECM, ECB, and ECH service codes are authorized to the same Qualified Vendor.

Service hours provided by the Masters-Level Consultant and the Bachelors-Level Consultant combined may not exceed 250 hours per child for a two-year period. Prior to the end of the two-year authorization period, all progress reports will be reviewed to determine the child’s progress and the continued need for the service. If the service is determined to be medically necessary, based on the review of the data and documentation, authorization is issued in six-month increments (six units per month) as long as medically necessary, but only until
the child is eligible for a first grade school program.

No additional hours of ECM/ECB will be authorized in the extension period until the initial 250 hours have been exhausted.

Barring exclusions noted in this section, ECM and ECB may include:

A. Habilitation Doctoral or Masters (ECM) (H habilitation Early Childhood Autism Specialized)

An ECM consultant provides the functions below:

1. Up to 20 hours for the initial intake and assessment, including:
   a. Completion of the Vineland Scales of Adaptive Functioning, Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Learning and Language Skills (ABLLS), and/or other standardized tool(s) to measure baseline adaptive functioning as approved by the Division
   b. Development of the intervention plan that explains targeted goals and objectives, including an operational definition for each behavior and/or skill and how goals/objectives will be 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. Estimate 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:
         • Antecedent-based interventions (e.g., environmental modifications, teaching interventions)
         • Consequence-based interventions (e.g., extinction, scheduling, reinforcement ratio).
      vii. Describe data collection procedures and how progress toward goals will be measured to reflect the increase or decrease of skills or behaviors.
   c. Summary of the parent(s)/caregiver(s) involvement and proposed goals/objectives, including a description of:
i. Behavior that the parent(s)/caregiver(s) is expected to demonstrate, including conditions under which they will demonstrate mastery

ii. Date of introduction of each goal/objective

iii. Estimated date of parent’s/caregiver’s mastery of each goal/objective

iv. Parent(s)/caregiver(s) training procedures

v. Data collection procedures.

d. Number of Habilitation (ECH) hours necessary to implement the plan based on identified interventions specific to the child’s needs.

e. A description for how this service will be coordinated with other services or therapies that the child is receiving from the Division or other sources (e.g., Behavioral Health, Health Plan, Education, Child Welfare).

f. A plan for transitioning the child from the service:

   i. Include individualized discharge criteria developed with specific, realistic, and timely follow-up care coordination recommendations.

   ii. Include plan for maintenance and generalization, including how and when this service will be transitioned to other lesser intensive services.

2. Regular consultative oversight to parent(s)/caregiver(s) and ECH providers, using the remaining hours within the initial 250 hour authorization.

3. Quarterly reports, provided in writing, to include the areas identified in the Division’s Provider Policy Manual Chapter 35 Progress Reporting Requirement.

4. Reassessment using the Vineland Scales of Adaptive Functioning or other industry accepted tool to be administered annually, at a minimum.

B. Habilitation Doctoral or Masters (ECM)/Habilitation Bachelors (ECB) (Habilitation Early Childhood Autism Specialized)

An ECM or ECB consultant provides the functions below:

1. Training, for the parent(s)/caregivers(s) and habilitation provider(s) within the first 90 days of service, that includes:

   a. Modeling implementation of the specific activities with the child while the Habilitation provider(s) and or parent(s)/caregiver(s) are observing
b. Observing the Habilitation provider(s) or parent(s)/caregiver(s) implement the plan.

2. With the hours remaining in the initial 250 hour authorization, providing regular consultative oversight to parent(s)/caregivers(s) and habilitation provider(s).

C. Habilitation (ECH) Hours-Habilitation (Habilitation Early Childhood Autism Specialized)

1. The number of ECH hours is determined by the ECM Consultant’s assessment and prior authorized by the Division.

2. The approval of ECH hours as recommended in the ECM Consultant’s assessment and authorized by the Division must be coordinated with the authorization of the ECM/ECB hours (the approval of ECH and ECM/ECB are for the same service period and terminate at the same time).

3. The ECH provider will follow the plan/treatment goals developed by the ECM/ECB Consultant when authorization of habilitation hourly is in conjunction with the ECM/ECB program.

D. Responsible Person(s)’ Participation (Habilitation Early Childhood Autism Specialized)

This service requires participation from parent(s)/caregiver(s) to maximize the benefit of the service and improve outcomes for the child. As part of this service, parent(s) and caregiver(s):

1. Must participate in training provided by a qualified ECM/ECB Consultant on the specific activities developed for their child

2. Must implement the intervention plan (specific strategies) developed by the ECM/ECB Consultant as described in this section

3. Are expected to attend and participate in the ECH sessions, which include the ECM or ECB Consultant, and to implement the program during the course of treatment. Attendance and participation help to ensure that the goals important to the family are included and to provide additional guidance on the specific strategies.

E. Considerations (Habilitation Early Childhood Autism Specialized)

Using the assessment and plan development processes described in this policy manual, the Support Coordinator must consider the following factors when assessing the need for this service:

1. Eligibility for this service must be determined prior to the age of five.

2. The child must be eligible for the Division under the diagnosis of, or at risk of, Autism/Autism Spectrum Disorder AND be eligible through the Arizona Long Term Care System (ALTCS) program.
3. Parent(s)’/caregiver(s)’ ability and interest in participation in service delivery:
   a. The ECM Consultant must identify a clinical reason for lack of participation and document this reason in the Planning Document (e.g., the presence of the parent(s)/caregiver(s) interferes with the teaching of a specific skill/task).
   b. When the parent(s)/caregiver(s) is unable to participate, the team must identify other natural or paid supports, including services that allow the parents to participate.

4. Identification of the need in the child’s Planning Document.

F. Settings (Habilitation Early Childhood Autism Specialized)
This service may be provided:
   1. Hourly, in the child’s home
   2. Hourly, in other community settings or activities (unless specifically excluded below).

G. Exclusions (Habilitation Early Childhood Autism Specialized)
   1. This service must not be provided in school or in transit to and from school.
   2. The ECH portion of this service must not be provided in conjunction with the hourly habilitation (HAH) service.
1240-G  HOME NURSING

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Service Description and Goals (Home Nursing)

This service provides nursing intervention in the member’s place of residence. Services may include patient care, coordination, facilitation, and education.


Intermittent Nursing Services

Intermittent nursing services must be ordered by a physician and provided by a registered nurse or a licensed practical nurse. Skilled nursing assessments are required for monitoring purposes. The service provider must also submit written monthly progress reports to the member’s primary care provider or attending physician for intermittent nursing services.

Continuous Nursing Services

Continuous nursing services/home health private duty nursing must be ordered by a physician and provided by a registered nurse or a licensed practical nurse in accordance with 42 CFR 440.80 (www.gpo.gov). Continuous nursing services may be provided for members who are Arizona Long Term Care System (ALTCS) eligible and reside in their own home. Continuous nursing services are provided as an alternative to hospitalization or institutionalization when care cannot be safely managed within the scope and standards of intermittent nursing care and when determined to be cost-effective.

The goals of this service are to:

A. Increase or maintain self-sufficiency of eligible members; and,
B. Improve or maintain the physical well-being of eligible members.

Service Settings (Home Nursing)

The service shall not be provided in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), Nursing Facility (NF) or hospital.

Service Requirements (Home Nursing)

Before Home Nursing can be authorized, the following criteria must be met:

A. All members receiving this service shall have a nursing assessment done by a Division Nurse to determine skilled intervention, which includes:
1. A review of the current medical files, including all pertinent health-related information, to identify potential health needs of the member related to the Division nursing assessment;

2. Assessment of the health status of the member by a review of the current medical data, communication with the member, team members and families, and assessment of the member in relation to physical, developmental and behavioral dimensions; and,

3. When home nursing services are identified by the Division Nurse, a referral is submitted to the Division contracted home health nursing providers. The home nursing service provider must obtain an order from the primary care provider to perform duties related to home nursing care.

B. A licensed primary care provider must prescribe the services as a part of a written “plan of care.” This “plan of care” must be reviewed and recertified by the primary care provider at least every 60 days.

C. The service shall follow a written nursing plan of care developed by the Division contracted Home Health provider, in conjunction with the Division’s Support Coordinator, the member/responsible person and the Division Nurse which includes:

1. Specific services to be provided;

2. The person who will provide the specific service;

3. Anticipated frequency and duration of each specific service;

4. Expected outcome of services;

5. Coordination of these services with other services being received or needed by the member;

6. Input of the member/responsible person; and,

7. Assisting the member in increasing independence.

The nursing plan of care shall be included in and reviewed by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team).

Target Population (Home Nursing)

Support Coordinators will identify members who potentially need nursing through the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan process (Planning Process) and will submit a referral to the Division Nurse. The Division Nurse upon referral from the Support Coordinator will complete a nursing assessment and if the need is justified, a referral will be made to a contracted Division nursing agency. The contracted Division nursing agency will be responsible to obtain a written order from the primary care provider to perform the duties of home nursing care. The allocation of skilled nursing care
hours is determined by the Division Nurse; based on the nursing needs identified on the Division nursing assessment.

**Exclusions (Home Nursing)**

Exclusions to the provision of Home Nursing include:

A. Nurses may not provide service under physician's orders and prescribed medical procedures that have been changed by someone other than the physician;

B. Nurses may not be paid to provide other services, such as personal care during the time they are providing home nursing;

C. Home nursing shall not be used for day care; and,

D. Nurses shall not provide direct supervision of non-licensed persons engaged in service provision.

**Service Provision Guidelines (Home Nursing)**

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Nursing being provided. The Division Nurse will complete this assessment.

**Provider Types and Requirements (Home Nursing)**

Designated District staff will ensure all contractual requirements related to Home Nursing are met before services can be provided. Additionally, all providers of ALTCS must be certified by the Division and registered with the AHCCCS prior to service initiation.

**Service Evaluation (Home Nursing)**

A. Written assessment shall be completed quarterly by the Division Nurse, maintained on file and a copy sent to the Support Coordinator.

B. The Division contracted home health provider shall complete a nursing care plan and submit a copy to the Division Nurse and the Support Coordinator.

C. Each nursing plan of care from the Division contracted home health nursing provider shall be updated at least every 60 days. Any revisions to the plan shall be sent to the Division Nurse and the Support Coordinator.

D. All physician orders shall be maintained and implementation documented in each member's file.

E. Any contact made on behalf of the member shall be documented.

**Service Closure (Home Nursing)**

Service closure should occur when assessments by the Division Nurse, in conjunction with the Support Coordinator, indicate no further need for skilled nursing.
A. The Division Nurse is to inform the primary care provider that skilled nursing service is no longer required.

B. The Division Nurse is to inform the Division contracted home health provider that skilled nursing service is no longer required. The Division contracted home health provider is to obtain a discharge order from the primary care provider.

In addition to the member’s home, nursing services may also be provided in Group Homes, Developmental Homes, Level I and Level II Behavioral Health Facilities, or Day Treatment and Training programs as appropriate.
1240-H HOME HEALTH AIDE

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Service Description and Goals (Home Health Aide)

This service provides intermittent medically necessary health maintenance, continued treatment or monitoring of a health condition, and supportive care for activities of daily living at the member's place of residence. A Home Health Aide serves as an assistant to the primary caregiver, under the supervision of a licensed, registered nurse following a plan of care based upon the member's medical condition as prescribed by the Primary Care Provider (PCP), and authorized by Health Care Services (HCS).

The goal of this service is to increase or maintain self-sufficiency of eligible members.

Service Settings (Home Health Aide)

Home Health Aide services are provided in the member's home, but are not provided in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) Nursing Facility (NF) or hospital.

Service Requirements (Home Health Aide)

A. This service shall be supervised by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse. The agency supervisor shall conduct home visits at least every 60 days.

B. The service shall follow a plan of care developed by the supervisor, member and provider, in accordance with the PCP, which includes monitoring vital signs; changing dressings and/or bandages; care and prevention of bedsores; assistance with catheter (not to include insertion); assistance with bowel, bladder and/or ostomy program; assistance with self-medication; nail and skin care; assistance with personal hygiene; assistance with eating; assistance with ambulation, range of motion and exercise activities; assistance with special appliances and/or prosthetic devices; and transfers to and from wheelchair.

C. The service may include teaching the primary caregiver how to perform the home health tasks contained in the plan of care.

D. The service must be prescribed by a licensed physician as part of a written plan of care that shall be reviewed and recertified by the physician at least every 60 days.

Target Population (Home Health Aide)

This service is indicated for members who have a health condition that requires intermittent assistance, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan.
Exclusions (Home Health Aide)

Exclusions to the provision of Home Health Aide services include, but are not limited to:

A. Home Health Aide service shall not be used in place of another, more appropriate service such as Personal Care or Habilitation; and,

B. Home Health Aides shall not provide skilled nursing services.

Service Provision Guidelines (Home Health Aide)

In addition to requiring a physician's order, a nursing assessment must be completed prior to Home Health Aide service being provided. This assessment may be done by the District Utilization Review Nurse or by a nurse from HCS. Approval for this service must come from HCS.

Provider Types and Requirements (Home Health Aide)

Designated District staff will ensure all contractual requirements related to Home Health Aide providers are met before services can be provided. Additionally, all providers of Arizona Long Term Care Services (ALTCS) must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

Service Evaluation (Home Health Aide)

A. The physician will review the plan of care at least every 60 days and prescribe continuation of the service.

B. The agency nurse supervisor will review the plan of care at least every 60 days for appropriateness.

C. The provider will submit progress notes on the plan of care on a monthly basis to the Support Coordinator.

Service Closure (Home Health Aide)

Service closure should occur in the following situations:

A. Based on the plan of care, it is determined by the physician that the service is no longer needed;

B. The member/responsible person decline the service;

C. The member moves out of state;

D. The member requires other, more appropriate services (e.g., home nursing or personal care); and,

E. The member/responsible person has adequate resources or other support to provide the service.
1240-I HOME MODIFICATIONS

REVISION DATE: 3/2/2015
EFFECTIVE DATE: June 30, 1994

Overview

Home Modification is the process of adapting the home to promote the independence and functional ability of persons with disabilities. Adaptations may include physically changing portions of the residence to create a living environment that is functional according to the member’s specific needs. Terms often associated with this process include barrier removal, architectural access, assistive technology, retrofitting, home modifications, environmental access, or universal design.

Members who are eligible for the Arizona Long Term Care System (ALTCS) are also eligible for medically necessary home modifications for architectural access to and within his/her natural/private home. The goal of a home modification is to provide the person greater independence and ability with assistance for daily living in their home. Home modifications must be medically necessary, cost-effective, and reduce the risk of an increase in Home Community Based Services (HCBS) or institutionalization.

A Home Assessment will be done to develop an individualized home modifications plan. The plan will ensure that only appropriate diagnosis related modifications be completed in the home. This plan also provides for a cost-effective, predictable, medically beneficial, and measurable rehabilitative service for the member.

The Division must approve or deny requests for home modifications within 14 calendar days from the “identified need date.” A request that requires an additional extension for up to 14 days and is in the member’s best interest. Requires the member receive written notice including the reason for the extension. The Support Coordinator should request an assessment via the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process when attempting to identify the most appropriate modification for the member. The Planning Team identifies the need for a home modification assessment only. The assessment must be completed within 30 days. A certified staff person must conduct a home visit to make this assessment. The "identified need date" is determined at the time the team agrees to the recommendations as a result of the assessment.

When a request is for a specific home modification, such as a curbless shower, "handrails,” or widen doors, the Support Coordinator via the Planning Document can make a request for that specific modification. The “identified need date” starts at this time and the request for home modifications must be approved or denied within 14 days. A request that requires an additional extension for up to 14 days, and is in the member’s best interest, requires the member receive written notice including the reason for the extension. This method may result in a denial of service. The home modification unit would make a broad “contingent” recommendation if sufficient evidence is present to move forward with the request.

Scope of Home Modifications

The unit of service is one home modification project. Using the member’s primary and secondary diagnoses in conjunction with a home evaluation, a project plan to provide home
modification for the person will include, but not be limited to, the following areas of the home:

A. Member’s bedroom;

B. Most appropriate, cost-effective bathroom;

C. Most appropriate, cost-effective entrance/exit to the member’s home, i.e., a ramp; and,

D. Most appropriate, cost effective locations of the kitchen area, when determined to be medically necessary when the member lives alone.

The types of permanent installations for architectural barrier removal include:

A. Widening of doorways – entrance and exit to one bathroom and the member’s bedroom;

B. Accessible routes to one bathroom and the member’s bedroom;

C. One bathroom environment; (roll-in/curb-less) accessible shower, roll-under sink, high rise toilet with handrails, handrails and grab bars in accessible shower, as prescribed;

D. One wooden or concrete ramp/low inclined walkway; and,

E. Kitchen modifications; accessible cooking surface, minimum accessible pantry storage, accessible kitchen sink/faucet. Kitchen modifications are considered medically necessary when the member lives alone and cannot independently prepare necessary meals without modifications.

Home Modification recommendations (e.g., curb-less showers) will consider the use of durable medical equipment (e.g., shower chair) to be used; the Health Care Services Office can provide technical assistance on durable medical equipment. The member must request any new Durable Medical Equipment via their Primary Care Provider (PCP) who forwards the need to their contracted health plan.

Home Repairs, Home Improvement

General home repairs and maintenance are the responsibility of the homeowner. Home Modifications are for medically necessary environmental access and do not intend to include remodeling for home improvement or home safety. Although home safety is an outcome from architectural barrier removal when home modifications have been completed, it is the responsibility of the homeowner to ensure the home is safe; and to maintain important safe entrances from the home in case of emergency, for all inhabitants. Requests for home modifications that are determined to be for home repairs, home improvement, or home safety will be denied. Repairs will be carried out to existing structures only when the approved modifications have begun and cannot be completed because of unforeseen circumstances. These repairs must
necessary for building code correction, thereby granting the building contractor the ability to achieve completion of approved medical environmental modifications.

**New Construction**

The service covers only modifications to existing structures of a member/family owned home where the person resides. Members/families that are planning for a new home are responsible for all the architectural access design/ construction of a new home. The service does not cover the construction of additional rooms to the existing structure or provide for an additional bathroom. Technical assistance may be available to help with environmental access.

**Homes Not Owned by the Member (Rental/Lease)**

The owner of the residence must approve the modifications. When the home being considered for home modifications is not owned but is rented or leased by the family/member, documentation providing permission to allow for renovations on behalf of the member is required from the landlord/owner. Written confirmation must include agreement of participation, signature of the landlord/owner with indication of ownership, and address of residence requested for environmental access.

The Division will incur the cost to restore the home to the original condition prior to the renovation when the landlord/owner requires such after the member has vacated the property.

No Title XIX funds may be used to return a home to its pre-modification state as outlined in Arizona Health Care Cost Containment System (AHCCCS) policy (www.azahcccs.gov/Regulations).

It will be the responsibility of the landlord/owner to demonstrate that the removal of architectural barriers in the rented unit will result in the inability to negotiate a new rental agreement with another member or family. The landlord/owner must also demonstrate that it is a financial disadvantage to maintain environmental access to the rented unit. Additionally, the landlord/owner must demonstrate that the unit will not retain the retail value of a single family dwelling because of the removal of architectural barriers.

**Requirements for Medically Necessary Environmental Modifications**

Requests for the environmental access to the person's home must include all of the following:

A. The need for environmental access documented in the member’s Individual Support Plan/Individualized Family Services Plan/Person Centered Plan;

B. ALTCS Primary Care Provider order;

C. An assessment by a qualified professional, e.g., Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant. The Division's Medical Director must be contacted to review the request if an assessment by a qualified professional cannot be obtained;
D. An authorization by the Home Modifications Manager; and,

E. The evidence that the member resides in a private residence. Members residing in alternative residential settings are not eligible to receive Home Modifications.

If the request is denied due to lack of medical necessity, it may be authorized, approved or paid by Assistance to Families funds. Medically contraindicated requests shall not be authorized.

Procedures

When a member has recognized a need for home modifications, a request for a home modification begins by contacting the member's Support Coordinator.

The Support Coordinator will forward the request to the Home Modifications Office using the “Initial Request for Home Visit” fax form upon receipt of a member’s request for a home modification. This request must be made via the Individual Support Plan/Person Centered Plan process. A written order by a Primary Care Provider (PCP) is another way to make this request. Requests for a home modification may also be made using a home assessment from a Physical/Occupational Therapist. At the time of request for home modifications the Support Coordinator shall enter into the case file via the “Individual Support Plan” or the “Change of Individual Support Plan” form, the need for an assessment to determine specific modifications.

The date recorded in the member’s Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) becomes the date for the request for an assessment. This request date determines the beginning of the required 30 days to complete a home visit and assessment. Once the assessment is completed, the team can request the specific modifications and the date of this request becomes the “need identified” date.

The Division must approve or deny requests for home modification within 14 days of the identification of need date. A request that requires an additional extension for up to 14 days and is in the member’s best interest, requires the member receive written notice including the reason for the extension. Projects should be completed as soon as possible following approval, not to exceed 90 days. Extenuating circumstances that prevent project completion within 90 days of approval will be documented in the member’s case record.

A scheduled home assessment will be conducted within 30 days after the Home Modification unit in Central Office receives a request. The Support Coordinator must be present during the home environmental assessment.

The purpose of a home modification is to increase a member's independence. The home visit will assess the relationship of the member’s ability to function independently in the current environment as a result of the proposed home modifications. The home visit will also coordinate the Home Modification Packet production.

The home assessment will include:

A. Consideration for member’s abilities and disabilities based upon aids to daily living;
B. Consideration of information that is obtained from the member, family or others in the household and members of the Planning Team;

C. Consideration of hazardous areas of the home based on physical and/or cognitive/intellectual disabilities;

D. Identification of the Planning Documents needs as they relate to delivering services to the member;

E. Identification of diagnosis-related modifications;

F. Provisions for necessary assistive devices and durable medical equipment;

G. Provisions for necessary architectural barrier removal; and,

H. Recording architectural measurements of floor plans and specification sheet.

Review the required documents for the Home Modifications Packet with the member’s Support Coordinator. This includes:

A. Reviewing the Professional Assessment for environmental access. An Occupational Therapist, Physical Therapist, or Certified Environmental Access Consultant for the project can provide the professional assessment. A review may be requested from the Division’s Medical Director if a professional assessment cannot be obtained at all or obtained in a timely fashion.

B. Obtaining the PCP order for the project using the prescription form approved by the AHCCCS at 15 days from the “need identified” date. After this 15-day period, the Home Modifications unit will send a second prescription form to the PCP with instructions that services will be denied if the prescription form is not received.

C. Obtaining the Project Specification Sheet and Floor Plans. The Home Modification Office will be responsible for the development and implementation of the Project Specification Sheet and drafting of floor plans for each Project. A bid request will be forwarded to the appropriate providers. The Home Modifications Unit will review and award the bid to the approved provider upon return of the proposal.

D. The following authorities will be used as reference for determining accessibility and defining a living environment that provides greater independence and architectural access for the member upon developing the Project Specification Sheet. These include Uniform Building Code Chapter 11 - Accessibility, and guidelines in accordance with the Americans with Disabilities Act. Note: The Division will only approve medically beneficial, cost-effective environmental access.

Obtain Home Modification Bids - (at least two (2) bids). The Division will use only a licensed, bonded/insured - B or B3 Contractor/Builder for the accessible renovation of the member’s residence.

Complete the Environmental Modifications Request Form to track progress of the project. Ensure that member’s identification information, Provider/Contractor name, cost of service, the signatures of the Support Coordinator, supervisor, and District Program.
Administrator/District Program Manager or designee (cost of service must be indicated prior to submitting to the Lieutenant Program Manager/District Program Manager) are included. The project can be approved and started whether or not the form has been completed but must be completed to ensure everyone has knowledge of the project and the project costs.

Submit the project packet to the Home Modification Office for review/approval.

The packet will include the following:

A. Environmental Modifications Request;

B. Member’s Planning Documents (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan) indicating need for medical environmental access;

C. Professional assessment dated within time of request or review with signature from Division’s Medical Director;

D. PCP order dated within time of request;

E. Project Specification Sheet and Floor plan (before and after, site plan); and,

F. Contractor bids.

Review Procedures

The Home Modifications Manager will ensure the District representative has reviewed costs and signatures are present upon receipt of the Project Packet.

The Home Modifications Manager will review and sign the request only upon verification that all necessary documents have been provided.

A second level of approval will be required if a Home Modification Project Packet has a total project cost greater than $9000.00. The Home Modifications Manager will forward the project packet to the Assistant Director or designee for review and a final decision. The second level review will be monitored as to avoid delay and maintain Project Packet progress with in required time frames.
1250-B HOSPICE

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Service Description and Goals (Hospice)

Hospice services significantly impacts members/families served by the Division who are in the process of making end of life decisions. The Division is determined to ensure that the existence of a member’s disability bears no influence on end of life decisions and is committed to protect the best interest of people with developmental disabilities.

The Division is also determined to ensure that the decision to provide life-sustaining treatment to members is determined by using the same standards of judgment used to assess the same decisions regarding persons without developmental disabilities.

The Division is opposed to decision-making to hasten death due to the perception that people with developmental disabilities have a “low quality of life” and believes that the lives of all people are valuable. As a result, the Division is committed to helping members obtain the best care possible. The Division also believes that treatment should be conducted in accordance with the member’s wishes or what is understood to best represent the member’s best interests.

Situations may arise where the burden of medical treatment outweighs the benefit to the member. The Division is aware of situations where members, families, and health care providers weigh the benefits of care when there is no hope for improved health and the prolonging of life no longer benefits the “patient.”

The Division discourages the removal of life sustaining devices. If the member, surrogate, and medical experts determine that life sustaining devices are not in the member’s best interest, they may determine other options. A member’s disability should not be a determining factor when considering whether or not to remove life sustaining devices.

First, treatment that provides no discomfort and alleviates pain may be continued. Next, treatment that needlessly prolongs suffering may be eliminated while maintaining those devices that allow for comfort and rest. Finally, all life sustaining devices may be removed in an effort to allow the progression of natural events to take place, unless the cessation of certain devices would cause pain and discomfort.

Division staff confronted with end of life situations shall do the following:

A. Share the Division’s perspective on the lives of members;

B. Emphasize that the member’s disabilities should not influence medical decisions;

C. Encourage cooperation, and open communication to determine the member’s best interest with family members, surrogate decision makers, and health care providers; and,
D. When a member has an advanced directive, durable power of attorney, health care directive power of attorney, or any such legal document, the Division respects the member’s lawful wishes as specified in the legal document.

E. If there is no such legal document providing guidance in end of life situations the following need to be considered:

1. The member’s ability to participate in the activities and functions that provide pleasure and value to their lives;
2. The member’s health condition;
3. The benefit of treatment;
4. Treatment options; and,
5. The members best interest.

Hospice services are provided to Arizona Long Term Care System (ALTCS) members who meet medical criteria/requirements and are not based on a person’s disability. Hospice services provide palliative and support care for terminally ill members and their family or caregivers. Hospice services provide health care and emotional support for terminally ill members and their families/caregivers during the final stages of life.
1250-C MEDICAL AND ACUTE CARE SERVICES

EFFECTIVE DATE: May 13, 2016

A. Medical/acute care services provided to members eligible for ALTCS are the same as those provided to members enrolled in the acute care program, with the exception of therapies.

B. Medical/acute care services require orders from the member’s primary care provider or attending physician, and in some cases, authorization from the member’s Support Coordinator.

C. Medical/acute care services may be provided to members eligible for ALTCS residing in their own home, institutional setting, or any ALTCS approved alternative HCB residential setting.
1250-D  RESPITE

EFFECTIVE DATE: June 30, 1994
REFERENCES: Rate Book; AzEIP

Service Description and Goals (Respite)

This service provides short-term care to relieve caregivers. Members who are cared for by Respite providers must be eligible for supports and services through the Division. Respite providers may be required to be available on a 24-hour basis. Respite services are intended to temporarily relieve unpaid caregivers. Respite services are not intended as a permanent solution for placement or care. The number of hours authorized for Respite services must be used for Respite services and cannot be transferred to another service.

Service Settings (Respite)

Respite may be provided in any of the following settings:

A. The member’s home
B. A Medicare/Medicaid certified Nursing Facility
C. A Group Home, Foster Home or Adult Developmental Home certified by the Division
D. A certified Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID)
E. A provider's home that complies with the requirements of the Department of Health Services or the Division.

Service Requirements (Respite)

Before Respite can be authorized, the following requirements must be met:

A. Prior to initiating service, the provider shall meet with the primary caregiver to obtain necessary information regarding the member;

B. The provider shall:
   1. Supervise the member and meet their social, emotional, and physical needs;
   2. Ensure the member receives all prescribed medications in the ordered dose and time;
   3. Administer First Aid and give appropriate attention to injury or illness;
   4. Supply food to meet daily nutritional needs including any prescribed therapeutic diets;
5. Furnish transportation as needed to day programs and appointments;
6. Carry out any programs as requested by the Planning Team;
7. Report any unusual incidents to the Division in accordance with policies and procedures; and,
8. Ensure appropriate consideration of member needs, compatibility and safety when caring for unrelated members.

**Target Population (Respite)**

Respite, as a medically related social service, is appropriate based upon family needs, as written in the Individual Support Plan/Individualized Family Support Plan/Person Centered Plan (Planning Documents). Respite services are also appropriate based on the following factors:

A. The primary caregiver is unable to obtain Respite and other supports from his/her immediate/extended family or from other community resources.

B. The primary caregiver needs time to recover from abnormally stressful situations in order to resume his/her responsibilities.

C. The member with a developmental disability presents intense behavioral challenges or needs a high degree of medical care.

D. The primary caregiver is experiencing an emergency that temporarily prevents performance of normal responsibilities.

E. The primary caregiver requires more frequent or extended relief from care responsibilities due to advanced age or disability.

F. The family is experiencing unusual stressors, such as care for more than one person who has a developmental disability.

G. Respite services can only be provided for children ages 0 to 3 related to required training for the primary caregiver. This training requirement must be documented in the Individualized Family Services Plan (IFSP).

**Exclusions (Respite)**

Exclusions to the provision of Respite services may include any of the following:

A. Respite shall not substitute for routine Transportation, day care, or another specific service;

B. Respite shall not substitute for a residential placement;

C. Respite providers shall not serve more than three people at one time;
D. Child Developmental Homes and Adult Developmental Home providers shall not give services to more members than would exceed their Division license;

E. Child Developmental Homes and Adult Developmental Home Respite providers shall not give services to children and adults simultaneously. This is only allowed if stated on the license. Additionally, the provider shall not offer services to adults if the license is for children and vice versa;

F. Respite is not available for members living in Group Homes or an ICF/IID; and,

G. Assisted Living Centers, non-state operated ICF/IID, Skilled Nursing Facilities; Level I or Level II Behavioral Health Facilities and members living independently are not approved for Respite.

**Service Provision Guidelines (Respite)**

A. The federal government and the Arizona Health Care Cost Containment System (AHCCCS) set the upper limit of 600 hours per year regarding Respite services for members who are eligible for Arizona Long Term Care (ALTCS). Respite Service hours are determined on a yearly basis by the initial Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents.

B. Members who are eligible for Respite services funded by the state are subject to the availability of these funds. The continuation of Respite services is determined on a yearly basis through the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and periodic review of these documents. Respite services are intended to allow unpaid primary care givers a break and, as such, the assessment for Respite hours will need to be reconciled with the amount of time an unpaid primary caregiver usually provides support.

C. All hours of Respite utilized by the member/family will be tracked and reported. Respite hours for members who are eligible for ALTCS will be reported to AHCCCS.

D. For Respite billing information see Department of Economic Security, Division of Developmental Disabilities Rate Book located on the Division’s website at:

https://des.az.gov/services/disabilities/developmental-infant

E. A negotiated rate will be applied for families who have more than one person eligible for Respite. This negotiated rate will be reported by the provider, with the total actual hours of service given to each member on the Uniform Billing Document. This method of rate setting will be applied when these members receive Respite at the same time. The hours used will be deducted by the Division from the authorized level of Respite for each person.

F. Families receiving Respite for a member eligible for services from the Division who wish other non-eligible members to receive care will be responsible for the costs of serving the non-eligible member. The Division will only pay for services delivered to
members authorized to receive such service and will pay the provider at a multiple client rate.

**Provider Types and Requirements (Respite)**

Designated District staff will ensure all contractual requirements related to Respite providers are met before service can be provided. Additionally, all providers of ALTCS services must be certified by the Division and registered with AHCCCS prior to service initiation.

**Service Evaluation (Respite)**

The Support Coordinator must continually assess the quality of the services provided to members with developmental disabilities in accordance with the mission statement. Additionally:

A. The provider shall submit attendance reports summarizing the members served and the number of hours of service to the designated District representative. All incidents shall be reported to the Division within the required timelines; and,

B. The Support Coordinator and the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team (Planning Team) shall determine the ongoing appropriateness of the service based upon the input from the providers and the member’s caregiver(s).

**Service Closure (Respite)**

A. Respite shall terminate when the member begins to live independently or in a Group Home, Vendor Supported Developmental Homes or, Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) or Nursing Facility (NF).

B. Respite shall terminate when the family no longer desires the service.

C. Respite for members who are eligible for services through the ALTCS shall terminate when the maximum amount allowed has been used and there are no State funds available.
Habilitative Therapy

Habilitative therapy directs the member’s participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in the these respective documents. Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis, and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitative therapy may utilize direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

Occupational, Physical, and Speech Therapy

Description (Occupational, Physical and Speech)

Therapy services provide medically necessary activities to develop, improve, or restore functions/skills. Therapy services require a prescription, are provided or supervised by a licensed therapist, and are not intended to be long term services.

Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement, and eating.

Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

Speech therapy may address receptive and expressive language, articulation, fluency, eating, and swallowing. Barring exclusions noted in this section, Therapy includes the following:

A. Evaluation of skills;
B. Development of home programs and consultative oversight with the member, family and other providers;
C. Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety;
D. Modeling/teaching/coaching parents and/or caregivers specific techniques and approaches to everyday activities, within a member’s routine, in meeting their priorities and outcomes; and,
E. Collaboration with all team members/professionals involved in the member’s life.
Responsible Person’s Participation (Occupational, Physical and Speech)

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, parents/family or other caregivers (paid/unpaid) are required to:

A. Be present and actively participate in all therapy sessions; and,
B. Carry out the home program.

Considerations (Occupational, Physical and Speech)

The following will be considered when approving this service:

A. Developmental/functional skills;
B. Medical conditions;
C. Member’s network of support (e.g., family/caregivers, friends, providers);
D. Age; and,
E. Therapies provided by the school.

Settings (Occupational, Physical and Speech)

Therapy shall be provided in settings that support outcomes developed by the team. This includes:

A. The member’s home;
B. Community settings;
C. Division funded settings such as day programs and residential settings for the purpose of training staff;
D. Daycare; and,
E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include, but are not limited to the following:

A. Rehabilitative therapy (acute therapy) due to an accident, illness, medical procedure, or surgery. Rehabilitative therapy includes restoring former functions or skills due to an accident or surgery.
Funding for rehabilitative therapy shall be sought from:

1. Private/third party insurance;
2. Children’s Rehabilitative Services (CRS);
3. American Indian Health Services (AIHS);
4. Comprehensive Medical and Dental Plan (CMDP);
5. Arizona Health Care Cost Containment System (AHCCCS); or,
6. Division of Disabilities (DD)/Arizona Long Term Care Service (ALTCS) Acute Health Care Plan.

B. Physical therapy is provided by the DD/ALTCS Acute Health Care Plan for members 21 years and older and will not exceed 15 visits for developmental/restorative, maintenance, and rehabilitative therapy for the benefit year.

C. Therapy for educational purposes.

**Respiratory Therapy**

**Service Description and Goals (Respiratory Therapy)**

This service provides treatment to restore, maintain or improve respiration.

The goals of this service are to:

A. Provide treatment to restore, maintain or improve respiratory functions; and,

B. Improve the functional capabilities and physical well-being of the member.

**Service Settings (Respiratory Therapy)**

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).

**Service Requirements (Respiratory Therapy)**

Before Respiratory Therapy can be authorized, the following requirements must be met:

A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration, and scope of the therapy.

B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association’s
Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

C. The provider shall be designated for members who are eligible for ALTCS services and registered with the AHCCCS.

D. Tasks may include:

1. Conducting an assessment and/or review previous assessments, including the need for special equipment;

2. Developing treatment plans after discussing assessments with the Primary Care Provider, the District Nurse and the Planning Team;

3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member’s treatment plan;

4. Monitoring and reassessing the member’s needs on a regular basis;

5. Providing written reports to the Division staff, as requested;

6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff;

7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals;

8. Consulting with members, families, Support Coordinators, medical supply representatives, and other professional, and paraprofessional staff on the features and design of special equipment; and,

9. Giving instruction on the use and care of special equipment to the member and care providers.

Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).

Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state- operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy shall not exceed eight (8) fifteen (15) minute sessions per day.
Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of ALTCS must be registered with the AHCCCS prior to service initiation.

Service Evaluation (Respiratory Therapy)

A. The Primary Care Provider (PCP) will review the plan of care at least every 60 days and prescribe continuation of service.

B. If provided through a Medicare certified home health agency, the supervisor will review the plan of care at least every 60 days.

C. The provider will submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in the following situations:

A. The physician determines that the service is no longer needed as documented on the "Plan of Care";

B. The member/responsible person declines the service;

C. The member moves out of State;

D. The member requires other services, such as home nursing; and,

E. The member/responsible person has adequate resources or other support to provide the service.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics, and schools. The Division contracted therapists shall collaborate with other service providers and agencies involved with the member.
1250-F  MEDICAL SUPPLIES, EQUIPMENT, APPLIANCES, & CUSTOMIZED DURABLE MEDICAL EQUIPMENT

EFFECTIVE DATE: June 30, 1994

Adaptive Aids (Acute Care Services)

Certain medically necessary adaptive aids qualify as a covered service if prescribed by a specialist physician, practitioner, or dentist upon referral by a Primary Care Provider (PCP).

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment. It is important to remember that this service is based on “assessed need” and not a person’s or the family’s stated desires regarding specific services.

Covered adaptive aids are limited to:

A. Traction equipment
B. Feeding aids (including trays for wheelchairs)
C. Helmets
D. Standers, prone, and upright
E. Toileting aids
F. Wedges (positioning)
G. Transfer aids
H. Augmentative communication devices
I. Medically necessary car seats
J. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.

Augmentative Communication Devices

Service Description and Goals (Augmentative Communication Devices)

Augmentative communication devices are those devices that enhance a member’s ability to communicate with others at his/her highest level of independence.

Service Settings (Augmentative Communication Devices)

Augmentative communication devices are appropriate for use in all settings.
Service Requirements (Augmentative Communication Devices)

The member and their Individual Support Plan/Individualized Family Services Plan/Person Centered (Planning Team) team must identify the need for an augmentative/alternative communication evaluation. This determination shall be made by using the Pre-Admission Screening (PAS) tool, the Inventory for Client and Agency Planning (ICAP) tool and any other available information to assess whether there may be a functional gap between the member’s receptive and expressive language skills, and/or the member demonstrates communicative intent as determined by the Communicative Intent Checklist. The Support Coordinator must prepare a packet of information and forward it to Health Care Services in Central Office within 15 working days of the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meeting (Planning Meeting). The packet must include all of the following:

A. The completed Augmentative Communication Referral Checklist
B. The current Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) that includes long-term communication goals
C. A prescription for the augmentative/alternative communication evaluation and equipment as needed dated within the past 12 months.
D. A speech and language evaluation dated within the past 12 months
E. The current Individualized Education Plan (IEP) if school age
F. Documentation of previous use of low technology devices such as picture boards or dial scanners.
G. Occupational therapy evaluation dated within the past 12 months if the member has fine/sensory motor problems that may impact the ability to touch a small target square, to push hard enough to operate a switch or if there are limitations in the member range of motion or head control.
H. Physical therapy evaluation dated within the past 12 months if the member has seating, positioning, and/or mobility needs related to augmentative/alternative communication device use.
I. Formal or functional hearing test within the past 12 months
J. Formal or functional vision test within the past 12 months
K. Therapy progress reports, if therapy has been provided during the past 12 months
L. Third-Party Liability (TPL) insurance information
M. Any previous or current augmentative communication evaluation reports, if available.
N. Any other reports relating to the acquisition of the skills and/or abilities necessary to operate an augmentative/alternative communication device, if available, e.g., a current psychological/psychoeducational evaluation, wheelchair/seating clinic evaluations.

An evaluation conducted by the school system is acceptable for school age members.

Health Care Services will either refer for further evaluation or order the device, as appropriate within 15 working days of receipt of the complete packet. Further evaluations may include referral to the contracted Augmentative/Alternative Communication Evaluation Team, Rehabilitation Engineering for access assessment or medical review.

Once the device is obtained, it will be sent to the Support Coordinator. The Support Coordinator delivers the device and obtains the responsible person’s signature on the Acknowledgment of Receipt of Durable Medical Equipment form. This form is to be retained in the member’s case record, with a copy sent to Health Care Services. Training on the use of the device will be arranged per case.

Target Population (Augmentative Communication Devices)

Members who are potentially eligible for communication systems are those who show communicative intent but whose expressive skills are currently below their receptive language skills and are not adequately meeting their day to day functional communication needs. For example, members may attempt to communicate through non-verbal approaches such as pointing, gesturing, signing, vocalizing sounds, or eye gazing. Receptive language refers to understanding of spoken language, while expressive language refers to language output (traditionally speech). Such members may be candidates for an intervention strategy that includes the use of alternative forms of expressive communication. For such a strategy to be effective, other factors must be considered to ultimately guarantee benefit to the member, e.g., the long term goal, appropriate outcomes, valuation methods, mode of learning, follow up training, and overall quality of life.

Exclusions (Augmentative Communication Devices)

Augmentative communication devices will not be provided under the following circumstances:

A. The member has received appropriate teaching and therapeutic strategies and the prognosis for developing effective oral communication is poor.

B. The member does not demonstrate the ability to make choices independently.

C. The member will use the device solely in an educational setting.

D. The member has used light/high technology communication systems and has not demonstrated the intent to communicate.

E. The member has a history of destructive behavior and a plan of intervention has not been identified.
F. The Planning Team outcomes and goals do not indicate a commitment to use the device in all settings.

Service Provision Guidelines (Augmentative Communication Devices)

The following service provision guidelines apply to augmentative/alternative communication devices:

A. Devices will not be provided if not medically necessary and prescribed by the Primary Care Provider (PCP).

B. One (1) device and the medically necessary accessories for operation will be provided.

C. Only one (1) option will be provided (other options must be furnished by an alternative resource) if a device can be equipped with both voice and print capabilities.

D. One (1) mount will be provided unless a second is medically necessary.

E. Children under the age of 3 (who are referred as possible candidates for a device) will have their needs reviewed on a member basis. Toys are not a covered item.

F. Replacement of equipment is covered in the following situations:
   1. Loss or irreparable damage or wear not caused by carelessness or abuse
   2. Equipment replacement is recommended by an authorized re-evaluation. Re-evaluations for the purpose of upgrading the device will not be authorized for 6 months after the receipt of the current device.

Re-evaluations may be obtained if the current device is not meeting the member’s needs despite adequate training of at least 3 months, there is a change in the member’s medical condition, or communication goals were met or exceeded with the current system. Re-evaluations must include the same requirements as noted in this Chapter.

Evaluation (Augmentative Communication Devices)

The Support Coordinator must perform a review of the Individual Support Plan/Individualized Family Service Plan/Person Centered Plan (Planning Documents) as noted in this Policy Manual.

Service Closure (Augmentative Communication Devices)

All devices and accessories will be returned to the Division when no longer medically necessary as determined by the Individual Support Plan, Individualized Family Services Plan, or Person Centered Plan (Planning Documents). The Support Coordinator is responsible for picking up the device and accessories and returning them to Health Care.
Services. Health Care Services will then arrange for the device to be refurbished and reused. However, if the member moves out of state, the member will retain the device and does not return it to the Division.
1250-G  NUTRITIONAL ASSESSMENTS & NUTRITIONAL THERAPY

REVISION DATE: 7/3/2015, 9/15/2014
EFFECTIVE DATE: June 30, 1994

Supplemental Nutritional Feeding

This policy provides criteria for the evaluation and authorization of supplemental nutritional feedings (oral-ental formula) for members eligible for Arizona Long Term Care Services (ALTCS) covered services through the Division. It also addresses the issue of medical necessity, assessment, and authorization of non-specialty formula.

Criteria for Medical Review and Prior Authorization (Supplemental Nutritional Feeding)

A. The Primary Care Provider (PCP) or physician specialist must make the request. A Physician has requested nutritional feeding by a physician assistant or nurse practitioner. In order to make this request, the physician assistant or nurse practitioner must be under the medical management of the PCP. A request made by a physician specialist must be routed through the PCP for continuity of care.

Requests shall be routed through appropriate channels of the health plan or to the Prior Authorization Nurse in Health Care Services for fee-for-service. Items to be submitted for medical review include:

1. All current diagnoses;
2. Current or recent (within 6 months) laboratory data such as chemistry panel, iron binding studies;
3. Growth chart with current height and weight history. A family history of unusual growth patterns, i.e., emaciated, short stature, etc. should be included, as appropriate;
4. The history of ambulation or physical activities;
5. The history of gastrointestinal health;
6. A current nutritional assessment and a summary of client/caregiver education done by a registered dietitian;
7. A 3, 5, or 7 day diary of dietary intake, as appropriate;
8. The speech or occupational therapy evaluation related to any oral-motor, dentition, chewing, or swallowing problems, as applicable;
9. Current medications including an analysis of possible medication/nutrient interaction affecting absorption;
10. All alternative approaches to the use of oral-ental formulas attempted and the outcomes; and,
11. The specific goals of oral-enteral formulas with a follow-up and weaning plan over a specific time frame.

B. Monitoring of the client’s progress on the oral-enteral formula is the responsibility of the PCP or designee and shall include:

1. Nutritional assessment follow-up at the following intervals:
   a. Members on oral-enteral formulas less than five (5) years shall receive an assessment every three (3) months;
   b. Members on oral-enteral formulas five (5) to fourteen (14) years shall receive an assessment every six (6) months; and,
   c. Members on oral-enteral formulas over fourteen (14) years shall receive an assessment annually.

2. Alternatives to commercially prepared formulas shall be considered whenever possible including blenderized foods for members beyond the normal formula age (3 years) if possible.

C. Members who are eligible for the Arizona Supplemental Nutrition Program for Women, Infant & Children (WIC) program should be encouraged to use that program first. The Division’s fee-for-service or the subcontracted health plan will make up the difference between the WIC Program, the authorized amount and the PCP requested amount.

Member Management (Supplemental Nutritional Feeding)

Members should be followed by:

A. The health plan;

B. The agency providing the formula; and,

C. The Division’s Health Care Services for Fee-For Service.

Authorization Process (Supplemental Nutritional Feeding)

A. Definitions

1. Enteral - “within or by way of the intestine.” For the purposes of this policy, enteral will mean the delivery of nutritional feedings to the intestinal tract by way of a feeding tube such as nasogastric, oral-gastric, gastrostomy, jejunostomy, or a gastrostomy button.

2. Oral - any nutritional formula or food that is ingested by mouth.
B. Authorization guidelines

1. Authorization for oral-enteral formula or supplemental nutritional feedings will be granted if the following criteria are met. The health plan Medical Director or the Division Medical Director must also deem oral-enteral formula or supplemental feedings as medically necessary for Fee for Service. The criteria for authorization are as follows:
   a. The member is at or below the 10th percentile on the appropriate growth chart for their age, gender, or disability, e.g., Down syndrome, for greater than three months;
   b. The member has reached a plateau in growth and/or nutritional status for greater than six months (pre-pubescent);
   c. The member has demonstrated a decline in growth status within the last three months;
   d. The member is able to obtain/eat no more than 50% of his/her nutritional requirement from normal food sources;
   e. Absorption problems as evidenced by emesis, diarrhea, dehydration, weight loss, and intolerance to milk or formula products have been ruled out; and,
   f. Unsuccessful trials of alternatives, such as blenderized foods, have been documented over a reasonable period of time with the involvement of a nutritionist.

2. The Prior Authorization Nurse will submit all documentation for evaluation by the health plan Medical Director or the Division Medical Director regarding fee-for-service.

3. Re-authorization for supplemental nutritional feeding formula will be determined by the age of the member (based on the nutritional evaluation for age set forth in this chapter).
1250-H TRANSPORTATION

EFFECTIVE DATE: June 30, 1994

Transportation (Non-Emergency)

Service Description and Goals (Transportation)

Non-emergency transportation shall be provided for members who are unable to provide their own transportation for medically necessary services. This service provides non-emergency ground transportation as previously approved by the Division, if the member’s natural supports cannot provide such transportation.

The goal of this service is to increase or maintain self-sufficiency, mobility, and/or community access of eligible members.

Service Requirements (Transportation)

Transportation can be provided for members who are eligible for Arizona Long Term Care Service (ALTCS) to and from other covered services.

Target Population (Transportation)

A. The need for transportation is assessed and documented by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process.

B. Transportation is appropriate when member/family resources, supports or community resources are not adequate or available.

Exclusions (Transportation)

Exclusions for transportation services include:

A. Providers shall not transport more members than can travel safely.

B. Transportation for members who are eligible ALTCS to medical appointments should be coordinated through the health plan.

C. Members residing in Vendor Supported Child Developmental Homes and Vendor Supported Adult Developmental Homes, Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Group Homes shall not receive additional transportation.

Service Provision Guidelines (Transportation)

A. Members who are eligible for ALTCS may use forty-six (46) trips per month to covered day programs. The Division may authorize additional trips as required for members who are eligible for ALTCS.
B. The Division may authorize additional trips as required for members who are eligible for other ALTCS.

Provider Types and Requirements (Transportation)

Designated District staff will ensure all contractual requirements related to Transportation providers are met before services can be given. Additionally, all providers of ALTCS must be certified by the Division and registered with the Arizona Health Care Cost Containment System (AHCCCS) prior to service initiation.

Service Evaluation (Transportation)

This service shall be reviewed at all Planning Team meetings.

Service Closure (Transportation)

A. This service shall be terminated when the member no longer requires transportation.

B. This service shall be terminated if other resources become available.
1280  STATE FUNDED SERVICES

REVISION DATE: 3/2/2015
EFFECTIVE DATE: June 30, 1994

Member and Family Assistance

Member and Family Assistance is flexible support funding intended to enable families to care for children at home and for adult members to live independently in their communities. Member and Family Assistance is based on available funding and is not intended to replace natural or other means of support and assistance. They may be Emergency Support or Ongoing Support as described below.

General Guidelines

All payments from these funds must be made to a vendor, not the family or member unless extenuating circumstances prevent it. For instance, in the case of rent subsidy payable to a family member who is renting to a member all exceptions must be prior approved in writing by a Lieutenant and Program Manager Services that may be purchased with Member and Family Assistance funds include those listed in the Arizona Taxonomy of Services, as well as financial assistance for specific purposes. These services may include:

A. Automotive repairs (if the vehicle is unable to be driven and would put the member at risk if not repaired);

B. Clothing;

C. Corrective lenses;

D. Dental needs;

E. Diapers;

F. Equipment repairs;

G. Medication;

H. Moving expenses;

I. Rent and/or living subsidy;

J. Transportation; and,

K. Utilities.

Payments may produce a Federal Income Tax form 1099 that is sent to the recipient of these funds.
Receipts

Receipts must be obtained for all purchases/payments with few exceptions. Exceptions may include ongoing rent so long as an annual rental agreement is on file, showing monthly rent with beginning and end dates. Receipts may also be submitted in the form of a bill or invoice in the case of utility bills or monthly service fees. Receipts are to include the following information:

A. Vendor name/place of business;
B. Date of purchase;
C. Description of item(s) purchased;
D. Name of Member; and,
E. Name of Support Coordinator.

All disbursements from Member and Family Assistance funds shall be documented as expended by submission of the original itemized receipt(s) within 30 days. No further funds shall be granted to the vendor until the receipts are submitted, unless approved by the District Program Administrator/Manager or in case of health and safety concerns.

The funds may only be spent for the approved purchase and not for any other items. If there are any excess funds, they are to be returned to the Division.

Emergency Support

Emergency Support provides a one-time payment in emergent or extraordinary circumstances to eligible families on behalf of a member with a developmental disability living in the family home, or (for an adult) in either the family or her/his own home or in rare cases for a member living in a vendor operated setting with prior written approval by the Lieutenant Program Manager for health and safety purposes.

One-time payment amounts typically should not exceed $500 per member or family. Any amounts over $300 require Lieutenant Program Manager approval.

Eligible Services

Only authorized services may be purchased with Member and Family Assistance funds. Authorized services are those recommended by the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Team) and approved by the District Program Administrator/District Program Manager or designee. The Division will only approve services that can be purchased at a reasonable cost.

Emergency Support cannot be used to supplement the level of services already furnished to the family or member under Division contracts with service providers.
Emergency Support cannot be used to purchase services otherwise readily available to the family or members who are eligible for Arizona Long Term Care Service (ALTCS). Emergency Support is not available for Licensed Child Developmental or Adult Developmental Homes unless for health or safety matters not funded elsewhere members who have failed to take all reasonable steps to enroll in the ALTCS program are not eligible for Emergency Support.

Other service options must be explored in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan process and, if appropriate, applications for alternative services or benefits may be made a condition of eligibility to receive Member and Family Assistance. These alternatives might include:

A. ALTCS;
B. Income supplements such as Supplemental Security Income, Social Security Survivors Benefits, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Assistance to Needy Families, General Assistance and Emergency Assistance;
C. Food stamps, Arizona Supplemental Nutrition Program for Women, Infants & Children (WIC) and food banks;
D. Housing benefits available through Housing and Urban Development;
E. Vocational Rehabilitation Services and the Job Training Partnership Act Program;
F. Benefits rendered because of injury to persons or property;
G. Education programs;
H. Child support and adoption subsidies;
I. Arizona Health Care Cost Containment System (AHCCCS), Medicare, Indian Health Services and private health insurance; and,
J. Supplemental Payments Program and benefits furnished under the Older Americans Act.

**Eligibility**

All members/families must meet the following criteria to receive Emergency Support:

A. Enrolled in the Division service system.
B. Participation in the program by parent, other close relative, legal guardian or by the member. This participation usually takes the form of a co-payment for services.
C. Require funds for health or safety concerns for which no other funding is available.
**Determination of Participation by Responsible Person**

The Member and Family Assistance/Emergency Support funds are intended to form a partnership between families and the Division in meeting the needs of children or adults who live at home, or in independent or supported living arrangements not contracted as residential programs by the Division.

Emergency Support is “needs-based” and is not tied to a specific income eligibility level unlike the ALTCS. Families must demonstrate their co-pay participation related to cost for the service, item, or other purchase to be eligible for Emergency Support.

In the case of an adult with a developmental disability living in her/his own home, the member must be able to demonstrate how much income is devoted to shelter and food before Member and Family Assistance/Emergency support payment can be approved. The member must also demonstrate how much income is devoted to an Individual Support Plan Team-approved program before an Emergency Support payment can be provided. The member's remaining resources are available for personal and incidental expenses. Members with more than $3,000 in liquid assets (cash) are ineligible for Assistance to Families funds.

The Support Coordinator and member/responsible person shall complete the Member and Family Assistance Request Worksheet and Agreement when requesting participation in this program. The Planning Team shall review these documents and forward them, with a recommendation, to the District Program Manager/Lieutenant Program Manager or designee. The packet must reflect the items or services funded by Emergency Support dollars, the type and amount of support, and the level of participation by the member or family.

**Guidelines for Approving Emergency Support**

The District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors in evaluating requests for Emergency Support:

A. Age and/or health status of the parents/family members;
B. Complexity of the member’s needs the stress that these place on the family, and the family's ability to respond to that stress;
C. Degree of member or family participation in the cost of services relative to their means;
D. Degree to which the member is already receiving other Division funded services;
E. Availability of funding from all sources; and,
F. Reason for the emergent or extraordinary request.

The District Program Manager/Lieutenant Program Manager should respond to a request for Emergency Support within five (5) working days of the recommendation by the Planning Team.
**Payments**

Services are authorized and participation/co-payments identified on the Member and Family Assistance Worksheet and Agreement. If approved, the payment will go directly to the vendor identified by the member or family.

**Waivers**

The District Program Administrator/Lieutenant Program Manager must approve any waivers for procedures or family participation. The waiver is only allowed if the goals and intent of the program are otherwise met. The member, family, or Support Coordinator is permitted to initiate a written request for a waiver. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan Team may also initiate a written waiver request. The request must identify the specific requirements to be waived. The Lieutenant Program Manager/Program Manager will determine whether approval of the requested waiver will enable the goals and intent of the program to be met. The Lieutenant Program Manager/District Program Manager will respond to the initiator of the request, in writing, within ten working days. Payments to other than a vendor must also be approved by the Division’s Business Operations Administrator.

**Ongoing Support**

Ongoing Support is an on-going payment to a vendor intended to support the family’s effort to maintain its family member with a disability in the family home, thereby preventing out-of-home placement; or to support an adult to live in their own home, thereby preventing placement in more restrictive settings. Payments are made directly to the vendor identified by the member or family or in the case of members living in Individually Designed Living Arrangements (IDLA), payments may be made to the provider who will make payments to landlords, utilities, and other living cost on behalf of a member.

When Ongoing Support payments are made to a provider for members living in an IDLA, the provider is required to maintain a detailed expenditures log for each member identifying all expenditures on behalf of the member, including:

A. Date;
B. Vendor;
C. Purchase/payment detail;
D. Amount; and,
E. Declining balance with all supporting documentation and receipts attached.

This expenditure log must be made available to the Division and/or the guardian upon request at any time.
Eligible Services – Ongoing Support

The Division will only approve services that can be purchased at a reasonable cost and that advance/meet the goals of the Member and Family Assistance program and the Division.

Ineligible Services

Ongoing Support cannot be used for the following:

A. Services available under ALTCS;
B. Members who live in Developmental Homes, Group Homes, Intermediate Care Facilities for Persons with an Intellectual Disability, Nursing Facilities, or Assisted Living Centers;
C. Members who have failed to take all reasonable steps to enroll in the ALTCS; and,
D. Families with income that exceeds 300% of the federal poverty level.

Alternative Options

The Individual Support Plan/Individual Family Services Plan/Person Centered Plan Team members must explore other service options and, if appropriate, applications for alternative services or benefits may be made as a condition of eligibility to receive Ongoing Support. These alternatives include:

A. The ALTCS;
B. Income supplements such as Supplemental Security Income, Social Security, Social Security Disability Income, Railroad Retirement, Veterans Administration, Temporary Aid to Needy Families, General Assistance, and Emergency Assistance;
C. Food stamps, WIC, and food banks;
D. Housing benefits available through Housing and Urban Development and other housing assistance;
E. Vocational Rehabilitation Services and assistance through the Job Training Partnership Act;
F. Education programs;
G. Child support and adoption subsidy;
H. AHCCCS, Medicare, Indian Health Services, and private health insurance;
I. Supplemental Payment Program and benefits furnished under the Older Americans Act; and,
J. Other community, and religious based services, and programs.
Eligibility

All members/families must meet the following criteria during any month wherein Ongoing Support is received:

A. Enrolled in the Division;

B. Participation in the program by parent, other close relative, legal guardian, or by the member. This participation usually takes the form of a co-payment for goods or services, although it may involve participation in the form of a contribution of labor. Members in an IDLA with no familial supports or source of other income or require extensive supports and medically or behaviorally unable to participate in their own service delivery may be exempt from this requirement.

Determination of Participation by Responsible Person

Whenever possible, families or members must demonstrate their participation in the cost of service, item or other purchase to be eligible for Community Living Support.

The member must be able to demonstrate how much income is devoted to shelter, food, and program cost. The Individual Support Plan/Individualized Family Services Plan/Person Centered Plan team must approve the programs referenced. The member’s remaining resources are available for personal and incidental expenses. Members with more than $1,500 cash or $2,000 in liquid assets are ineligible for Ongoing Support. The member’s Ongoing Support payment will be interrupted or terminated until they can demonstrate the need for continued or renewed support.

The Support Coordinator and the Planning Team shall review these documents, the family’s resources, and any funds the member may have:

A. Savings and checking accounts;
B. Bonds;
C. Trust funds;
D. Tort-feasor (civil judgments) funds;
E. Annuities;
F. Estates;
G. Wages;
H. Benefits;
I. Child support payments; and,
J. Other financial resources and income.
The Support Coordinator shall then submit the request, including the items or services to be purchased and amount of family or member participation.

**Guidelines for Approving Ongoing Support**

In evaluating requests for Ongoing Support, the District Program Manager/Lieutenant Program Manager (or designee) shall consider the following factors:

A. **Availability of funding;**

B. The likelihood that Ongoing Support will enhance the family’s integrity, prevent the need for residential placement, avoid a more restrictive placement, or foster a smooth transition to more independent living for an adult with a developmental disability;

C. The age and/or health status of the parents/family members;

D. The complexity of the member’s needs, the stress that these place on the family and the family’s ability to respond;

E. The degree of member or family participation in the cost of services relative to their means;

F. The anticipated duration of the need for service;

G. The degree to which the family/member is already receiving other Division funded services; and,

H. Other resources that may be available to the member/family.

The District Program Manager/Lieutenant Program Manager shall approve the response to a request for Ongoing Support funds within 14 working days of the recommendation by the Support Coordinator and Planning Team.

**Payments**

Authorized services, vendor payments and co-payments are identified on the Member and Family Assistance Request Worksheet and Agreement. They must be ongoing payments.

The Ongoing Support Payments may only be made when the initial/prior payment has been verified as expended for the authorized purpose (receipts, or when not available, then via a written, signed statement by the recipient member or family, or upon receipt of a bill, rental agreement, invoice, or quote from a vendor). In some cases, receipts totaling less than the advanced sum will result in a reduction of the subsequent payment of the Ongoing Support award and will require a return of the unspent supports.

Ongoing supports for food for members living in an Individually Designed Living Arrangement do not require an automatic reduction in the ongoing monthly support unless an ongoing trend in unspent Support is demonstrated, in which case the Support Coordinator shall make a re-determination regarding on the level on Ongoing Support required. Receipts exceeding the authorized amount will not result in an increase in the
subsequent payment. In-kind contributions including volunteer time must be documented in writing and submitted along with the receipts.

**Waivers**

Waivers of any Ongoing Support procedures, including member or family participation requirements, may be granted by the District Program Manager/Lieutenant Program Manager, if the goals and intent of the program are otherwise met.

The member, Support Coordinator, or Planning Team may initiate a written waiver request. The request must identify the specific requirements to be waived. The District Program Manager/Lieutenant Program Manager will determine whether approval of the waiver request will enable the goals and intent of the program to be met. The District Program Manager/Lieutenant Program Manager will respond to the initiator of the request, in writing within ten working of receipt of the request.
Exhibit 1240A-1 ATTENDANT CARE SUPERVISION REQUIREMENTS
AGE 17 AND UNDER

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to meet medical necessity for general supervision for children age 17 and under as part of the Attendant Care service.

Age 17 and under: A child must meet the criteria indicated in one of the four categories outlined below:

A. Unsafe Behaviors

1. Documentation of behaviors placing the child at risk of injury to self or others; AND,

2. Documentation that the child is receiving or pursuing services through a behavioral health agency/professional; or,

3. Documentation of behaviors placing the child at risk of injury to self or others; AND,

4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical

Documentation is required from a medical professional describing a severe medical need or physical condition that would place the child at risk if left alone.

C. Confused/Disoriented

Documentation indicating a loss of skills (e.g., due to accident or injury) that are unlikely to be regained.

D. Wandering risk (age 13 - 17 only)

1. Documentation of the child leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; AND,

2. The youth is at risk to self or others when alone in the community or may be unable to return safely.

When a child age 17 and under meets one of the criteria outlined above, general supervision is then based on age criteria. The requirements outlined below may be waived with District Program Manager approval.
For children **age 12 and under**, general supervision may be provided when **all of the following are met**:

A. The child cannot attend a typical day care center because
   
   1. The child’s health and safety would be at risk; **OR**,
   
   2. The health and safety of others will be at risk; **OR**,
   
   3. A fundamental alteration of a day care center would be required. This requires documentation from the day care center;

   **AND,**

B. Child care in a private home or a before/after school program offered by the school/local city or county is not available or cannot meet the child’s needs;

   **AND,**

C. The parent, guardian, or other adult is not in the home;

   **AND,**

D. Division funded summer or after school program is not available or cannot meet the child’s needs (Only applies to age 3 and above.)

For children **age 13-17 general supervision** may be provided when **all of the following are met**:

A. A Division funded program is not available or has been considered and is not appropriate;

   **AND,**

B. The youth receives enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP);

   **AND,**

C. The parent, guardian or other adult is not in the home;

   **AND,**

D. The youth has received, is receiving or will receive Habilitation to minimize the need for supervision in the future, if a wandering risk or has unsafe behaviors.
Exhibit 1240A-2 ATTENDANT CARE SUPERVISION REQUIREMENTS
AGE 18 AND ABOVE

EFFECTIVE: March 1, 2013

Overview

This information clarifies the criteria to qualify for general supervision for adults age 18 and above as part of the Attendant Care service.

Age 18 and above: An adult must meet one of the criteria outlined below:

A. Unsafe behaviors
   1. Documentation that behaviors place the adult at risk of injury to self or others; and,
   2. Documentation that the person is receiving or pursuing services through a behavioral health agency/professional;
   3. Documentation that behaviors placing the adult at risk of injury to self or others; or
   4. Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past.

B. Medical
   Documentation is required from a medical professional describing a severe medical need or physical condition that would place the adult at risk if left alone.

C. Wandering risk
   1. Documentation of the adult leaving a situation or environment neither notifying nor receiving permission from the appropriate individuals; and,
   2. The adult is at risk when alone in the community and may be unable to return safely.

D. Confused/disoriented
   1. Documentation of the presence of confusion or disorientation (prior to being diagnosed with dementia); or,
   2. Documentation indicating a loss of skills (e.g., due to accident or injury) and are unlikely to be regained.

E. Unable to call for help even with a lifeline.
Documentation is available in the member’s file that the adult is unable to use a telephone or press a button to alert the lifeline system.

When an adult 18 years of age and older meets one of the criteria outlined above, supervision is then based on the following age criteria. The requirements outlined below may be waived with District Program Manager approval.

For adults age 18 and above supervision may be provided when the first criteria and the others (if applicable) are met:

A. A Division funded employment/day program is not available or has been considered and not appropriate.

B. If still in school, the adult must receive enhanced staffing (self-contained) or assistance from an aide at school as documented on the Individual Education Program (IEP).

C. If appropriate, an adult who has an identified wandering risk or has unsafe behaviors must have received, is receiving or will receive habilitation to minimize the need for supervision in the future.
Overview

Documents that may provide justification of medical necessity for supervision include, but are not limited to the following:

A. Individual Support Plan;
B. Individualized Education Program (IEP);
C. Multi-Disciplinary Education Team (MET);
D. Medical Documentation;
E. Psychiatric/Psychological Evaluation;
F. Clinical Notes;
G. Incident Reports;
H. Pre-Admission Screening (PAS);
I. Police Reports;
J. Inventory for Client and Agency Planning (ICAP); and,
K. Adaptive Mini-Mental (Pre-Dementia Screening Tool).
### Exhibit 1240G-1 SKILLED NURSING MATRIX

**REVISION DATE:** 1/31/2014  
**EFFECTIVE DATE:** August 30, 2013

<table>
<thead>
<tr>
<th>Condition or Need</th>
<th>Medical Definition</th>
<th>Skilled Nursing Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulant Therapy</td>
<td>Medications used to make the blood less likely to clot or form scabs.</td>
<td>Assessment and monitoring for unstable anticoagulant therapy.</td>
</tr>
<tr>
<td>Apical Pulse Check</td>
<td>Use of a stethoscope to listen to the heart beat at the level of the heart.</td>
<td>Listening to heart beat on chest for full minute.</td>
</tr>
<tr>
<td>Bi-level positive airway pressure</td>
<td>A machine that helps an individual breathe.</td>
<td>Turning on and off, changing settings, respiratory assessment, circuit changes.</td>
</tr>
<tr>
<td>(BiPAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure Checks</td>
<td>Assessment of Blood Pressure.</td>
<td>Blood pressure monitoring and treatment when it is too high or too low.</td>
</tr>
<tr>
<td>Chest percussion therapy</td>
<td>Therapy by clapping on the chest either manually or with a machine.</td>
<td>Application of the therapy techniques and assessment of effectiveness, respiratory assessment.</td>
</tr>
<tr>
<td>(CPT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex wound care</td>
<td>Assessment and treatment of wound.</td>
<td>Assessment and treatment of wound, including but not limited to wound cleaning and bandage changes.</td>
</tr>
<tr>
<td>Complex/Unstable Seizure Disorder</td>
<td>A change in the way a person acts or moves that is not normal due to a brain problem.</td>
<td>Neurological assessment and emergency medical intervention for unstable seizure activity.</td>
</tr>
<tr>
<td>Coughalator/cough assist device</td>
<td>A machine that causes the member to cough.</td>
<td>Application of machine and assessment of effectiveness of machine; respiratory assessment.</td>
</tr>
<tr>
<td>Condition or Need</td>
<td>Medical Definition</td>
<td>Skilled Nursing Task</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Dialysis (occurring at home)</td>
<td>Cleaning of blood through a machine or tube.</td>
<td>Assessment and monitoring; starting and stopping of the treatment.</td>
</tr>
<tr>
<td>Extremity edema checks when ordered by a physician</td>
<td>Assessment of extra fluid buildup in the extremities.</td>
<td>Checking for fluid in the legs or arms; assessment.</td>
</tr>
<tr>
<td>GJ Tube Gastrostomy/Jejunostomy</td>
<td>A feeding tube into the gastric (stomach) continuing to the Jejunum (small intestine).</td>
<td>Insertion of liquid food, water and/or medication into the tube.</td>
</tr>
<tr>
<td>Injections</td>
<td>Medication given with a needle.</td>
<td>Administering medication with a needle.</td>
</tr>
<tr>
<td>Insulin Administration</td>
<td>Medications given with a needle to treat diabetes.</td>
<td>Administering insulin with a needle.</td>
</tr>
<tr>
<td>Intermittent partial pressure breathing (IPPB)</td>
<td>A machine to assist with breathing all the time.</td>
<td>Monitoring effectiveness of machine, changing settings on machine as ordered, respiratory assessment and intervention, circuit changes.</td>
</tr>
<tr>
<td>Intravenous (IV) Therapy (For individuals living at home)</td>
<td>Administration of fluids and medications into the venous blood supply.</td>
<td>Administering medications through an IV into the blood and any dressing changes needed.</td>
</tr>
<tr>
<td>J-Tube (Jejunum-tube)</td>
<td>A feeding tube through the Jejunum (small intestine).</td>
<td>Insertion of liquid food, water and/or medication into the tube.</td>
</tr>
<tr>
<td>Nasogastric enteral feeding (NG tube)</td>
<td>Liquid food and water fed through a tube from the nose into the stomach.</td>
<td>Checking tube placement; start feeding; stop feeding.</td>
</tr>
<tr>
<td>Nephrostomy</td>
<td>Surgically placed tubes used to flush fluid to clean the kidney(s).</td>
<td>Flushing fluid into tubes that cleans the kidney(s).</td>
</tr>
<tr>
<td>Ostomy irrigation</td>
<td>Flushing of an opening into the body with fluid.</td>
<td>Cleaning out the organ with fluid.</td>
</tr>
<tr>
<td>Condition or Need</td>
<td>Medical Definition</td>
<td>Skilled Nursing Task *This may result in Skilled Nursing Services being authorized</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Oxygen Titration</td>
<td>Giving oxygen at an amount that changes dependent on the person’s blood oxygen level.</td>
<td>Changing the level of oxygen administration based on pulse oximeter readings.</td>
</tr>
<tr>
<td>Postural drainage</td>
<td>A treatment to clear the lungs by moving the body in a downward position.</td>
<td>Assessment and draining the lungs of fluids.</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>An area of the skin that breaks down when something keeps rubbing or pressing against the skin.</td>
<td>Assessment and monitoring of the care and healing of the pressure ulcer.</td>
</tr>
<tr>
<td>Pulse Oximeter</td>
<td>A machine that measures oxygen levels in the blood.</td>
<td>Monitoring the amount of oxygen in the body.</td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>The temporary stoppage of breathing during sleep.</td>
<td>BiPAP machine or Vent used to treat the condition, respiratory assessment (the assessment for Apneic episodes).</td>
</tr>
<tr>
<td>Small Volume Nebulizer (SVN) (varied or unscheduled)</td>
<td>Medications given at varied times using a small-volume nebulizer, a device that holds liquid medicine which is then turned into a fine mist.</td>
<td>Assessment of needed time for medicated breathing treatments.</td>
</tr>
<tr>
<td>Sputum sample</td>
<td>Chest fluid sample test.</td>
<td>Collection of fluid from chest.</td>
</tr>
<tr>
<td>Suctioning (tracheal or deep through the nose or mouth)</td>
<td>Use of a tube to suction out the throat and lungs through a tube in the throat or deep into the mouth.</td>
<td>Inserting tube into the throat and/or lungs through the mouth or the nose to get fluid out.</td>
</tr>
<tr>
<td>Tracheotomy</td>
<td>A surgery to make an opening through the neck into the windpipe to allow for breathing.</td>
<td>All tracheotomy management and care.</td>
</tr>
<tr>
<td>Condition or Need</td>
<td>Medical Definition</td>
<td>Skilled Nursing Task</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Urinary Catheter</td>
<td>A tube into the bladder to drain out urine.</td>
<td>Insertion of a tube into the bladder to drain out urine.</td>
</tr>
<tr>
<td>Ventilator</td>
<td>A machine that provides breathing support continuously.</td>
<td>All ventilator management and care.</td>
</tr>
</tbody>
</table>
1100 RESERVED
1300 RESERVED
1400 RESERVED
1500  RESERVED
1610 COMPONENTS OF SUPPORT COORDINATION

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

Components of Support Coordination

The Support Coordinators’ roles include, but are not limited to the following:

A. Planning and Coordination
   1. Based on assessed need, identifies Cost Effective Services;
   2. Develops the Service Plan;
   3. Ensures members and families know the steps to report unavailability of services or other problems;
   4. Coordinates acute, behavioral health, and long term care services that will assist the member in maintaining or progressing toward his/her highest potential; and,
   5. Reassesses needs and modifies Service Plan as needed.

B. Brokering of Services
   1. Identifies appropriate community resources for members and families;
   2. Obtains all funded services as assessed; and,
   3. Offers a substitute service, when the assessed service is not available.

C. Facilitation/Advocacy: Addresses and resolves issues timely

D. Monitors services for continuing appropriateness

E. Gatekeeping: assess and determine the need for, and cost effectiveness of services for members

The Support Coordinator shall:

A. Follow current Division policy;
B. Comply with all Arizona Health Care Cost Containment System (AHCCCS) requirements;
C. Complete Department of Economic Security (DES)/Division of Developmental Disabilities (DDD) requirements/paperwork;
D. Document accurately;
E. Complete assigned tasks; and,
F. Be punctual and available

**Support Coordination/Arizona Early Intervention Program**


**Contracted Support Coordination (Case Management)**

A Qualified Vendor provides contracted Support Coordination services to members who are eligible for Division services.

The goal of this service is to coordinate needed assistance to members and their families/responsible persons to help ensure members attain their maximum potential for independence, productivity, and integration into the community.

The Qualified Vendor is responsible for the following:

A. Assessment in conjunction with the Planning Team, by gathering, reviewing, and evaluating information to assist families/members/responsible persons to determine the member’s goals, outcomes, and services needed.

B. Plan Development by facilitating an interdisciplinary team, including the family/member/responsible persons and the development of an annual Planning Document. Planning Meeting facilitation may be deferred to the Person Centered Plan Facilitator if the family/member/responsible person so chooses.

C. Plan Coordination by ensuring that supports, services, activities and objectives identified in the Planning Document are accessible to the family/member/responsible person and are implemented.

D. Plan Monitoring by ensuring the family/member receives quality supports and services in a cost effective manner in accordance with the Division’s Support Coordination supervision by:

1. Providing opportunities for regular supervision to discuss work done on behalf of families/members through case review and problem solving;

2. Scheduling monthly discussions with a Division Supervisor or Division Liaison; and,

3. Conducting file audits.

The Division will retain various Support Coordination activities including: completing the intake process; determining and re-determining eligibility; authorizing services; and monitoring service delivery.
Only providers who have been awarded a contract for Support Coordination may perform Contracted Support Coordination services. The requirements/prohibitions for Qualified Vendors related to Contracted Support Coordination and service delivery are as follows:

A. The Qualified Vendor must avoid any conflict of interest between the delivery of Support Coordination services and the delivery of direct services to the member;

B. The Qualified Vendor may not deliver direct services and Support Coordination to the same member. However, the Qualified Vendor may deliver both direct services and Support Coordination to members who are enrolled in the early intervention program of the Division; and,

C. Unless the Qualified Vendor receives approval from the Division’s Assistant Director/Designee, the Qualified Vendor must wait six (6) months before delivering services to a member who previously received Support Coordination services from the Qualified Vendor. This requirement does not apply to services delivered to members who are enrolled in the early intervention program.

**Navajo Nation Contracted Support Coordination**

The Division has an Intergovernmental Agreement with the Navajo Nation to provide contracted Support Coordination services to members who are eligible for Arizona Long Term Services (ALTCS) and are:

A. Enrolled by the Department of Economic Security with the Navajo Nation to receive case management services;

B. Affiliated as members of the Navajo Tribe by virtue of being federally recognized Tribal members and who either live on the Navajo reservation or did live on the Navajo reservation prior to placement in an eligible ALTCS setting; and,

C. American Indians who are not affiliated members with the Navajo Nation by virtue of being federally recognized members, but currently physically reside on the Navajo reservation or did physically reside on the Navajo reservation but were subsequently placed off reservation in an eligible ALTCS setting.

For members receiving Home and Community Based Services (HCBS) on the reservation or in a nursing facility on or off reservation, the contracted Support Coordinator shall:

A. Develop and implement a Planning Document;

B. Coordinate medical needs with the members’ Primary Care Provider (PCP);

C. Assist members/families with identifying qualified providers for ALTCS services, if they are unable to choose a provider without assistance;

D. Monitor and update Planning Documents in accordance with this Policy Manual;
E. Assess the cost effectiveness of services and recommend the least most cost effective service alternatives;

F. Inform members of alternative services when the HCBS services exceed 100% of the Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID) rate; and,

G. Implement necessary corrective action to bring services into compliance.

The Division will retain various Support Coordination activities including: completing the intake process; determining and re-determining eligibility; authorizing services; and monitoring service delivery.
1620-G  BEHAVIORAL HEALTH STANDARDS

EFFECTIVE DATE: May 13, 2016

The following apply to members who need or receive Behavioral Health services:

A. Direct referrals for behavioral health evaluations may be made by the member or by any health care professional.

B. Requests for behavioral health services made by the member or member representative are assessed for appropriateness by the behavioral health authority within three business days of the request. If it is determined that services are needed, the referral for evaluation will be made within one business day.

C. Behavioral health services, which have been determined to be medically necessary by a qualified behavioral health professional (as defined in Arizona Administrative Code) will be provided.

D. The Support Coordinator ensures there is communication with the PCP and behavioral health providers involved in the member’s care and that care is coordinated with other agencies and involved parties.

E. The Support Coordinator ensures the timely involvement of a behavioral health professional to assess, develop a care plan, and assist members with difficult to handle behaviors.

F. Information from the Pre-Admission Screening and Resident Review (PASRR) Level II Evaluation for determination of mental illness (completed by the Arizona Department of Health Services when indicated by PASRR Level I screening) regarding a member’s need for specialized services will be incorporated into the member’s service plan.

G. Behavioral health appointments will be provided within the following timeframes:
   1. Within 24 hours of referral for emergency appointments; or
   2. Within 30 days of referral for routine appointments.

H. Support Coordination for a member receiving behavioral health services is provided in consultation/collaboration with a qualified behavioral health professional in those cases where the Support Coordinator does not meet the qualifications of a behavioral health professional (as defined in Arizona Administrative Code.) The consultation does not have to be with the provider of behavioral health services. It may be with the Division’s Behavioral Health Coordinator or other qualified designee.
I. Support Coordinators complete an initial consultation with the behavioral health professional for all members receiving/needing behavioral health services. Quarterly consultations are required thereafter as long as the member continues to receive/need Behavioral Health services.

J. Initial and quarterly consultations are not required for members who are stable on psychotropic medications and/or are not receiving any behavioral health services other than medication management.

K. The Support Coordinator documents the content and results of the initial and quarterly consultation with the behavioral health professional. The consultation is a communication between the Support Coordinator and a behavioral health professional about the member’s status and plan of treatment.

L. As part of the service plan monitoring, the Support Coordinator reviews the psychotropic medications being taken by the member. Only those medications used to modify behavioral health symptoms need to be included in this special monitoring. Examples of medication uses that do not require this monitoring are sedative hypnotics when used to treat insomnia or on an as needed basis prior to a procedure, anti-anxiety medications used for muscle spasms, and anticonvulsants used to treat a seizure disorder.

M. The medication review is clearly documented in the member record. The review takes place at each reassessment and includes the purpose and effectiveness of the medication, as well as any adverse side effects that may have occurred. Any concerns and plan of action to address issues (e.g., medication ineffectiveness, presence of adverse side effects, multiple medication prescriptions for the same diagnosis) is discussed with the Behavioral Health Consultant and/or prescribing practitioner, and is documented in the case file.

N. Support Coordinators identify, assist, and monitor the unique needs and requirements related to members who are unable or unwilling to consent to treatment.

O. The behavioral health code is updated in Focus at the time of each review.
1630  ADMINISTRATIVE STANDARDS

EFFECTIVE DATE: May 13, 2016
REFERENCES: 42 C.F.R. §441.555c

Support Coordinator Qualifications

Individuals hired as Support Coordinators will have:

A. A bachelor’s or master’s degree in social worker or related field OR be a licensed registered nurse or Licensed Practical Nurse
   OR

B. Two years’ experience in providing support coordination (case management) services when the individual does not have a degree or a license
   OR

C. A minimum of two consecutive years of experience in long term care services to persons who are elderly and/or persons with physical or developmental disabilities.

Documentation

The Division uses the following standardized forms from the AHCCCS AMPM Chapter 1600:

A. Uniform Assessment Tool
B. Member Service Plan
C. AHCCCS/ALTCS Member Contingency/Back-Up Plan

The Division has a mechanism to transmit Focus data elements to AHCCCS biweekly.

Training

Adequate orientation and ongoing training on subjects relevant to the Division is provided. Documentation of training dates and staff attendance, and copies of materials used, are maintained for record keeping.

A. The Division provides uniform training to all Support Coordinators. This includes formal training classes and mentoring-type opportunities for newly hired Support Coordinators.

B. Newly hired Support Coordinators are provided orientation and training in the following areas:
   1. The role of the Support Coordinator in utilizing a member-centered approach to Arizona Long Term Care System (ALTCS) support coordination, including maximizing the role of the member and their family in decision-making and service planning
   2. The principle of most integrated, least restrictive settings for member placement
   3. Member rights and responsibilities
4. Support Coordination responsibilities as outlined in the AHCCCS AMPM Chapter 1600, including, but not limited to service planning, contingency plans, reporting service gaps and Notices of Action.

5. Support Coordination procedures specific to the Division

6. An overview of the AHCCCS/ALTCS program

7. The continuum of ALTCS services, including available service delivery options, placement settings and service restrictions/limitations

8. The Division provider network by location, service type and capacity, including information about community resources for non-ALTCS covered services.

9. Information on local resources for housing, education and employment services/program that could help members gain greater self-sufficiency in the areas.

10. Responsibilities related to monitoring for and reporting of quality of care concerns, including, but not limited to, suspected abuse, neglect and/or exploitation

11. General medical information, such as symptoms, medications and treatments for diagnostic categories common to the population served by the Division.

12. General social service information, such as family dynamics, care contracting, dealing with difficult people, risk management.

13. Behavioral health information, including identification of member’s behavioral health needs, covered behavioral health services and how to access those services within the Division’s network, and the requirements for initial and quarterly behavioral health consultations

14. The Pre-Admission Screening and Resident Review (PASRR) process

15. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) standards for members under the age of 21, and

16. ALTCS management information system Client Assessment Tracking System (CATS) that maintains member-specific data such as Cost Effectiveness Studies, Placement/Residence codes, behavioral health codes, and review dates. The level of orientation to CATS will be dependent on the level of direct usage by Division staff.

C. In addition to review of areas covered in orientation, all Support Coordinators are provided with regular ongoing training on topics relevant to the population served by the Division.
D. The Division maintains staff who are designated as the expert(s) on housing, education and employment issues and resources within the Division’s service area. These staff are available to assist Support Coordinators with up-to-date information designed to aid members in making informed decisions about their independent living options.

**Caseload Management**

Adequate numbers of qualified and trained Support Coordinators are provided to meet the needs of enrolled members.

The Division has protocols to ensure newly enrolled ALTCS members are assigned to a Support Coordinator immediately upon enrollment.

**Accessibility**

Members and/or member representatives are provided adequate information in order to be able to contact the Support Coordinator or DDD office for assistance, including what to do in cases of emergencies and/or after hours.

A system of back-up Support Coordinators is in place for members who contact an office when their primary support coordination is unavailable.

A mechanism is in place to ensure members, representatives and providers are called back in a timely manner when messages are left for Support Coordinators.

**Time Management**

The Division ensures Support Coordinators are not assigned duties unrelated to member-specific support coordination for more than 15% of their time if they carry a full caseload.

**Conflict of Interest**

The Division ensures Support Coordinators are not:

A. Related by blood or marriage to a member, or any paid caregiver of a member, on their caseload

B. Financially responsible for a member on their caseload

C. Empowered to make financial or health-related decisions on behalf of a member on their caseload

D. In a position to financially benefit from the provision of services to a member on their caseload

E. Providers of ALTCS services for any member on their caseload

F. Individuals who have an interest in, or are employed by, a provider of ALTCS services for any member on their caseload.

Exceptions to the above may be made under limited circumstances as described under 42 CFR 441.555c with prior approval from AHCCCS Administration.
Supervision

A supervisor to Support Coordinator ratio is established that is conducive to a sound support structure for Support Coordinators. Supervisors must have adequate time to train and review the work of newly hired Support Coordinators and provide support and guidance to established Support Coordinators.

A system of internal monitoring of the support coordination program, to include case file audits and reviews of the consistency of member assessments and service authorizations, has been established and applied, at a minimum, on a quarterly basis.

Results from this monitoring, including the development and implementation of continuous improvement strategies to address identified deficiencies, are documented and made available to AHCCCS upon request.

Inter-Departmental Coordination

The Division has established and implemented mechanisms to promote coordination and communication across disciplines and departments within their own organization, with particular emphasis on ensuring coordinated approaches with Medical Management (MM) and Quality Management (QM). For example, there is coordination of information between support coordination, MM and QM regarding poly-pharmacy issues to ensure measures are taken to effectively address this issue.

The Division’s Medical Director is available as a resource to support coordination and is advised of medical management issues as needed.

Reporting Requirements

A Support Coordination Plan is submitted annually to AHCCCS on or before November 15th. The plan addresses how the Division will implement and monitor the support coordination and administrative standards outlined in the AHCCCS AMPM Chapter 1600, including specialized caseloads.

An evaluation of the Division’s Support Coordination Plan from the previous year is also included in the plan, highlighting lessons learned and strategies for improvement.
1640 TARGETED SUPPORT COORDINATION STANDARDS

EFFECTIVE DATE: May 13, 2016

Targeted Support Coordination (TSC) is a covered service provided by the Division to members with Developmental Disabilities who are financially eligible for the Title XIX and Title XXI acute care programs, but do not meet the functional requirements of the ALTCS program. The Division provides the TSC services to these members; however, the members receive their acute care services through the AHCCCS Acute Care Contractors. Members are given a choice of available Acute Care Contractors and primary care providers registered with AHCCCS and a choice of Support Coordinators from the Division.

Members receiving TSC may choose the type (on-site visit, telephone, letter) and frequency of support coordination contact except under the circumstances in The Division’s Operations Manual Chapter 2000:2002.

A. Support Coordinator responsibilities include, but are not limited to, informing the member of:

1. Service options, including medical services available from Acute Care Contractors based on assessed needs.

2. Visit options and requesting their decision on the options.

3. Coordinating and participating in Planning Meetings, including developing, revising and monitoring of the Planning Document.

4. Locating, coordinating and arranging social, educational and other resources to meet the member’s needs.

5. Providing necessary information regarding the member’s functioning level and any changes in the member’s level of functioning to assist the medical providers in planning delivering and monitoring services.

6. Providing family members, or other caregivers, the support necessary to obtain optimal benefits from available services/resources.

7. Providing assistance to strengthen the role of family as primary caregivers.

8. Providing assistance to reunite families with children who are in an alternative setting whenever possible, and

9. Identifying services provided by other agencies to eliminate costly duplication.
B. Division responsibilities include, but not limited to:

1. Ensuring staff receive initial and ongoing training regarding support coordination responsibilities for the TSC program.

2. Identifying new members who are eligible for TSC services and assigning support coordinators.

3. Establish and maintain an internal monitoring system of the TSC program, and make results available at the time of annual review, to include a summary/analysis and corrective action plan, when applicable.
<table>
<thead>
<tr>
<th>Chapter 100</th>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 200</td>
<td>Requirements for Division Eligibility Overview</td>
</tr>
<tr>
<td>200</td>
<td>Requirements for Division Eligibility Overview</td>
</tr>
<tr>
<td>200-A</td>
<td>Residency</td>
</tr>
<tr>
<td>200-B</td>
<td>Citizenship or Legal Residency</td>
</tr>
<tr>
<td>200-C</td>
<td>Social Security Numbers</td>
</tr>
<tr>
<td>200-D</td>
<td>Consent for Application for Services</td>
</tr>
<tr>
<td>200-E</td>
<td>Responsible Person and Application</td>
</tr>
<tr>
<td>200-F</td>
<td>Cooperation with Arizona Long Term Care System Eligibility Process</td>
</tr>
<tr>
<td>200-G</td>
<td>Diagnostic and Functional Criteria for Persons Age 6 and Above</td>
</tr>
<tr>
<td>200-H</td>
<td>Criteria for Children Birth to Age 6</td>
</tr>
<tr>
<td>200-I</td>
<td>Adult Applicants with Limited Documentation</td>
</tr>
<tr>
<td>Chapter 300</td>
<td>Referral Procedures</td>
</tr>
<tr>
<td>Chapter 400</td>
<td>Eligibility Determination Process</td>
</tr>
<tr>
<td>Chapter 500</td>
<td>Assignment of Support Coordinators</td>
</tr>
<tr>
<td>Chapter 600</td>
<td>Re-Determination of Eligibility</td>
</tr>
<tr>
<td>Chapter 700</td>
<td>Determination of Arizona Long Term Care System Eligibility</td>
</tr>
<tr>
<td>Chapter 800</td>
<td>Eligibility for the Arizona Early Intervention Program</td>
</tr>
<tr>
<td>Chapter 900</td>
<td>Eligibility Categories</td>
</tr>
<tr>
<td>Chapter 1000</td>
<td>Responsibilities of the Member/Responsible Person When Eligible for the Division</td>
</tr>
<tr>
<td>Chapter 1001</td>
<td>Inventory for Client and Agency Planning</td>
</tr>
</tbody>
</table>
100 RESPONSIBILITIES

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. § 36-596(B); A.A.C. R6-6-401, R6-6-603.

Making more choices and exerting more control over one’s life also means assuming some amount of responsibility. Members applying for and/or receiving supports and services through the Division of Developmental Disabilities have certain responsibilities. These responsibilities begin when a person applies for services by providing the Division with accurate and complete personal information on the application. These responsibilities continue once a Member is determined eligible, for example, by being actively involved in developing, implementing, and monitoring the Individual Service Plan (ISP). These responsibilities last throughout the duration of services, through actions such as being respectful of the rights, and property of others.

The Division encourages members to assume some reasonable responsibilities for the success of their supports and services. Their increased involvement in their care increases the likelihood of achieving the best results. Therefore, fulfilling these responsibilities is important as Members contribute to the success of the Division’s supports and services.

Members receiving supports and services from the Division have a responsibility to:

A. Cooperate with the Division staff by providing required information relative to personal information required on the application. When accepted for supports and services, the Member is responsible for informing their Support Coordinator of any change in such data;

B. Participate in the development of their Planning Document and to signify agreement or disagreement by signing the Planning Document;

C. Assign to the Division rights to first party health insurance medical benefits to which the Member is entitled and which relate to the specific supports and services, which the person has received or will receive as part of their Planning Document; and,

D. Uphold all laws local, state, and federal bodies.

Members applying for and/or consumers receiving, supports and services through the Arizona Long Term Care System have additional responsibility to:

A. Provide accurate and complete information regarding their health history;

B. Report unexpected changes in their health status;

C. Follow the recommendations of the planning team, or the responsibility for his/her actions if the recommendations as documented are not followed as prescribed (in some cases, the plan may need revision if it has been deemed ineffective);
D. Be considerate of the rights of other residents and facility personnel in regards to personal behavior, control of noise, and number of visitors; and,

E. Be respectful of others property.
<table>
<thead>
<tr>
<th>Chapter 200</th>
<th>Requirements for Division Eligibility Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>200</td>
<td>Requirements for Division Eligibility Overview</td>
</tr>
<tr>
<td>200-A</td>
<td>Residency</td>
</tr>
<tr>
<td>200-B</td>
<td>Citizenship or Legal Residency</td>
</tr>
<tr>
<td>200-C</td>
<td>Social Security Numbers</td>
</tr>
<tr>
<td>200-D</td>
<td>Consent for Application for Services</td>
</tr>
<tr>
<td>200-E</td>
<td>Responsible Person and Application</td>
</tr>
<tr>
<td>200-F</td>
<td>Cooperation with Arizona Long Term Care System Eligibility Process</td>
</tr>
<tr>
<td>200-G</td>
<td>Diagnostic and Functional Criteria for Persons Age 6 and Above</td>
</tr>
<tr>
<td>200-H</td>
<td>Criteria for Children Birth to Age 6</td>
</tr>
</tbody>
</table>
200 REQUIREMENTS FOR DIVISION ELIGIBILITY OVERVIEW

EFFECTIVE DATE: January 15, 1996

A person is eligible to receive services, within available appropriations, from the Division if that person voluntarily applies, is a resident of Arizona, is a citizen or legal resident of the United States, gives informed consent, cooperates with the Arizona Long Term Care System (ALTCS) eligibility process, and meets established diagnostic and functional criteria. It is the responsibility of the applicant, with guidance from the Division as needed, to provide the Division with a full complete record of the applicant’s developmental, educational, familial, health, histories, including all relevant and accessible reports of psychological evaluations completed for the applicant.

The specific criteria for each of these eligibility requirements are described in this chapter.
A person is eligible to apply for services from the Division if such person is a bona fide resident of the State of Arizona. Resident means a person who physically resides within the State of Arizona with the intent to remain. The person who would receive the services must be the resident except in the case of minors whose residency is deemed to be the same as that of the custodial parent(s). The residency requirement is not applicable to foster children who are placed pursuant to A.R.S. § 8-548 and federal law regarding the Interstate Compact on the Placement of Children (ICPC).

The person signing the DDD application is affirming that the individual who would receive the services is a resident of the State of Arizona.
200-B  CITIZENSHIP OR LEGAL RESIDENCY

EFFECTIVE DATE: 5/29/2019
REFERENCES: A.R.S. §§ 46-140-01 (formerly known as Arizona Proposition 200)

A person is eligible to apply for services from the Division if the person is a citizen of the United States, legal resident of the United States or otherwise lawfully present in the United States.

All applicants must provide documentation showing that the person who would receive the services has lawful legal status. Legal status information is only required for the person needing services.
200-C       SOCIAL SECURITY NUMBERS

REVISION DATE:  4/17/2015
EFFECTIVE DATE:  January 15, 1996

The Federal Privacy Act, 5 U.S. Code § 552a (1974) provides that a state agency cannot require, as a condition for receiving any right, benefit or privilege provided by law, the disclosure of a member's Social Security Number unless:

A.  The records system predates 1975 and used Social Security Numbers as identifiers; or,

B.  It has received special permission from Congress to require a Social Security Number.

The Division of Developmental Disabilities does not meet either criteria and, therefore, cannot require an individual or family to disclose their Social Security Number.

An individual or family may voluntarily disclose their Social Security Number.
200-D CONSENT FOR APPLICATION FOR SERVICES

EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. § 36-560(A); 36-560(D); 36-560(E); A.A.C. R-6-6-402

Application shall be made on the forms specified in this chapter. Such form(s) must be signed by the responsible person. No admission to services may be made for any person without the consent of the responsible person.

For persons age 18 or over, the responsible person is the individual, unless that person has been adjudicated legally incapacitated and a guardian established by court order, in which case the legal guardian is the responsible person.

For persons under the age of 18, the legally responsible person is the parent, or a court appointed guardian. If the child is a dependent ward of the court, the Department of Child Safety caseworker may sign the application. For children between the ages of 14 to 18 who live in residential settings supported by the Division, the child must also sign the application unless the Eligibility Specialist determines that the child does not appear to be capable of giving voluntary informed consent.

An adult capable of giving consent may apply for services from the Division. If an adult applies for admission and reasonably appears to the Department to be impaired by a developmental disability to the extent that they lack sufficient understanding or capacity to make or communicate responsible decisions regarding their person, the Division will require that prior to receiving programs or services, the person have a guardian appointed or shall have had a judicial determination made that it is not necessary to appoint a guardian for such person.

An adult applying for services will be presumed capable of giving consent unless there is a court order declaring the person is legally incapacitated or the person's records indicate a diagnosis of profound or severe cognitive/intellectual disability. Family members applying on behalf of an individual described as having profound or severe cognitive/intellectual disability will be advised to review legal options which may include guardianship; conservatorship; durable general power of attorney; representative payee; and/or Advanced directives for Health and Mental Health Care, Prehospital Medical Care Directive, and Living Will.
200-E RESPONSIBLE PERSON AND APPLICATION

EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. § 36-551(36)

The responsible person as defined in A.R.S. § 36-551(36) must:

A. Sign application provided by the Division;
B. Participate in face-to-face interview with a designated Department employee if requested by the Eligibility Specialist or applicant;
C. Show evidence that the person who would receive the services is a resident of Arizona;
D. Provide proof of the person who would receive the services age and health insurance; and,
E. Supply documentation of the developmental disability in conjunction with the application.
200-F COOPERATION WITH ARIZONA LONG TERM CARE ELIGIBILITY PROCESS

REVISION DATE: 5/29/2019
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. §§ 36-559(B) (C), 36-560(C)

The Division must inform the individual/responsible person of the eligibility requirement regarding application for the ALTCS, as described in this policy. The individual/responsible person shall cooperate with the ALTCS application process prior to receiving services from the Division. Applicants voluntarily refusing to cooperate in the ALTCS eligibility process, including re-determination, are not eligible for Division services. Voluntary refusal to cooperate will not be construed to mean that the applicant is unable to obtain documentation required for eligibility determination.

In situations of immediate and compelling need, short-term services may be provided to members with a developmental disability who are in the process of ALTCS eligibility determination.

The responsible person must sign the DD-525 Application for Eligibility Determination form explaining loss of benefits due to voluntary refusal to cooperate in the ALTCS eligibility determination process. See this Policy Manual regarding determination of potential eligibility for ALTCS.
200-G DIAGNOSTIC AND FUNCTIONAL CRITERIA FOR INDIVIDUALS AGE SIX AND ABOVE

EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. §§ 36-551 and 36-559; A.A.C. R6-6-303

Individuals age six and above are eligible to receive services from the Division, subject to appropriation, if they have a developmental disability and meet all other criteria for eligibility with the Division, pursuant to A.R.S. §§ 36-551 and 36-559, and Title 6, Chapter 6, Article 3 of the Arizona Administrative Code (A.A.C.).

"Developmental disability" as defined in A.R.S. § 36-551 means either a strongly demonstrated potential that a child under six years of age has a developmental disability or will develop a developmental disability, as determined by a test performed pursuant to A.R.S. § 36-694 or by other appropriate tests, or a severe, chronic disability that:

A. Is attributable to cognitive disability, cerebral palsy, epilepsy, or autism.
B. Is manifested before the age of eighteen.
C. Is likely to continue indefinitely.
D. Results in substantial functional limitations in three or more of the following areas of major life activity:
   1. Self-care.
   2. Receptive and expressive language.
   3. Learning.
   4. Mobility.
   5. Self-direction.
E. Reflects the need for a combination and sequence of individually planned or coordinated special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration.

"Manifest before age eighteen," as defined in A.R.S. § 36-551, means that the disability must be apparent and have a substantially limiting effect on an individual’s functioning before age eighteen. At least one of the four qualifying conditions identified in A.R.S.§ 36-551, (cognitive/intellectual disability, autism, cerebral palsy, or epilepsy), must exist prior to the individual's eighteenth birthday.

"Likely to continue indefinitely," as defined in A.R.S. § 36-551, means that the developmental disability has a reasonable likelihood of continuing for a protracted period of time or for life. According to professional practice, “likely to continue” in relation to Traumatic Brain Injury (TBI) occurring prior to age 18, means that the condition must
continue to exist at least two years after the diagnosis was made.

"Substantial functional limitation," as defined in A.R.S. § 36-551, means a limitation so severe that extraordinary assistance from other people, programs, services, or mechanical devices is required to assist the individual in performing appropriate major life activities.

**Cognitive/Intellectual Disability**

"Cognitive disability," as defined in A.R.S. § 36-551, means a condition that involves subaverage general intellectual functioning, that exists concurrently with deficits in adaptive behavior manifested before age of eighteen, and that is sometimes referred to as "intellectual disability."

"Subaverage general intellectual functioning," as defined in A.R.S. § 36-551, means measured intelligence on standardized psychometric instruments of two or more standard deviations below the mean for the tests used.

"Adaptive behavior," as defined in A.R.S. § 36-551, means the effectiveness or degree to which the individual meets the standards of personal independence and social responsibility expected of the individual’s age and cultural group.

A. **Cognitive/Intellectual Disability** is a neurodevelopmental disorder with onset during the developmental period. The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions. Acceptable documentation of cognitive/intellectual disability is a psychological or psychoeducational report prepared by a licensed psychologist, a certified school psychologist, or a psychometrist working under the supervision of a licensed psychologist or certified school psychologist. The psychologist must administer or supervise the administration of a reasonable battery of tests, scales, or other measuring instruments (instruments). The administered instruments must be valid and appropriate for the individual being tested, which includes considerations of physical impairments as well as being culturally and linguistically appropriate and psychometrically sound. The instruments used should be editions current for the date of testing. Critical components for tests administered include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy.

B. **Documentation** must show the following were considered during the psychological evaluation:

1. Other mental disorders identified in current guidelines established by the American Psychiatric Association, including schizophrenia, bipolar disorder, attention deficit hyperactivity disorder, and substance abuse;

2. Significant disorders related to language or language differences;

3. Physical factors, including sensory impairments, motor impairments, acute illness, chronic illness, and chronic pain;

4. Testing performed during an acute inpatient hospitalization;

5. Educational or environmental deprivation; and

6. Psychosocial factors.

**200-G Diagnostic and Functional Criteria for Individuals Age Six and Above**
“Measured intelligence” means individually administered tests of intelligence measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with cognitive/intelectual disability have scores of two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65–75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance. Examples of tests of intelligence typically accepted include, but are not limited to, the Wechsler Intelligence Scales (Wechsler Preschool and Primary Test of Intelligence, Wechsler Intelligence Scale for Children or Wechsler Adult Intelligence Scale), the Stanford-Binet, and the Kaufman Assessment Battery for Children.

C. Examples of testing instruments from which IQ equivalent scores are sometimes obtained, but cannot be used as the sole source for determining cognitive/intelectual disability include, the Peabody Picture Vocabulary Test, Raven's Coloured or Standard Progressive Matrices, Matrices Analogies Test, Wechsler Abbreviated Scale of Intelligence, or assessments in which only portions of a Wechsler test are administered.

D. The presence of cognitive/intelectual disability must be properly documented in the diagnostic section of the psychological or medical report. To determine eligibility, a diagnosis of cognitive/intelectual disability must also be supported by medical or psychological documentation to support the diagnosis and related impairments in adaptive functioning. A report that contains only an IQ test score must not be used as the sole source of justification that there is a presence of cognitive/intelectual disability.

E. The purpose of psychoeducational evaluations is not diagnostic, but instead to identify educational accommodations and placement. If the available documentation is a psychoeducational evaluation, the educational classifications of a child with Mild Mental Retardation (MIMR) and a child with Moderate Mental Retardation (MMR) are not equivalent to a diagnosis of cognitive/intelectual disability for the purpose of eligibility with the Division. Psychoeducational evaluations from school psychologists that do not include a formal diagnostic statement regarding cognitive/intelectual disability may eventually contribute to the eligibility determination if the data in the educational record is consistent with the diagnosis of cognitive/intelectual disability per A.R.S. § 36-551.

F. A complete psychological or psychoeducational evaluation report includes a medical, social, and/or educational history, a summary of previous testing results, results of the evaluator's interview with and/or observations of the individual and results of the individual tests of the battery administered. Useful scales designed to quantify adaptive behavior include, the expanded form of the Vineland Adaptive Behavior Scales and the American Association on Intellectual and Developmental Disabilities Adaptive Behavior Scales. Test scores alone are not a sufficient measure of adaptive behavior since most instruments are informant-based, rather than dependent upon direct observation of the individual, therefore, the most desirable assessment of adaptive behavior includes both standardized informant-based measures and direct observation of the individual in the individual's natural settings of home, school, or employment.

G. The best indicators of an impairment of adaptive behavior are the results of an
appropriately administered, scored, and interpreted comprehensive measure (e.g.,
communication, academic/vocational, level of leisure activities).

H. Conditions such as acute or chronic mental illness, behavioral disturbances,
substance abuse, adjustment disorders, and sensory impairments have been shown
in clinical research to reduce the level of adaptive functioning. When these factors
or other potentially influencing factors are present for an individual, the impact of
the factor or factors on adaptive functioning should be fully discussed in the
psychological report.

Cerebral Palsy

"Cerebral palsy," as defined in A.R.S. § 36-551, means a permanently disabling condition
resulting from damage to the developing brain that may occur before, after, or during
birth and that results in loss or impairment of control over voluntary muscles.

A. Acceptable documentation must be by a licensed physician indicating the presence
of cerebral palsy.

B. If the medical records contain a diagnosis of spastic quadraparesis, hypotonia,
athetosis, and similar conditions but do not refer specifically to cerebral palsy,
there must be documentation to confirm the condition results from injury to the
developing brain.

C. Unacceptable documentation of cerebral palsy includes muscular dystrophies,
arthrogryposis, and muscular or skeletal conditions. Individuals who have acquired
impairment in control of voluntary muscles as a result of illnesses or traumatic
brain injury occurring after age six are not eligible in the absence of other
qualifying conditions.

Epilepsy

"Epilepsy," as defined in A.R.S. § 36-551, means a neurological condition characterized by
abnormal electrical-chemical discharge in the brain. This discharge is manifested in various
forms of physical activity called seizures.

A. Acceptable documentation must be by a licensed physician (e.g., neurologist,
orthopedist, or specialist in rehabilitation medicine) with expertise in diagnosing
neurological disorders.

B. When records of an evaluation by a neurologist are unavailable but there are
records available that include a diagnosis and clinical documentation of epilepsy or
seizure disorder by a licensed physician who does not specialize in neurology, the
Division Medical Director will review the available medical records to confirm a
diagnosis.

C. Individuals with a history of febrile seizures or febrile convulsions in the absence of
other qualifying diagnoses are not eligible for services from the Division.

Autism

"Autism" is defined in A.R.S. § 36-551 as a condition characterized by severe disorders in
communication and behavior resulting in limited ability to communicate, understand,
learn, and participate in social relationships.
A. Autism Spectrum Disorder is a neurodevelopmental disorder with onset during the developmental period.

B. A comprehensive evaluation shows the presence of diagnostic criteria and the appropriate number of symptoms of Autism Spectrum Disorder based on the current guidelines in the American Psychiatric Association’s Diagnostic and Statistical Manual.

C. Acceptable documentation of autism must be from one of the following
   1. Psychiatrist,
   2. Licensed psychologist,
   3. Neurologist,
   4. Developmental pediatrician who has expertise in diagnosing autism, or
   5. Pediatrician who has completed specialized training approved by the Division in the diagnosis of Autism Spectrum Disorder.

D. A comprehensive evaluation of autism identifies a diagnosis of Autistic Disorder (American Psychiatric Association’s Diagnostic & Statistical Manual [DSM] IV Code 299.00/International Classification of Diseases-9 [ICD-9] Code 299.00 or Autism Spectrum Disorder [DSM 5 Code 299.00/ICD-10 Code F84.0]). In older records, autism may also be called Kanner’s Syndrome and/or early infantile autism.

E. Documentation must show the following were considered during the evaluation process:
   1. Other neurodevelopmental, mental, medical and physical conditions
   2. Significant disorders related to language or language differences
   3. Physical factors (e.g., sensory impairments, motor impairments, acute illness, chronic illness, and chronic pain)
   4. Educational and/or environmental deprivation
   5. Situational factors at the time of evaluation or psychological testing
   6. If psychological testing is performed, the test must be developmentally appropriate at the time of administration.

F. Medical and/or psychological records that refer to “autistic tendencies,” “autistic behavior,” or “autistic-like disorder” are insufficient to establish eligibility. A diagnosis of DSM-5 Social (Pragmatic) Communication Disorder does not qualify for services.

G. The diagnostic features and symptomology of Autistic Disorder or Autism Spectrum Disorder must have been evident during the developmental stages. The presence of symptoms in the developmental period can be documented in the present with a thorough developmental interview.
H. The purpose of psychoeducational evaluations is not diagnostic, but instead to identify educational accommodations and placement. When the available documentation is a psychoeducational evaluation, the educational classifications of a child with autism or Autism Spectrum Disorder are not equivalent to a diagnosis of autism for the purpose of eligibility with the Division.

**Substantial Functional Limitations**

In addition to a diagnosis of cognitive/intellectual disability, cerebral palsy, epilepsy, or autism before age 18, documentation must verify substantial functional limitations attributable to one of the qualifying diagnoses in at least three of the following major life activities:

A. **Self-care**

Self-care means the performance of personal activities that sustain the health and hygiene of the individual appropriate to the individual’s age and culture. This includes bathing, toileting, tooth brushing, dressing, and grooming.

A functional limitation regarding self-care is described in A.A.C. R6-6-303 as when an individual requires significant assistance with eating, hygiene, grooming or health care skills, or when the time required for an individual to complete these tasks is so excessive as to impede the ability to retain employment or to conduct other activities of daily living.

Acceptable documentation of substantial functional limitations for self-care may include recent:

1. Medical or behavioral records;
2. Individualized Education Program (IEP) that addresses limitations of self-care goals and objectives;
3. Relevant comments in a psychological or psychoeducational evaluation;
4. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool;
5. Relevant scores on the Vineland Adaptive Behavior Scales; or
6. Other structured standardized tests of adaptive functioning.

B. **Receptive and Expressive Language**

Receptive and expressive language means the process of understanding and participating in conversations in the individual's primary language, and expressing needs and ideas that can be understood by another individual who may not know the individual.

A functional limitation regarding receptive and expressive language, as described in A.A.C. R6-6-303, occurs when an individual is unable to communicate with others, or is unable to communicate effectively without the aid of a mechanical device, a third person, or a person with special skills.
Acceptable documentation of substantial functional limitations for receptive and expressive language may include recent:

1. Psychological, psychoeducational, or speech evaluation records;
2. Individualized Education Program (IEP) references of severe communication deficits;
3. Use of sign language, a communication board, or an electronic communication device; or
4. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool.

C. Learning

Learning means the ability to acquire, retain, and apply information and skills.

A functional limitation regarding learning, as described in A.A.C. R6-6-303, occurs when an individual’s cognitive factors, or other factors related to the acquisition and processing of new information (such as attention factors, acquisition strategies, storage and retrieval), are impaired to the extent that the individual is unable to participate in age appropriate learning activities without utilization of additional resources.

Acceptable documentation of limitations for learning includes verification of placement in a special education program.

D. Mobility

Mobility means the skill necessary to move safely and efficiently from one location to another within the individual’s home, neighborhood, and community.

A functional limitation regarding mobility, as described in A.A.C. R6-6-303, occurs when an individual’s fine or gross motor skills are impaired to the extent that the assistance of another individual or mechanical device is required for movement from place to place or when the effort required to move from place to place is so excessive as to impede ability to retain employment and conduct other activities of daily living.

Acceptable documentation of limitations for mobility may include:

1. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool; or
2. Medical or educational records indicating the need to regularly use a wheelchair, walker, crutches, or other assistive devices, or to be physically supported by another person when ambulating.

E. Self-direction

Self-direction means the ability to manage one's life, including:

1. Setting goals,
2. Making and implementing plans to achieve those goals,
3. Making decisions and understanding the consequences of those decisions,
4. Managing personal finances,
5. Recognizing the need for medical assistance,
6. Behaving in a way that does not cause injury to self or others, and
7. Recognizing and avoiding safety hazards.

A functional limitation regarding self-direction, as described in A.A.C. R6-6-303, occurs when an individual requires assistance in managing personal finances, protecting self-interest, or making independent decisions that may affect well-being. For children under the age of 18, the Division must compare the child’s abilities in this area with age and developmentally appropriate abilities based on the current guidelines of Centers for Disease Control and Prevention and American Academy of Pediatrics.

Acceptable documentation of limitations for self-direction may include:

1. Court records appointing a legal guardian or conservator,
2. Relevant comments in medical or behavioral records,
3. Relevant comments in psychoeducational or psychological evaluation,
4. Relevant objectives in the individualized Education Program (IEP), or
5. Relevant scores on the ALTCS assessment, Preadmission Screening (PAS) tool.

F. Capacity for Independent Living

Capacity for independent living means the performance of necessary daily activities in one's own residence and community, including:

1. Completing household chores;
2. Preparing simple meals;
3. Operating household equipment such as washing machines, vacuums, and microwaves;
4. Using public transportation; and
5. Shopping for food, clothing, and other essentials.

A functional limitation regarding the capacity for independent living, as described in A.A.C. R6-6-303, occurs when an individual needs supervision or assistance for the individual's safety or well-being on at least a daily basis in the performance of health maintenance and housekeeping. For children under the age of 18, the Division must compare the child's abilities in this area with age and developmentally appropriate abilities based on the current guidelines of Centers for Disease Control and Prevention and American Academy of Pediatrics.
Disease Control and Prevention and American Academy of Pediatrics, including:

1. Age of the child,
2. Culture,
3. Language,
4. Length of time to complete task,
5. Level and type of supervision or assistance needed,
6. Quality of task performance,
7. Effort expended to complete the task performance,
8. Consistency and frequency of task performance, and
9. Impact of other health conditions.

Documentation of limitations for the capacity for independent living may include:

1. Relevant comments in a psychoeducational or psychological evaluation,
2. Related objectives on the Individualized Education Program (IEP), or
3. Relevant comments in medical records.

G. Economic Self-Sufficiency

Economy self-sufficiency means the ability to independently locate, perform, and maintain a job that provides income above the federal poverty level.

A functional limitation regarding economic self-sufficiency as described in A.A.C. R6-6-303 occurs when an individual is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that earned annual income, after extraordinary expenses occasioned by the disability, is below the poverty level. For children under the age of 18, the Division must compare the child’s abilities in this area with age and developmentally appropriate abilities based on the current guidelines of Centers for Disease Control and Prevention and American Academy of Pediatrics.

Acceptable documentation of limitations for economic self-sufficiency may include:

1. The receipt of Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits, or
2. Eligibility for Vocational Rehabilitation Services.

RECORDS REQUIRED FOR INDIVIDUALS “AT RISK”

Eligibility for services from the Division prior to the age of six is due to being determined as “at-risk” of developmental disability does not guarantee a member will continue to be eligible for services from the Division after turning six years old. The criteria for an individual age six years and above must be met. If the Division has documentation of an
eligible diagnosis and required functional limitations that meet all requirements for eligibility, no new documentation is required. If an eligible diagnosis is not clear in the individual’s records, additional records will be required to establish eligibility.
200-H CRITERIA FOR CHILDREN BIRTH TO AGE 6

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.C. R6-6-301(F)

A child under the age of 6 years may be eligible for services if there is a strongly demonstrated potential that the child is or will have a developmental disability as determined by the appropriate tests. Developmental Disability is defined in this Policy Manual.

In the absence of other qualifying circumstances, children with the following conditions are not eligible for services:

A. Congenital Heart Defect;
B. Muscular Dystrophy;
C. Orthopedic Disorders;
D. Speech Delay Involving Only Intelligibility;
E. Significant Auditory Impairment; or,
F. Significant Visual Impairment.

In accordance with A.A.C. R6-6-301(F), to be eligible for Division services, a child birth to age 6 shall meet at least one of the following criteria:

A. Have a diagnosis of cerebral palsy, epilepsy, autism, or cognitive/intellectual disability;
B. There is a strong demonstrated potential that a child is or will have a developmental disability (i.e. the parent or primary caregiver has a developmental disability and there is likelihood that without early intervention services the child will have a developmental disability.) Children diagnosed with the following conditions may be at risk of a developmental disability:

1. Spina bifida with Arnold Chiari malformation;
2. Periventricular leukomalacia;
3. Chromosomal abnormalities with high risk for cognitive/intellectual disability such as Downs Syndrome;
4. Autism Spectrum Disorders;
5. Post natal traumatic brain injury such as “shaken baby syndrome” or near drowning;
6. Hydrocephaly;
7. Microcephaly;
8. Alcohol or drug related birth defects such as Fetal Alcohol Syndrome; and,

C. Have demonstrated a significant developmental delay based on performance on a norm-referenced or criterion-referenced developmental assessment that is culturally appropriate. This developmental assessment must also be a professionally accepted tool which indicates that the child has 50% delay in one of the following five developmental domains, or that the child has 25% delay in two or more of the following five domains:

1. Physical (fine and/gross motor, vision or hearing);
2. Cognitive;
3. Communication;
4. Social Emotional;
5. Self Help.

Developmental delay will be determined by a physician or person formally trained in early childhood development who evaluates the child through the use of culturally appropriate and recognized developmental tools and his/her informed clinical opinion.

Example: Child is 24 months old at testing

Test Results:

1. Cognitive - 18 months
2. Gross Motor - 23 months
3. Fine Motor - 23 months
4. Social/Emotional - 22 months
5. Adaptive/Self Help - 22 months
6. Communication - 18 months

In this example, the child has 25% delay in both cognitive and communication skills and is at risk of a developmental disability.
Examples of acceptable developmental evaluation tools include, but are not limited to, the Bayley Scales of Infant Development, the Battle, and the Hawaii Early Learning Profile (H.E.L.P.).

Acceptable documentation of the potential that a child birth to age 6 is or will have a developmental disability includes, medical records indicating an at-risk condition, results of an acceptable developmental assessment, or a signed statement from a licensed physician, licensed psychologist, or other professional trained in early childhood development specifying his/her clinical opinion as to the child's disability or delay.
ADULT APPLICANTS WITH LIMITED DOCUMENTATION

EFFECTIVE DATE: 5/29/2019
REFERENCES: A.R.S. § 36-551

When documents are not available indicating the person, who would receive the services had a qualifying diagnosis prior to age 18, the following documentation can be provided in lieu of the documentation requirements described in the Diagnostic and Functional Criteria (Section 200-G).

A. Establishing a Qualifying Diagnosis

Documentation of a diagnosis or condition that is likely to result in a qualifying diagnosis may be accepted.

1. For Cognitive/Intellectual Disability, documentation of the following is accepted:
   a. Agenesis of the Corpus Callosum
   b. Cri Du Chat Syndrome
   c. Chromosome 8p deletion
   d. Congenital Cytomegalovirus (CMV)
   e. Dandy Walker Syndrome
   f. DNA Methyltransferase 3 Alpha (DNMT3A)
   g. Fetal Alcohol Syndrome / Fetal Alcohol Spectrum Disorders
   h. Kabuki Syndrome
   i. Lowe Syndrome (Oculo-Cerebro-Renal Disease)
   j. Mowat-Wilson Syndrome
   k. Periventricular Leukomalacia
   l. Post-natal Traumatic Brain Injury (e.g.: near drowning, stroke)
   m. Smith Lemli Opitz
   n. Trisomy 8 (Warkany syndrome)
   o. Trisomy 13 or 18 (Edwards Syndrome)
   p. Trisomy 21 (Down Syndrome)
   q. Williams Syndrome
2. For Epilepsy, documentation of the following is accepted:
   a. Agenesis of the Corpus Callosum
   b. Cri Du Chat Syndrome
   c. Congenital Cytomegalovirus (CMV)
   d. Dandy Walker Syndrome
   e. Kabuki Syndrome
   f. Lowe Syndrome (Oculo-Cerebro-Renal Disease)
   g. Maple Syrup Urine
   h. Phenylketonuria (PKU)

3. Cerebral Palsy, documentation of the following is accepted:
   a. Mowat-Wilson Syndrome
   b. Agenesis of the Corpus Callosum

4. Autism Spectrum Disorder, documentation of the following is accepted:
   a. Smith Lemli Opitz

B. Establishing Substantial Functional Limitations

An applicant may have difficulty showing substantial functional limitations if they are not enrolled in an educational program, work program or day program. In this case, an Inventory for Client and Agency Planning (ICAP) can be completed to show substantial functional limitations.
300       REFERRAL PROCEDURES

REVISION DATE: 4/17/1996
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.C. R6-6-402(A).

A. Referrals for Division services may be accepted from a variety of sources, including the applicant, the applicant's family, public schools, hospitals, or other state agencies such as the Arizona Long Term Care System (ALTCS), Department of Child Safety (DCS), Adult Protective Services (APS), and Disability Determination Services Administration (DDSA). Referrals may occur by phone, mail, or in person. The person receiving the referral should document the contact on the Intake Record form and ensure an intake worker is assigned according to local office procedures.

B. If the referral is from other than the applicant/responsible person, the intake worker shall, within 5 working days, contact the applicant/responsible person, explain the Division's services and eligibility criteria, and determine if the responsible person wishes to apply for services. If the responsible person cannot be contacted by phone, a letter shall be sent asking the responsible person to contact the intake worker within 10 days of the date of the letter if application is desired. If the responsible person wishes to apply for services, the intake worker will schedule an intake interview, which should occur within 10 working days of the date of initial contact with the responsible person. If the responsible person does not wish to apply, cannot be located, or does not respond, the intake worker will document the result and close the case.

C. All referrals for children in foster care will be completed through the district the Department of Child Safety (DCS) staff is located.

Intake Interview

The assigned intake worker will conduct the intake interview at the time and in the location mutually agreed upon during the initial contact with the responsible person. The intake process should include a face-to-face contact with the person for whom application is made.

For children birth through three years of age, the intake worker is encouraged to coordinate with the Arizona Early Intervention Program (AzEIP) initial planning process contractor to jointly visit with the family when possible.

The intake worker will complete the following during the intake interview:

A. Application for Eligibility Determination form;

B. For persons age 6 and older, Intake Application – 3 Years and Older form;

C. For persons age 6 and above, the Inventory for Client and Agency Planning (ICAP). Hard copies of this tool may be obtained in District offices;

D. Authorization for Release of Information form in sufficient quantity to send to each school, social services agency, psychologist, physician, and hospital who has served the applicant, and who may have records needed to determine eligibility and/or plan
appropriate services for the applicant. In particular, the intake worker will ensure that the Division requests copies of medical records such as hospital discharge summaries, specialist’s consultation reports, and results of any significant medical tests; and,

E. Explain and provide a copy of, *Statement of Rights*, and obtain the signature of the responsible person on Form, *Acknowledgment of Publications/Information, Pre-PAS Screening Tool form*, and the *Application for the Arizona Health Care Cost Containment System (AHCCCS) Medical Benefits Part I*, are required for some members following determination of Division Eligibility (see Section 506). The intake worker may wish to complete these at the time of the intake interview.

The intake worker must request copies of the following documents during the intake interview:

A. Court documents relating to guardianship, if appropriate;

B. Birth certificate; and,

C. Psychological evaluations, school records, medical records, or social service agency records applicable to determination of eligibility and/or identification of needs which may be in the possession of the individual/responsible person.

Prior to obtaining the responsible person’s signature on the appropriate application and the *Authorization to Release Information* form, the intake worker will explain:

A. Division eligibility criteria;

B. Confidentiality rights;

C. Requirement to cooperate with ALTCS screening and application process;

D. Third party liability requirements;

E. Grievance and appeal rights;

F. Services available from the Division; and,

G. Services available from other agencies that might assist the applicant.

The intake worker will provide the applicant/responsible person with the following documents:

A. Mission and Value Statement;

B. Eligibility; and,

C. The DDD information booklet, *Working with you.*
Proof of Age

An applicant shall provide proof of age of the person to receive services by providing two of the following:

A. Citizenship documents;
B. Federal or state census records;
C. Hospital records of birth;
D. Copy of birth certificate;
E. School registration, if appropriate;
F. Military records;
G. Notification of birth registration;
H. Religious records showing age of or date of birth;
I. Dated school records showing age or school records showing date of birth;
J. Affidavit signed by the licensed physician, licensed midwife, or other health care professional who was in attendance at the time of the birth, attesting to the date of birth;
K. U.S. passport; and, or
L. If an applicant has made all reasonable efforts to obtain documented verification as described above and has been unsuccessful, the application signed by the applicant shall be sufficient to verify age of the person to receive services.
400 ELIGIBILITY DETERMINATION PROCESS

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.A.C. R6-6-303.

Determinations or re-determinations of eligibility are subject to review at any time by the Division Assistant Director or designee.

Following the intake interview, the intake worker will immediately mail the signed Authorization for Release of Information form to the applicable agencies and professionals in order to obtain needed medical, psychological, school, and social service records.

A. The Eligibility Clock

Eligibility for all applicants shall be determined within 60 days of the application date. If records required to complete the eligibility determination have not been received within 30 days of the application date, the applicant/responsible person shall be notified by letter that records shall be received within 30 days or the application may be denied, unless the child is eligible for the Arizona Long Term Care System (ALTCS) or is age birth to three years.

There are two circumstances in which the eligibility clock is shorter, please refer to “B” and “C” below.

B. The Eligibility Clock for Arizona Early Intervention Program (AzEIP) (children, birth to three years).

Eligibility for children birth through three years of age who are referred by or for AzEIP must be determined within 30 days and an initial Individualized Family Services Plan (IFSP) meeting held within 45 days of referral to AzEIP.

C. The Eligibility Clock for Initial Referrals Directly from Arizona Health Care Cost Containment System (AHCCCS)

Eligibility for initial referrals must be determined within 30 days of receipt of the initial referral when the referral source is ALTCS. If records required to complete the eligibility determination have not been received within 15 days of the referral date, the applicant/responsible person will be notified by letter that the records must be received within 15 days of the letter or the application will be denied.

The Division works with AzEIP who is responsible for the eligibility process.

Upon receipt of records, the intake worker will forward the entire intake file to the staff designated to make the eligibility determinations or re-determinations for that district/area. Designated staff will summarize the reasons for determination of eligibility or ineligibility with particular attention to describing functional limitations, when applicable.

Prior to determination or re-determination, the following types of situations shall be referred to the office of the Division Assistant Director/designee for specialized review and recommendation:
A. Traumatic brain injury occurring prior to age 18, in the absence of an appropriate rehabilitation history;

B. Pervasive developmental disorder, not otherwise specified or pervasive developmental disorder;

C. Asperger's Disorder, if there is question as to whether the person has a developmental disability as defined by Arizona statute;

D. Persons with an IQ in the cognitive/intellectual disability range who have an Axis I mental health diagnosis, if the diagnosis of a developmental disability as defined by Arizona statute is questionable;

E. Persons with a full scale IQ in the cognitive/intellectual disability range, if there is a difference of one or more standard deviations between the performance IQ and the verbal IQ and the diagnosis of a developmental disability as defined by Arizona statute is questionable;

F. Cerebral palsy diagnosed after the age of 6;

G. Rare degenerative conditions, if the diagnosis of a developmental disability as defined by Arizona statute is questionable; and,

H. Children under the age of 6 who have a significant medical disorder that impedes age appropriate functioning but the likelihood of developing one or the four developmental disabilities is unclear.

For these situations, the Division Assistant Director/designee shall ensure that all available records have been obtained and that the entire intake file is reviewed by the appropriate professional(s). The Division Assistant Director/designee shall maintain records regarding the disposition of each referral and identify trends in cases that are referred, coordinating the incorporation of this information into the Division ongoing eligibility training. The date of eligibility shall be the date the person making the eligibility determination signs and approves the application form.

Upon eligibility determination, the intake worker or assigned district staff will update focus and send notice of the decision to the applicant/responsible person. Written notice of ineligibility and intent to deny an application shall be issued by certified mail return receipt requested and shall include notice of appeal rights.
500 ASSIGNMENT OF SUPPORT COORDINATORS

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996

Each person eligible for the Division is assigned a Support Coordinator. As part of the intake process, individuals/responsible persons will be informed of the option of choosing a Support Coordinator if a choice is available. Members who are currently eligible for services through the Division will be informed of the option of choosing a Support Coordinator as part of the Individual Support Plan/Individualized Family Services Plan. Children in foster care will be assigned a Support Coordinator in the District the assigned Department of Child Safety (DCS) staff is located.

If the chosen Support Coordinator has a full caseload or is otherwise not available, the Support Coordinator Supervisor will attempt to match the member/responsible person with another Support Coordinator who has the skills and abilities the member/responsible person desires. The member/responsible person may also choose to be placed on a pending list for their first choice of Support Coordinator. If the member/responsible person chooses placement on a pending list, another Support Coordinator will be assigned in the interim. Support Coordinator Supervisors will ensure the member/responsible person is placed with the Support Coordinator of choice whenever possible.

Each person eligible for the Division will have a designated back-up Support Coordinator. If a member/responsible person/contacts an office and the assigned Support Coordinator is not available, the person should be referred immediately to the back-up Support Coordinator for assistance.

In instances where a back-up Support Coordinator is not an option or is not available, the Support Coordination Supervisor will act as back-up. Whenever a change in Support Coordinator assignment is made, the member/responsible person must be notified of the change in writing and in advance of the change, whenever possible.
600       RE-DETERMINATION OF ELIGIBILITY

REVISION DATE:  4/17/2015
EFFECTIVE DATE:  January 15, 1996
REFERENCES:  A.A.C. R6-6-301(E).

Re-evaluation of eligibility shall be made prior to age 6. The Support Coordinator will ensure the Division file contains all current assessment and evaluation records and will forward the file to the Division Staff designated to complete eligibility determinations/re-determinations for the district/area. That staff will review these records to ensure the child continues to meet the eligibility requirements as outlined in this Policy Manual. A new application form is not required at age 6. The results of the re-evaluation will be documented in the Support Coordinator's progress notes and entered into Focus. If the re-evaluation indicates that the child is no longer eligible, a Notice of Intended Action as referenced in the Division Operations Manual shall be sent by certified mail, return receipt requested, to the responsible person.

Re-determination of eligibility shall also be made at age 18. The member/responsible person must sign an application form requesting continuation of services. The re-determination process shall follow the criteria and procedures outlined in this Policy Manual.

A re-evaluation or re-determination may also be required at any time. For a child under the age of 6, as new information such as therapy, developmental, or psychological evaluations or updated medical records indicate that a strongly demonstrated potential that the child is or will become developmentally disabled no longer exists, a re-evaluation of eligibility will be conducted.

Even though a person may at one time fully meet the Division's eligibility criteria, effective services may later reduce functional limitations to the extent they are no longer substantial. When in the opinion of the Division Assistant Director or designee, after a review pursuant to A.A.C. R6-6-301(E), it is necessary for a person to receive continued services to maintain skills or prevent regression; the person will remain eligible for services.
700 DETERMINATION OF ARIZONA LONG TERM CARE SYSTEM ELIGIBILITY

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996
REFERENCES: A.R.S. § 36-559(C); AHCCCS Eligibility Manual.

Following determination of eligibility for services from the Division, newly eligible members shall be screened for referral to the Arizona Long Term Care System (ALTCS) unless the referral source was ALTCS. Persons who are identified from the screening as potentially eligible for ALTCS shall not receive state funded Division services, except as outlined in this Policy Manual, until the Arizona Health Care Cost Containment System (AHCCCS) determines the person is eligible or ineligible for ALTCS services.

Persons who meet the criteria for both the Resource Screening and the Functional Screening shall be referred to ALTCS.

Resource Screening for Arizona Long Term Care System

The criteria for the financial screening are cash resources less than $2,000 and at least one of the following:

A. Receipt of Supplemental Security Income (SSI); or,

B. Eligible for Temporary Assistance to Needy Families (TANF), 6th Omnibus Budget Reconciliation Act (SOBRA), or other Medical Assistance (MA) categories; or,

C. Monthly income not to exceed 300% of the maximum Supplemental Security Income (SSI) benefit.

A child’s income and resources will be considered in the eligibility determination. The income and resources of parents may be waived if the child would have been eligible to receive an ALTCS covered service within 30 days prior to the date of application for ALTCS.

The specific financial criteria used by ALTCS are extremely complicated. Whenever there is doubt about whether a person might meet ALTCS financial criteria, the member should be referred to ALTCS. Additional information regarding ALTCS eligibility is available in the ALTCS Eligibility Manual.

Functional Screening for Arizona Long Term Care System

The age appropriate Preadmission Screening (PAS) evaluation must be completed for all applicants, unless the referral source was ALTCS. The Support Coordinator should explain to the members/responsible person that the Division may not be able to provide services, other than Support Coordination, to non-ALTCS eligible members, consequently, the members/responsible person may choose to apply for ALTCS, even though the Division is not making a referral.
Pre-Admission Screening

The PAS is both a tool and a process used by AHCCCS to determine medical/functional eligibility for the ALTCS program.

The PAS tool compiles demographic, functional, and medical information for each ALTCS applicant. The PAS instrument measures the level of functional and medical disability and determines when the member is at risk of institutional placement. The PAS is administered by AHCCCS by a registered nurse and/or a social worker. Generally, responsibility for the completion of the PAS for persons served by the Division is as follows:

A. ALTCS nurse and/or social worker perform the PAS for members who are medically involved, including all persons who are dependent upon a ventilator, regardless of placement.

B. Nurses or social workers, as single PAS Assessors, may perform the PAS for members who reside in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), group home, developmental home or any Home and Community Based Services (HCBS) setting, who are not medically fragile or dependent upon a ventilator.

The PAS Assessors have an ALTCS physician consultant available for physician review should there be a question of medical eligibility. ALTCS completes their eligibility process within a 45 day period for most applicants.

AHCCCS re-administers the PAS in rare situations. If the member is determined not ALTCS eligible, AHCCCS sends a file to the Division which is then distributed to the appropriate District for printing.

The Planning Team must use the PAS, along with the ICAP, and other assessment information, to develop the Planning Document and substantiate the need for the services to be provided.

Arizona Long Term Care System Referral Procedures

Members who meet both the financial and functional screening criteria will be referred to ALTCS by completion of the, AHCCCS Medical Benefits Part I form. The Support Coordinator shall assist the member/responsible person to complete this form and to take or mail it to the local ALTCS Eligibility Office.

The Support Coordinator will ensure the member/responsible person understands that the ALTCS eligibility process requires two steps:

A. Completion of the Part II Application via interview with an ALTCS Eligibility Worker and completion of the PAS evaluation, via an interview with an ALTCS nurse and/or social worker.

B. ALTCS may also refer a member who is age 18 or over and not receiving Supplemental Security Income or Social Security Administration benefits to Disability Determination Services to establish disability.
The Support Coordinator may serve as an Authorized Representative for ALTCS only for those members who are not able to complete the application process independently and who do not have a family member or guardian readily available to serve as the Authorized Representative.

**Arizona Health Care Cost Containment System Roster**

The Support Coordinator must check, review and initiate the task assigned in focus on a daily basis to determine when there are members newly eligible for ALTCS. If so, the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Document) must be reviewed/developed in accordance with the timelines and procedures specified in this Policy Manual.

**Appeal of Arizona Long Term Care System Eligibility Decisions**

The Support Coordinator may, upon request of the member or the responsible person, assist the member in completing forms and taking other procedural steps to appeal a denial of ALTCS eligibility.
Arizona Early Intervention Program (AzEIP) defines as eligible a child between birth and 36 months of age who is developmentally delayed, or who has an established condition that has a high probability of resulting in a developmental delay.

A developmental delay is met when the child has not reached 50% of the developmental milestones expected at his/her chronological age in one or more of the following domains:

A. Physical (fine and/or gross motor, vision or hearing);
B. Cognitive;
C. Communication;
D. Social Emotional; or
E. Self-Direction.

Developmental delay shall be determined by a person meeting the AzEIP personnel standards, such as a physician or person formally trained in early childhood development who evaluates the child through the use of culturally appropriate and recognized developmental tools. Eligibility shall be based on informed clinical opinion and parental input.

When a child is eligible for more than one AzEIP participating agency (e.g., Arizona State School for the Deaf and Blind, Division of Developmental Disabilities) the Individualized Family Services Planning team makes the decision, based on the needs of the family and child which agency will perform the Support Coordinator function.

In order for a child who is AzEIP eligible to receive services through the Division, the child must also meet the Division eligibility criteria outlined in this Policy Manual.
900 ELIGIBILITY CATEGORIES

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996

There are three types of eligibility: State funded (Division of Developmental Disabilities (DDD)), Targeted Support Coordination (TSC), and Arizona Long Term Care System (ALTCS). Each type has a different mandatory minimum review cycle. Any member receiving services funded by the Division is required to follow the minimum requirements of service review and contact established by this Policy Manual.

A. Members who are DDD receive Support Coordination and direct services based on assessed need and availability of state funds. Members in this category have the right to choose the type of contact, as applicable. These members are not eligible for TSC or ALTCS.

DDD Members have the right to choose the type of contact for required meetings. The types of contact include:

1. In person;
2. By phone; and,
3. By email/mail.

Members who are in this category can select to be placed in Inactive Status after one year of eligibility. Members who select Inactive Status will be contacted by phone annually. For further information, contact the Support Coordinator.

B. Members who are TSC are eligible for Title XIX acute care services including, Early Periodic Screening Diagnosis and Treatment (EPSDT). Members in this category receive Support Coordination and direct services based on assessed need and availability of state funds. Members who are TSC are not eligible for ALTCS.

Members who are TSC or their guardians have the right to choose the type and frequency of contact, as applicable. The member/responsible person may choose to change the type and frequency at any time.

Members who are in this category have the right to choose:

1. The type of contact:
   a. In person;
   b. By phone; and,
   c. By mail.
2. The frequency of contact:
   a. 90 days;
   b. 180 days; and,
   c. Annually.

C. ALTCS

Members who are ALTCS eligible receive Support Coordination, direct services based on assessed need including medical necessity and cost effectiveness, and acute services including, EPSDT. Members eligible for ALTCS have a choice of a Division contracted health plan. Members in this category receiving services funded by the Division are required to follow the minimum requirements of service review and contact established by this Policy Manual.
1000 RESPONSIBILITIES OF THE MEMBER/RESPONSIBLE PERSON WHEN ELIGIBLE FOR THE DIVISION

REVISION DATE: 7/3/2015
EFFECTIVE DATE: July 31, 1993

Responsibilities of the member/responsible person include but are not limited to:

A. Applying/re-applying for Arizona Long Term Care System (ALTCS);

B. Being available to meet for the required Individual Service Plan/Individualized Family Service Plan (ISP/IFSP) Planning Meeting and reviews;

C. Providing documentation for eligibility redetermination;

D. Reporting issues with providers of service including potential/suspected fraud and abuse;

E. Reporting changes of address;

F. Reporting major changes in member/family circumstances which may affect the provision of services;

G. Signing appropriate consents;

H. Providing appropriate receipts for Assistance to Families or Community Supported Living expenditures;

I. Providing appropriate documentation to obtain requested assistance from the Division;

J. Providing other documentation as requested by the Division (e.g., any changes in insurance policies with the effective date, third party liability information, burial insurance policies); and,

K. Complying with residential billing and cost of care requirements.
1001 INVENTORY FOR CLIENT AND AGENCY PLANNING

REVISION DATE: 4/17/2015
EFFECTIVE DATE: January 15, 1996

The Division requires that the Inventory For Client And Agency Planning (ICAP) be completed by the Support Coordinator during intake and at redeterminations for members age 6 and over. The Support Coordinator may not delegate responsibility for completion of this evaluation to a provider or to the family. The ICAP is protected by copyright; photocopies of the response booklet may not be used in the administration of the evaluation.

The ICAP is a standardized assessment tool which provides information regarding the member's medical condition and diagnoses, motor skills, social and communication skills, personal living skills, community living skills, social and leisure activities, and problem behaviors, if any.

The information contained in the ICAP is to be used, in conjunction with the Pre-Admission Screening tool and other assessment information, to develop functional statements of need in the Planning Document and to establish the necessity of the services to be provided.

The ICAP provides scores which can be used to determine the level of supervision a member needs.

The Support Coordinator will ensure that the ICAP score for each member is entered in Focus.
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 100</td>
<td>Definition and Applicability</td>
</tr>
<tr>
<td>Chapter 200</td>
<td>Prohibitions</td>
</tr>
<tr>
<td>Chapter 300</td>
<td>Violations</td>
</tr>
<tr>
<td>Chapter 400</td>
<td>Program Review Committee</td>
</tr>
<tr>
<td>Chapter 500</td>
<td>Individual Support Plan Team</td>
</tr>
<tr>
<td>Chapter 600</td>
<td>Restitution</td>
</tr>
<tr>
<td>Chapter 700</td>
<td>Behavior Modifying Medications, Monitoring Behavior</td>
</tr>
<tr>
<td></td>
<td>Behavior Modifying Medications and Treatment Plans</td>
</tr>
<tr>
<td>Chapter 800</td>
<td>Reserved</td>
</tr>
<tr>
<td>Chapter 900</td>
<td>Emergency Measures and Physical Management Techniques</td>
</tr>
<tr>
<td></td>
<td>Physical Management Techniques</td>
</tr>
</tbody>
</table>
100 DEFINITION AND APPLICABILITY

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.R.S. § 36-551; A.A.C. R6-6-901.

Arizona Administrative Code R6-6-901, is titled Managing Inappropriate Behavior. Commonly referred to as Article 9, it governs the Division of Developmental Disabilities’ (DDD) administration of a comprehensive statewide system for behavioral interventions, and establishes the structure for developing, approving, implementing and monitoring these plans.

All programs operated, licensed, certified, supervised or financially supported by the Division must comply with these policies and procedures. If a need to reduce inappropriate behaviors is identified, the Planning Team must determine whether a behavior treatment plan is needed. Behavior treatment plans, which include any of the interventions outlined in this Policy Manual, must be approved by the Program Review Committee (PRC) and reviewed by the Human Rights Committee (HRC).
200 PROHIBITIONS

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.R.S. §§ 36-551(A), 36-561, 36-561(B), 36-569(A); A.A.C. R6-6-9, R6-6-902, R6-6-903(A).

State statute prohibits abusive treatment or neglect of any individual with a developmental disability.

Abuse

Prohibited abusive treatment, as it relates to managing inappropriate behavior, includes programmatic abuse, which uses an aversive stimulus technique that has not been approved as part of a member's Individual Service Plan (ISP), and which is not contained in the rules and regulations. This includes individual isolation.

Neglect

Neglect of an individual with a disability is prohibited. Neglectful treatment means any intentional failure to carry out a behavior treatment plan developed for an individual by the Planning Team.

Behavioral Intervention Techniques

Identified below are those techniques which are prohibited under the provisions of Article 9:

A. Use of locked time-out rooms.

B. Use of over-correction. This means a group of procedures designed to reduce inappropriate behavior, consisting of:
   1. Requiring an individual to restore the environment to a state vastly improved from that which existed prior to the inappropriate behavior; or,
   2. Requiring an individual to repeatedly practice a behavior.

C. Application of noxious stimuli such as ammonia sprays, or Tabasco sauce to the tongue;

D. Physical restraints, including mechanical restraints, when used as a negative consequence to a behavior; and,

E. Any other technique determined by the Program Review Committee (PRC) to cause pain, severe discomfort, or severe emotional distress to the individual.

F. Techniques addressed in A.R.S. § 36-561(A):
   1. Psychosurgery;
   2. Insulin shock;
3. Electroshock; and,

4. Experimental drugs.

**Behavior Modifying Medications**

Except as indicated and specified in statute and rule, behavior modifying medications are prohibited if any one of the following criteria are met:

A. They are administered on an as-needed or PRN basis;

B. The Planning Team determines that the dosage interferes with the individual's daily living activities; and,

C. They are used in the absence of a behavior treatment plan.

See additional chapters in this Policy Manual for broader information regarding Behavior Modifying Medications.

**Behavior Treatment Plan Implementation**

No one shall implement a behavior treatment plan that:

A. Is not included as part of the ISP; and,

B. Contains aversive behavior intervention techniques which do not have approval of the (PRC) and review by Human Rights Committee (HRC).
300 VIOLATIONS

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.R.S. §§ 36-561, 36-569.

Any person violating the statutory provisions regarding the health and safety of persons with developmental disabilities is guilty of a class 2 misdemeanor.
400 PROGRAM REVIEW COMMITTEE

REVISION DATE: 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.A.C. R6-6-903, R6-6-903(E), R6-6-1701, et seq.; 42 CFR 483.440(f) (3).

The Program Review Committee (PRC) is an assembly designated by the District Program Manager (DPM) that reviews any behavior treatment plan that meets the criteria set forth in this Policy Manual. The Program Review Committee (PRC) approves plans, or makes recommendations for changes as necessary.

Composition

DPM is responsible for designating persons to serve on PRC. At a minimum, the team should include:

A. The DPM or designee as the chairperson;
B. A person directly providing habilitation services;
C. A person determined by the Division as qualified in the use of behavior management techniques, such as a psychologist or psychiatrist;
D. The parent/guardian of a person with a developmental disability, but not the parent of the person whose program is being reviewed;
E. Persons with no ownership/controlling interest in a facility, and no involvement in service provision to persons with developmental disabilities; and,
F. A person with a developmental disability when appropriate.

Responsibilities

PRC must review and respond in writing within 10 working days of the receipt of a behavior treatment plan. The written response must be signed and dated by each member in attendance, forwarded to the Planning Team and a copy sent to the chairperson of the Human Rights Committee (HRC). The written response shall include:

A. A statement of agreement that the interventions approved are the least intrusive, and that they are the least restrictive alternative,
B. Any special considerations/concerns, including specific monitoring instructions, and,
C. Any recommendations for change, with explanations.

PRC shall issue written reports to the DDD Assistant Director, summarizing its activities, findings/recommendations while maintaining the individual's confidentiality. Reports are required:

1. Monthly to the designated Division staff, with a copy to the chairperson of the HRC; and,
2. Annually, by December 31 of each calendar year, to the DDD Assistant Director or designee, with a copy sent to the Developmental Disabilities Advisory Council.
500  INDIVIDUAL SUPPORT PLAN TEAM RESPONSIBILITIES

REVISION DATE: 3/2/2015
EFFEECTIVE DATE: July 31, 1993

Responsibilities

The Individual Service Planning Team (Planning Team) must submit to the Program Review Committee (PRC) and Human Rights Committee (HRC) any behavior treatment plan that includes:

A. Techniques that require the use of force;
B. Programs involving the use of response cost. This means a procedure often associated with token economies, designed to decrease inappropriate behaviors, in which reinforcers are taken away as a consequence of inappropriate behavior;
C. Programs that might infringe upon the rights of the individual;
D. The use of behavior modifying medications; and,
E. Protective devices used to prevent an individual from self-injurious behavior.

Upon receipt of the PRC’s response, and as part of the plan development process, the Planning Team must either:

A. Implement the approved behavior treatment plan;
B. Accept the PRC recommendation, and incorporate the revised behavior treatment plan into the Individual Service Plan (ISP); or,
C. Reject the PRC recommendation and develop a new behavior treatment plan.

All revised behavior treatment plans must be re-submitted to the PRC and the HRC for review and approval. No implementation shall occur prior to approval.
600 RESTITUTION

REVISION DATE: 7/3/2019, 3/2/2015, 1/31/2014
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.R.S. § 36-551

Restitution

A. Means the act of paying or compensating for property loss or damage in order to learn alternative behaviors;
B. Does not include voluntary compensation by a parent or guardian; and
C. May not infringe on an individual’s rights protected by A.R.S. § 36-551.

Providers are required to have insurance to cover property loss or damage. If a member damages the property of another, the injured party may have a legal remedy in the small claims division of the Justice Courts.

The Division and its contracted providers cannot make restitution a condition for provision of services or supports. A Member’s Behaviors cannot prevent that member from receiving services through the Division.

Behaviors that result in property damage or loss should be addressed by the Planning Team.

A. Behavior Plans may include some level of restitution so long as all of the following are met:

1. The member’s behavior support plan includes the use of restitution, and has been approved by the planning team, including the member and/or family member/guardian and treating behavioral health professional if applicable;
2. The restitution furthers a goal identified and is individualized in a member’s behavior plan;
3. The member has an understanding of the restitution plan and purpose so that the member can accept their responsibility and learn;
4. The behavior plan was implemented as written;
5. The team establishes the restitution amount only after consideration of the member’s resources and determination that the member’s needs will not be adversely impacted by the payment amount, including that the amount will not adversely impact the member’s ability to pay for other items or activities that are necessary to further other plan goals;
6. An invoice and explanation of the cost for each restitution payment is reviewed and approved by the planning team before each restitution payment is made.
Behavior modifying medications are drugs prescribed, administered, and directed specifically toward the reduction and eventual elimination of specific behaviors. Herbal remedies will be included among medications due to their psychoactive and potentially behavior modifying properties.

Behavior modifying medications are only to be prescribed and used:

A. As part of the member's behavior treatment plan included in the Individual Service Plan (ISP); and,

When in the opinion of a licensed physician, they are deemed to be effective in producing an increase in appropriate behaviors or a decrease in inappropriate behaviors.

B. When it can be justified by the prescribing physician that the harmful effects of the behavior clearly outweigh the potential negative effects of the medication. Two examples of when the risks and benefits of the medications need to be reviewed with members with developmental disabilities, their families, and/or their guardians:

1. The older antipsychotic medications such as Thorazine (chlorpromazine), Mellaril (thioridazine), Haldol (haloperidol) and Navane (thiothixene) may cause such as tardive dyskinesia, a permanent muscular side effect. Tardive dyskinesia is characterized by slow rhythmic, automatic movements, either generalized or in single muscle groups.

2. The new antipsychotic medications such as Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quietapine), Abilify (aripiprazole) and Geodon (ziprasidone) are much less likely to cause tardive dyskinesia. However, these medications carry a high risk of significant weight gain. One study found 18 pounds average weight gain in three months. Such significant weight gain can result in the development of a metabolic syndrome, which is defined as three or more of the following:

   a. Increased waist circumference;
   b. Elevated triglycerides;
   c. Reduced HDL (good) cholesterol;
   d. Elevated blood pressure; and,
   e. Elevated fasting glucose.

   These factors lead to a much higher risk of heart disease and diabetes.
The use of behavior modifying medications requires the Division to make available the services of a consulting psychiatrist to review medical records and make recommendations to the prescribing physician, which ensures the prescribed medication is the most appropriate in type/dosage to meet the needs of the individual.

The Division must provide monitoring of all behavior treatment plans that include the use of behavior modifying medications to:

A. Ensure that data collected regarding an individual's response to the medication is evaluated at least quarterly at a medication review by the physician and a member of the ISP team, other than the direct care staff responsible for implementing the approved behavior treatment plan; and:

B. Ensure that each member receiving a behavior modifying medication is screened for side effects and tardive dyskinesia as needed, and that the results of such screening are:

1. Documented in the individual's central case record;
2. Provided immediately to the physician, individual/responsible person, and ISP team for appropriate action in the event of positive screening results for side effects/tardive dyskinesia; and,
3. Provided to the Program Review Committee (PRC) and Human Rights Committee (HRC), and the Division's Medical Director within 15 working days for review of the positive screening results.

The member/responsible person must give informed, written consent before behavior modifying medications can be administered. Non-scheduled or as-needed sleep preparations are not allowed, whether prescribed or over-the-counter. Aromatherapy does not require a behavior treatment plan, but must be done with the consent of the member or his/her legal guardian.

See the Division Operations Manual for more detailed information regarding informed consent and the related forms.

**Monitoring Behavior Modifying Medications/Treatment Plans**

For all behavior treatment plans that include the use of behavior modifying medications, the Division must:

A. Provide second level reviews by a consulting psychiatrist to provide recommendations to the prescribing physician, which ensure that the prescribed medication is the most appropriate in type and dosage to meet the member's needs;

B. Ensure that data collected regarding an individual's response to the medication is evaluated at least quarterly by the physician; and the member of the Individual
Service Planning Team (Planning Team) designated pursuant to A.A.C. R6-6-905, and other members of the Planning Team as needed; and,

C. Ensure that each individual receiving a behavior modifying medication is screened for side effects, and tardive dyskinesia as needed, and that the results of such screening are:

1. Documented in the member's case record;

2. Provided immediately to the physician, member, responsible person, and Planning Team for appropriate action in the event of positive screening results; and,

3. Provided to the Program Review Committee (PRC) and Human Rights Committee (HRC) within 15 working days for review of positive screening results.

In the event of an emergency, a physician's order for a behavior modifying medication may, if appropriate, be requested for a specific one time emergency use. The person administering the medication shall immediately report it to the Support Coordinator, the responsible person, and any applicable Division designee. The responsible person shall immediately be notified of any changes in medication type or dosage.

**Paper Reviews**

The following guidelines have been designed to provide an option to both the Planning Team and the PRC to meet minimum requirements for annual review of an established behavior treatment plan through a paper review process. This option is limited solely to situations where the individual is on psychotropic medications, and during the annual review by the PRC the presented information and data clearly demonstrate that the member’s behavior has been stable for one year.

**Applicability**

Paper reviews are considered appropriate when the member’s behavior treatment plan involves the use of psychotropic medications, including the use of over-the-counter and herbal medications when used to modify behavior, but does not involve the utilization of more restrictive approaches and/or strategies.

Note: The use of psychotropic medications is prohibited if they are administered on an as-needed, or PRN, basis, they are in dosages which interfere with the individual’s daily living activities (as determined by the Planning Team), or they are used in the absence of a behavior treatment plan.

If the member’s Behavior Treatment Plan includes any of the following techniques and/or strategies, the plan is not eligible for the PRC’s paper review process:

A. Techniques that require the use of force;

B. Programs involving the use of response cost;
C. Programs that might infringe upon the rights of the consumers pursuant to applicable federal and state laws, including A.R.S. § 36-551.01; and,

D. Protective devices used to prevent a person from sustaining injury as a result of the person's self-injurious behavior.

For members living in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), federal rules and regulations will take precedence over these guidelines for paper review.

Eligibility

A member’s behavior treatment plan may be monitored by the PRC’s annual paper review process, if the following criteria are met:

A. The member participated in their program, activities of daily living and chosen leisure/community activities without any significant behavioral disturbances for the previous 12 months. Significant behavioral disturbance is defined as any physical aggression, or pattern of verbal aggression, or other actions that are not typical for the member (such as significant deterioration in personal hygiene or social withdrawal);

B. There were no behavioral incidents requiring the use of emergency measures during the previous 12 months; emergency measures are defined as the use of physical management techniques or psychotropic medications in an emergency to manage a sudden, intense or out-of-control behavior;

C. During the previous 12 months, there were no changes in the member’s prescribed psychotropic medications; the exception to this criterion is when the member required an increase in an antidepressant medication and it was in the absence of any behavioral disturbances; and,

D. Through a review of all incident or serious incident reports for the member during the previous 12 months, there were no situations noted where the member’s behavior resulted in police involvement, psychiatric hospitalization, or crisis intervention through the behavioral health system.

Initial Consideration of Paper Reviews

For the PRC to consider annual reviews using the paper review process, the Planning Team must provide the following:

A. A copy of the member’s current Planning Document;

B. A copy of the member’s current behavior treatment plan, with data and information that meets the criteria set forth in the "Eligibility" section above;

C. Documentation that there is on-going medical monitoring, quarterly medication reviews, and laboratory testing as needed; and,
D. Copying of the Reassessment of the Planning Document for the previous 12 months.

Subsequent Annual Paper Reviews

For the PRC to complete subsequent paper reviews of a member’s behavior treatment plan, the Planning Team must provide at a minimum:

A. A copy of member’s current Planning Document;

B. A copy of the member’s current behavior treatment plan, with information or data indicating the individual’s continuous stable behavior;

C. Copies of on-going medical monitoring reports, quarterly medication reviews and any required laboratory testing, for the previous 12 months;

D. Copy of the Reassessment of the Planning Document for the previous 12 months; and,

E. Any other information requested by the PRC.

Responsibilities of the Program Review Committee

Upon receipt from the Planning Team of the required information detailed in the sections above, the PRC chairperson will:

A. Schedule a review of the submitted information by the entire membership of the PRC;

B. Request further information, and/or schedule a face-to-face review if during the paper review process it is determined that further information is needed; and,

C. Forward a disposition report to the Planning Team. The disposition report will indicate approval, any recommendations made, and the date of the next scheduled review.

Loss of Eligibility for Paper Review

If any of the following situations occur, the Planning Team must notify the PRC chairperson in writing within 30 days of the occurrence. The Planning Team must also reconvene and, if the behavior treatment plan was amended, forward a copy to the PRC within 90 days. This includes situations where:

A. The member cannot participate in their program, activities of daily living and/or leisure activities of their choice, due to any significant behavioral disturbance;

B. An emergency measure intervention was utilized (physical and/or chemical restraint):

C. Any change or increase in the member’s psychotropic medications was made;
D. The only exception to this criterion is when the member requires an increase in an antidepressant medication and it is in the absence of any behavioral disturbances; and,

E. The member’s negative behavior results in law enforcement involvement, psychiatric hospitalization, crisis intervention by the behavioral health system, or injury to oneself or others.

Upon receipt of the member’s behavior treatment plan from the Planning Team, the PRC will schedule a formal review of the plan. Subsequent PRC reviews of the behavior treatment plan will be conducted face-to-face until the member has been stable on their psychotropic medications for one year.

Exit Criteria
For a member’s behavior treatment plan to exit from the PRC’s required annual review the following criteria must be met:

A. Discontinuation of psychotropic medications as part of the behavior treatment plan strategy;

B. Psychotropic medication is clearly prescribed for a non-behavior modifying purpose:
   1. Rationale for the medication is clearly documented by the prescribing physician as being medical in nature (e.g., migraine, seizures), with no associated behavioral disturbance or issues.
   2. The PRC must be satisfied that use of the psychotropic medication will continue to be monitored by the prescribing physician and that there is clearly not a need for a behavior treatment plan to be developed by the Planning Team.
   3. Unless otherwise indicated, use of a psychotropic medication prescribed for a non-behavior modifying reason and without the need for a formal behavior treatment plan will only require a one-time review and approval by the PRC.

C. Elimination of the use of other more restrictive approaches/strategies within the behavior treatment plan that require PRC review and approval and/or annual review, per A.A.C. R6-6-903.A:
   1. Techniques that require the use of force;
   2. Programs involving the use of response cost;
   3. Programs which might infringe upon the rights of the individual pursuant to applicable federal and state laws, including A.R.S. § 36-551.01; and,
   4. Protective devices used to prevent a member from self-injurious behavior.

D. The member is discharged from services through the Division.
For members living in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/IID), federal rules and regulations will take precedence over the exit criteria outlined above.
900  EMERGENCY MEASURES AND PHYSICAL MANAGEMENT TECHNIQUES

REVISION DATE: 9/30/2016, 1/31/2014
EFFECTIVE DATE: July 31, 2014
REFERENCES: A.A.C. R6-6-906, R6-6-909.

Emergency Measures

When an emergency measure, including the use of behavior modifying medications is employed to manage a sudden, intense, and out-of-control behavior, the person employing the measure must:

A. Report the circumstances immediately to the person designated by the Division, the responsible person and the Support Coordinator;

B. Provide a written report of the circumstances of the emergency measure to the responsible person, the Support Coordinator, and the Program Review Committee (PRC) and Human Rights Committee (HRC) chairpersons within one day; and,

C. Request that the Support Coordinator reconvene the Planning Team to determine the need for a new or revised behavior treatment plan when any emergency measure is used two or more times within a 30-day period, or with an identifiable pattern.

The Support Coordinator is responsible for documenting in the member's case record the outcome of the Planning Team.

Upon receipt of a written report as specified above, the PRC must:

A. Review, evaluate, and track reports of emergency measures taken; and,

B. Report, on a case-by-case basis, instances of excessive or inappropriate use of emergency measures for corrective action to a person designated by the Division.

Physical Management Techniques

Client Intervention Training (CIT) establishes specific techniques to be employed by staff and providers during an emergency to manage a sudden, intense, and out-of-control behavior. These techniques can only be used by persons certified in CIT. Such physical management techniques must:

A. Use the least amount of intervention necessary to safely manage an individual;

B. Be used only when less restrictive methods were unsuccessful or are inappropriate;

C. Be used only when necessary to prevent the member from harming himself/herself or others, or causing severe property damage;

D. Be used concurrently with the uncontrolled behavior;

E. Be continued for the least amount of time necessary to bring the member's behavior under control; and,
F. Be appropriate to the situation to ensure safety.

Persons may be re-certified in CIT when their supervisor determines that there is a need for re-training. This re-training can be accomplished by:

A. Viewing a videotape of the techniques, passing a written test, and demonstrating the techniques to the satisfaction of an instructor; or,

B. Attending the entire CIT course again.
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Users of the Provider Policy Manual</td>
<td>1</td>
</tr>
<tr>
<td>Introduction to the Division of Development Disabilities</td>
<td>2</td>
</tr>
<tr>
<td>Provider Responsibilities and Expectations</td>
<td>3</td>
</tr>
<tr>
<td>Provider Service Departments</td>
<td>4</td>
</tr>
<tr>
<td>Covered and Non-Covered Services</td>
<td>5</td>
</tr>
<tr>
<td>Emergency Room Utilization</td>
<td>6</td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment</td>
<td>7</td>
</tr>
<tr>
<td>Dental</td>
<td>8</td>
</tr>
<tr>
<td>Maternity and Family Planning</td>
<td>9</td>
</tr>
<tr>
<td>PCP Assignments</td>
<td>10</td>
</tr>
<tr>
<td>Referrals to Specialists</td>
<td>11</td>
</tr>
<tr>
<td>ALTCS Grievances, Claim Disputes, and Appeals</td>
<td>12</td>
</tr>
<tr>
<td>Billing and Claim Submission</td>
<td>13</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>14</td>
</tr>
<tr>
<td>Remittance Advice, Eligibility, and Cost Sharing</td>
<td>15</td>
</tr>
<tr>
<td>Prior Authorization Requirements</td>
<td>16</td>
</tr>
<tr>
<td>Claims Medical Review</td>
<td>17</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>18</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse</td>
<td>19</td>
</tr>
<tr>
<td>False Claims Act</td>
<td>20</td>
</tr>
<tr>
<td>Formulary Information</td>
<td>21</td>
</tr>
</tbody>
</table>
Chapter 23  Appointment Standards
Chapter 24  American with Disabilities Act
Chapter 25  Enrollment Verification
Chapter 26  Cultural Competency
Chapter 27  Peer Review and Inter-Rater Reliability
Chapter 28  Member Rights
Chapter 29  Advising or Advocating on Behalf of a Consumer
Chapter 30  Clinical Practice Guidelines
Chapter 31  Change of Contractor
Chapter 32  Separation of Children and Adults in Center Based Programs
Chapter 33  Assessment Requirements for Members Placed in Residential Settings
Chapter 34  Provider Publications
Chapter 35  Progress Reporting Requirement
Chapter 36  Fire Safety
Chapter 37  Responsible Person/Caregiver Participation in Therapy Sessions
Chapter 38  Emergency Communication When Transporting a Member
Chapter 39  Reserved
Chapter 40  Insurance
Chapter 41  Termination of a Qualified Vendor Agreement Upon Request of the Qualified Vendor
Chapter 42  Electronic Monitoring/Surveillance System in Program Sites
Chapter 43  Respite Provided at Camp to ALTCS Members
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>44</td>
<td>Qualified Vendor Responsibilities for Planning Team Meetings</td>
</tr>
<tr>
<td>45</td>
<td>After-Hours Telephone Survey</td>
</tr>
<tr>
<td>46</td>
<td>Agency with Choice</td>
</tr>
<tr>
<td>47</td>
<td>Managing Vendor Call Lists, Provider Directories, Scope of Services and Reporting Requirements</td>
</tr>
<tr>
<td>48</td>
<td>Credentialing of Contracted Providers</td>
</tr>
<tr>
<td>49</td>
<td>Responsible Driving</td>
</tr>
<tr>
<td>50</td>
<td>Vendor Call Requirements for Qualified Vendors</td>
</tr>
<tr>
<td>51</td>
<td>Oversight and Monitoring of Developmental Home Services</td>
</tr>
<tr>
<td>52</td>
<td>Daily Habilitation Staffing Schedule – Group Homes and Individually Designed Living Arrangements</td>
</tr>
<tr>
<td>57</td>
<td>Third Party Liability</td>
</tr>
<tr>
<td>58</td>
<td>Medication Management Services</td>
</tr>
<tr>
<td>59</td>
<td>Benefit Coordination and Fiscal Responsibility for Behavioral Health Services and Physical Health Services</td>
</tr>
<tr>
<td>60</td>
<td>Provider Notification</td>
</tr>
<tr>
<td>61</td>
<td>Home and Community Based Services (HCBS) Certification and Provider Registration</td>
</tr>
<tr>
<td>62</td>
<td>Qualified Vendor Management of Gaps in Critical Services</td>
</tr>
<tr>
<td>63</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>A</td>
<td>QVADS Provider Instructions – Agency with Choice Option</td>
</tr>
<tr>
<td>B</td>
<td>DDD Agency with Choice User Guide – FOCUS Vendor</td>
</tr>
</tbody>
</table>
PREFACE – INTENDED USERS OF THE PROVIDER POLICY MANUAL

REVISION DATE: 7/14/2017, 5/31/2017
EFFECTIVE DATE: May 26, 2017

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

- American Indian Health Plan/Fee-For-Service (AIHP/FFS) providers
- Qualified Vendors/Qualified Vendor Applicants (QV/QVA)
- Acute Health Plans/Administrative Services Subcontractors (Acute/AdSS)
- State-contracted developmental homes
- Individual independent providers.

<table>
<thead>
<tr>
<th>Chapter #</th>
<th>AIHP/FFS</th>
<th>QV/QVA</th>
<th>Acute/AdSS</th>
<th>State-Contracted Developmental Home</th>
<th>Individual Independent Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>3</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>4</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>11</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>17</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>18</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>21</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
### Intended Users of the Provider Policy Manual

<table>
<thead>
<tr>
<th>Chapter #</th>
<th>AIHP/FFS</th>
<th>QV/QVA</th>
<th>Acute/AdSS</th>
<th>State-Contracted Developmental Home</th>
<th>Individual Independent Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>27</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>29</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>30</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>36</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>48</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>49</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>57-A</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57-B</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57-C</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57-D</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57-E</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>60</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Intended Users of the Provider Policy Manual

<table>
<thead>
<tr>
<th>Chapter #</th>
<th>AIHP/FFS</th>
<th>QV/QVA</th>
<th>Acute/AdSS</th>
<th>State-Contracted Developmental Home</th>
<th>Individual Independent Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>61</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
CHAPTER 1 - INTRODUCTION TO THE DIVISION OF DEVELOPMENTAL DISABILITIES

REVISION DATE: 12/13/2017, 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: A.R.S. § 36-554(A)(10)

Program Description

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

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

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

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

**Behavioral Health Services Network**

Behavioral health services are provided by Regional Behavioral Health Authority agencies (RBHAs). The RBHAs contract with AHCCCS, which receives funding from the legislature. The Division is responsible to coordinate care with the RBHA through an Interagency Service Agreement with AHCCCS.

The Division is responsible for ensuring that the delivery of behavioral health services meet the needs of members being served by coordinating care with RBHA providers.

**Home and Community Based Services Network**

Home and Community Based Services (HCBS) are supports to promote independence and inclusion within the community for eligible members with developmental disabilities and their families, in the least restrictive home and community-based settings. These services include, but are not limited to:

- In-home services (e.g., attendant care, habilitation, respite)
- Habilitative therapies
- Day programs
- Employment programs
- Residential services.

The Division contracts with over 600 Qualified Vendors and 1,800 Independent Providers to provide this array of HCBS.
Chapter 2 PROVIDER RESPONSIBILITIES AND EXPECTATIONS

REVISION DATE: 10/01/2019, 8/12/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: A.A.C R6-6-1001; A.A.C R6-6-1101; 42 CFR 438.100; 45 CFR parts 160 and 164; Service Specifications; DDD Rules; ALTCS Rules

National Provider Identifier

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

Member’s Privacy and Security

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

45 CFR 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


A. General requirements. Covered entities and business associates must do the following:
   a. Ensure the confidentiality, integrity, and availability of all electronic protected health information the covered entity or business associate creates, receives, maintains, or transmits.
   b. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information.
   c. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under subpart E of this part.
   d. Ensure compliance with this subpart by its workforce.
Member’s Rights

Qualified Vendors and Independent Providers will:

A. Provide services in a manner that supports and enhances the member’s independence, self-esteem, mutual respect, value, and dignity.

B. Actively participate in the member’s Planning Team meeting at the date, time, and location determined by the Division.
   1. The Planning Team may agree to have the provider(s) or health plan staff participate in the Planning Team meeting via phone or WebEx when technology allows for it if the meeting location will not accommodate a large number of participants and to take into consideration the travel time for the provider.

C. Meet with the member and, if applicable, the primary caregiver prior to initiating service and obtain necessary information.

D. Administer first aid and appropriate attention to injury or illness.

E. Report incidents in accordance with the Division’s Policy Manual.

F. As required, submit progress reports and teaching strategies (including measurable data to validate the effectiveness of the service) to aid the Support Coordinator in assessing the continued need for the service.

G. Notify the Support Coordinator to request a Planning Team meeting whenever there is a significant change in the member’s status.

H. Complete other assignments as determined by the Planning Team.

I. Provide services as authorized by the Division.

Qualified Vendors and Independent Providers will adhere to the member rights as outlined in 42 CFR 438.100, including the right to:

A. Be treated with dignity and respect,

B. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand,

C. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,

D. Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specific in 45 CFR part 164 and applicable state law,

E. Exercise his or her rights and that exercise of those rights must not adversely affect service delivery to the member.
The Division of Developmental Disabilities (Division) offers assistance for its providers. For assistance regarding billing/claims, contracts, and health care services, or to initiate a provider grievance (complaint), providers may contact the DDD Customer Service Center at 1-844-770-9500 or 602-542-0419. Providers may also e-mail DDDCustomerService-Provider@azdes.gov.

The Customer Service Center provides:

A. Assistance for new providers in:
   1. How to submit claims to the Division
   2. Focus onboarding
   3. Learning how to upload files to the Division’s secure server
   4. Accessing Division reporting tools.

B. Provider Grievance (Complaint) System and inquiry resolution:
   1. Reviewing inquiries and provider grievances (complaints).
   2. Tracking inquiries and provider grievances (complaints) until resolved
   3. Collaborating with subcontractors, staff, and members for resolution.

C. Provider Grievance (complaint) data including number of complaints, number of high profile complaints, type of complaint, and average number of days to resolve complaints. Reporting on Provider Grievance (complaint) data for tracking and trending is received:
   1. Monthly
   2. Quarterly
   3. Semiannually
   4. Annually

D. Claims assistance:
   1. Entering and resolving claims issues in the Division’s Resolution System
   2. Advising on how to submit a clean claim.
Medical providers providing services for members enrolled with an acute care contractor should contact the appropriate Health Plan:

- United Health Care Community Plan: 1-800-445-1638
- Care1st: 602-778-1800
- Mercy Care Plan: 1-800-624-3879
CHAPTER 4 – COVERED AND NON-COVERED SERVICES

EFFECTIVE DATE: March 29, 2013

Covered Services

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

A. Examples of covered services for members under the age of 21 years include, but are not limited to:

1. Emergency room services
2. Dental
3. Podiatry
4. Vision
5. Doctor’s office visits
6. Urgent care
7. Transplants
8. Family planning services
9. Medications
10. Behavioral health services
11. Therapies
12. Respite
13. Habilitation

B. Examples of covered services for members age 21 years and over include, but are not limited to:

1. Emergency room services
2. Dental
3. Podiatry
4. Doctor’s office visits
5. Urgent care
6. Family planning services
7. Medications
8. Behavioral health services
9. Respite
10. Habilitation
11. Attendant care services
12. Residential.

Non-Covered Services

A. Examples of non-covered services for members age 21 years and over:
   1. Percussive vest
   2. Certain transplants.

B. Examples of non-covered services for members of all ages:
   1. Vehicle modification
   2. Vehicle lift
   3. Day care
   4. Additions to homes
   5. Pill crusher
   6. Service animal
   7. Life coach
   8. Home repairs
   9. Rent.

C. Examples of Covered Behavioral Health Services:
   1. Behavior Management (behavioral health personal assistance, family support/homecare training, self-help/peer support)
   2. Behavioral Health Case Management Services
   3. Behavioral Health Nursing Services
   4. Behavioral Health Therapeutic Home Care Services (formerly known
as Therapeutic Foster Care

5. Emergency/Crisis Behavioral Health Care

6. Emergency and Non-Emergency Transportation

7. Evaluation, Assessment, and Screening

8. Individual, Group and Family Therapy and Counseling

9. Inpatient Hospital Services

10. Institutions for Mental Disease (with limitations)

11. Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis

12. Non-Hospital Inpatient Psychiatric Facilities (residential treatment centers and sub-acute facilities)

13. Opioid Agonist Treatment

14. Partial Care (supervised day program, therapeutic day program and medical day program)

15. Psychosocial Rehabilitation (living skills training; health promotion; supportive employment services)

16. Psychotropic Medication Adjustment and Monitoring

17. Respite Care
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.
Members age 20 years and under who are eligible for AHCCCS are also eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT offers comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by screenings. This includes required health, developmental, and behavioral health screenings.

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

Comprehensive unclothed physical examination, laboratory tests, vision services, hearing services and dental services are covered as specified in Arizona Administrative Code, R9-22-213.

EPSDT providers must document immunizations into the Arizona State Immunization Information System (ASIIS) and enroll annually in the Vaccine for Children Program.
CHAPTER 7 – DENTAL

REVISION DATE: 11/10/16, 4/15/15, 4/16/14
EFFECTIVE DATE: March 29, 2013
REFERENCES: AHCCCS Medical Policy Manual (AMPM) 310-D Covered Services Dental Services for Members 21 Years of Age and Older, 430 EPSDT Services

Dental Services for Members Age 20 and Younger

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

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

Dental Services for Members Age 21 and Over

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

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

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

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

Emergency dental care and extractions are covered for all members who are eligible for ALTCS, regardless of age.
CHAPTER 8 – MATERNITY AND FAMILY PLANNING

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

The Division of Developmental Disabilities (Division) contracts with three 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:

United Community Health Plan: 1-800-445-1638
Care1st: 602-778-1800
Mercy Care: 1-800-624-3879

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

EFFECTIVE DATE: March 29, 2013

Grievances

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

To file a grievance, contact:

Division of Developmental Disabilities Customer Service Center
1-844-770-9500 (toll free)

Provider Claim Disputes

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

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

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

Mail or fax written claim disputes to:

OFFICE OF ADMINISTRATIVE REVIEW
4000 North Central Avenue 3rd Floor
Suite 301 - Mail Drop 2HE5
Phoenix, Arizona 85012
Fax: 602-277-0026

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

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

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

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

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

Mail or fax written requests for State Fair Hearing to:

OFFICE OF ADMINISTRATIVE REVIEW
4000 North Central Avenue 3rd Floor
Suite 301 - Mail Drop 2HE5
Phoenix, Arizona 85012
Fax: 602-277-0026

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

Appeals

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

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

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

Reasons for filing an appeal include:

- Denial or limited authorization of a requested service, including the type or level of service
- Reduction, suspension, or termination of a previous authorization
- Denial, in whole or in part, of payment of a service
- Failure to provide service in a timely manner as defined by the State
- Failure to act within the timeframes provided in 42 CFP 438.408(b) required for standard and expedited resolution of appeals and standard disposition of grievances
• Failure of the health plan to act timely
• Denial of a rural enrollee’s request to obtain services outside the Contractor’s network under 42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area.

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

OFFICE OF ADMINISTRATIVE REVIEW
4000 North Central Avenue 3rd Floor
Suite 301 - Mail Drop 2HE5
Phoenix, Arizona 85012
Fax: 602-277-0026

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

**State Fair Hearings (Regarding Notice of Appeal Resolution)**

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

In your request for State Fair Hearing, reference:

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

Mail or fax written requests for State Fair Hearing to:

OFFICE OF ADMINISTRATIVE REVIEW
4000 North Central Avenue 3rd Floor
Suite 301 - Mail Drop 2HE5
Phoenix, Arizona 85012
Fax: 602-277-0026

If you have questions, call 602-771-8163 or 1-855-888-3106.
CHAPTER 12 – BILLING AND CLAIM SUBMISSION

REFERENCES: AHCCCS; Billing Information, ARS §36-2904 (G), §36-2904 (G) (1), §36-2903.01(K) Per 42 CFR 455.410.

Purpose

This policy outlines the requirements for the Division of Developmental Disabilities (the Division) American Indian Health Plan (AIHP) for Fee for Service (FFS) acute care claims billing and claims submissions.

Definitions

A. **American Indian Health Program (AHIP)** – The program provides medically necessary services for Division enrolled members. The program also provides coverage for preventive and behavioral health care services.

B. **Fee for Service (FFS)** - A method in which doctors and other health care providers are paid for each service performed.

C. **Clean claim** - As defined by ARS §36-2904 (G) (1) a “clean claim” is: 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.

D. **Void** - A void is a recoupment of a claim, with the entire claim being recouped.

E. **Claim Reference Number (CRN)** - Claim Reference Number that is unique to each claim and remains the same over the life of the claim.

F. **Evaluation and Management codes (E&M)** - a category of CPT codes are 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 the visit complexity and documentation requirements. (https://www.aafp.org/practice-management/payment/coding/evaluation-management.html)

G. **International Classification of Diseases 10th revision (ICD-10)** – the diagnosis coding system used by physicians and facilities.

Policy

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

For Home and Community Based Services (HCBS), the Division requires Qualified Vendors to submit claims using the Division’s FOCUS system which is the Division’s automated service authorization and payment processing system). Please refer to the Division’s HCBS Claims Submission Guide for more information.

For American Indian Health Plan (AIHP), Fee-for-Service (FFS), Acute Care Services, there are three different nationally standardized claim forms that must be used.

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

The Division complies with all AHCCCS billing and payment requirements when processing claims. AIHP FFS Acute Care claims processed through QNXT™ must be submitted with current code sets from the International Classification of Diseases (ICD-10), Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), Current Dental Terminology (CDT), and National Drug Codes (NDC).

Claim Submission Time Frames

In accordance with ARS §36-2904 (G), an initial claim for services provided to a Division member must be received by the Division no later than six months after the date of service, unless the claim involves retro-eligibility. In the case of retro-eligibility, a claim must be submitted no later than six months from the date that eligibility is posted. For hospital inpatient claims, “date of service” means the date of discharge of the patient. For DME claims, “date of service” means the first date the item(s) were given to the member.

A. Claims initially received beyond the six-month time frame, except claims involving retro-eligibility, will be denied.

B. If a claim is originally received within the six-month time frame, the provider has up to 12 months from the date of service to correctly resubmit the claim in order to achieve clean claim status, or to adjust a previously processed claim, unless the claim involves retro-eligibility. If a claim does not achieve clean claim status, or is not adjusted correctly within 12 months, the Division is not liable for payment.

When the Division Bills Members

Arizona Revised Statute §36-2903.01(K) prohibits providers from billing Division members, including QMB Only members, for Division covered services.

Upon oral or written notice from the patient, that the patient believes the claims to be covered by Medicaid, a provider or non-provider of health and medical services prescribed in §36-2907 shall not do either of the following unless the provider or non-provider has verified through the Administration that the person 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, and/or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.

B. Refer or report a member or person, who has been determined eligible, to a collection agency or credit reporting agency for the failure of the member or person, who has been determined eligible, to pay charges for system covered care or services, unless specifically authorized by this article or rules adopted pursuant to this article.

Note: “QMB Only” is a Qualified Medicare Beneficiary under the federal program, but does not qualify for Medicaid. Under A.A.C. R9-29-301 the Division only reimburses the provider for the Medicare deductible and coinsurance amount when Medicare pays first.

Claim Submission Requirements for Paper Claims

When a claim is submitted, ensure that the printed information is aligned correctly with the appropriate section/box on the form. If a claim is not aligned correctly, it may cause the OCR scanning system to misread the data, and the claim will be rejected.

A. The preferred font for claims submission is Lucinda Console, and the preferred font size is 10.

B. Claims for services must be legible and submitted on the correct form for the type of service(s) billed. Claims that are not legible or that are not submitted on the correct form will be returned to providers without being processed.

1. If a claim is returned, you must resubmit the claim on the correct type of claim form, submit it within the required time frame, and ensure that it is legible.

2. This resubmitted claim cannot be a black and white copy of the previously submitted claim. The resubmitted claim must be submitted on a new claim form.

C. The Division retains a permanent electronic image of all paper claims submitted, in accordance with State retention record requirements, requiring providers to file clear and legible claim forms.

D. Paper claims or copies that contain highlighter or color marks, copy overexposure marks or dark edges are not legible on the imaging system. Liquid paper correction fluid (“White Out”) may not be used. Correction tape may not be used.

E. Any documentation submitted with a claim is imaged and linked to the claim image. Documentation is required when resubmitting claims, even if the documentation was submitted with an earlier version of the claim and the claim number is referenced on the resubmitted claim. Documentation must be resubmitted. Each claim must stand on its own, as the system is unable to pull documentation from the previously submitted claim.
F. All paper claims should be mailed, with adequate postage, to:

Division of Developmental Disabilities
Attn: Claims Department
Mail Drop 2HC6
P.O. Box 6123
Phoenix, AZ 85005-6123

**Replacements and Voids**

The Division Claims Processing system will deny claims with errors that are identified during the editing process. These errors will be reported to the provider on the Division Remittance Advice. The provider should correct claim errors and resubmit claims to the Division for processing within the 12-month clean claim time frame.

A replacement can be used to adjust a paid or denied claim, and it can also be used to recoup previously paid lines. A replacement will allow individual lines to be recouped, rather than the entire claim to be recouped.

A. Replacements

For this section, when a claim is resubmitted, it will be referred to as a replacement. A replacement is the resubmission of a claim.

Occasionally, when a previously submitted claim (paid or denied) will need to be replaced with a new submission.

1. To replace a corrected claim for any of the following:

   a. The original claim was denied or partially denied.

   b. When a claim was paid by the Division and errors were discovered afterward in regards to the amounts or services that were billed on the original claim. For example, you may discover that additional services should have been billed for on a service span, or that incorrect charges were entered on a claim paid by the Division.

When replacing a denied claim or adjusting a previously paid claim, you must submit a new claim form containing all previously submitted lines. The original Division Claim Reference Number (CRN) must be included on the claim to enable the Division system to identify the claim being resubmitted. Otherwise, the claim will be entered as a new claim and may be denied due to it appearing to have been received beyond the initial submission time frame, or it may be denied as a duplicate submission.

If any previously paid lines are blanked out the Division system will assume that those lines should not be considered for reimbursement and payment will be recouped.

When replacing a claim, you must resubmit any documentation that was sent with the denied or previously paid claim.
Every field can be changed on the replacement except the service provider ID number, the billing provider ID number, and the tax ID number. If these must be changed, you must void the claim and submit a new claim.

2. To replace a denied CMS 1500 claim:
   
a. Enter “A” or “7” in Field 22 (Medicaid Resubmission Code) and the CRN of the denied claim or the CRN of the claim to be adjusted in the field labeled "Original Ref. No." Failure to replace a 1500 claim without Field 22 completed will cause the claim to be considered a “new” claim, and then it will not link to the original denial/paid claim. The “new” claim may be denied as timely filing exceeded.

b. Replace the claim in its entirety, including all original lines if the claim contained more than one line.

Note: Failure to include all lines of a multiple-line claim will result in a recoupment of any paid lines that are not accounted for on the resubmitted claim.

Example 1:
You submit a three-line claim to the Division. Lines one and three are paid, but Line two is denied.

When replacing the claim, you should replace all three lines. If only Line two is replaced, the Division system will recoup payment for Lines one and three.

Example 2:
You replace a three-line claim to the Division. All three lines are paid.

Discovery of an error in the number of units billed on line three and submit an adjustment.

When submitting the adjustment, you should replace all three lines. If only line three is replaced, the Division system will recoup payment for lines one and two.

An adjustment for additional charges to a paid claim must include all charges the original billed charges plus additional charges.

Example 3: You bill for two units for a service with a unit charge of $50.00 and are reimbursed $100.00. After receiving payment, you discover that three units of the service should have been billed.

When adjusting the claim, you should bill for three units and total billed charges of $150.00 (3 units X $50.00/unit). The Division system will pay the claim as follows: Allowed Amount (3 units) $150.00

   o Previously Paid to Provider <$100.00>
Reimbursement $50.00

If you billed for the one additional unit at $50.00, the Division system would recoup $50.00, as shown below:

- Allowed Amount (1 unit) $50.00
- Previously Paid to Provider <$100.00>
- Reimbursement (Amount recouped) <$50.00>

3. To replace a denied UB-04 claim:
   a. Replace the UB-04 with the appropriate Bill Type: xx7 for a replacement and corrected claim

   Note: Failure to replace a UB-04 without the appropriate Bill Type will cause the claim to be considered a “new” claim, and it will not link to the original denial. The “new” claim may be denied as timely filing exceeded.

   b. Type the CRN of the denied claim in the “Document Control Number” (Field 64).

   c. To replace a denied ADA claim or a previously paid ADA claim, the CRN of the denied claim must be entered in Field 2 (Predetermination/Preauthorization Number).

      i. Failure to replace an ADA claim without Field 2 completed will cause the claim to be considered a “new” claim and it will not link to the original denial or the previously paid claim. The “new” claim may be denied as timely filing exceeded.

      ii. Do not put the CRN in the Remarks section or in the white space at the top of the form. Replacements that have the CRN in the wrong section will be denied. The CRN must go in Field 2.

B. Voids

When voiding a claim, you should submit documentation stating the reason for the void. Only the provider who submitted the original claim may void the claim. When a claim is voided, all payment is recouped. This process should only be used when there is no other alternative.

Unlike resubmissions and adjustments, you should submit only the line(s) to be voided. Lines that should not be voided should be blanked out to avoid recoupment of payment for those lines.

1. To void a paid CMS 1500 claim enter "V" or "8" in Field 22 (Medicaid Resubmission Code) and the CRN of the claim to be voided in the "Original Ref. No." field.

2. To void a paid UB-04 claim, use bill type xx8
3. Enter the CRN of the claim to be voided in the “Remarks” field (Field 80).

4. If Field 80 is used for other purposes, type the CRN at the top of the claim form.

5. To void a paid ADA claim type the word “VOID” and enter the CRN of the paid claim to be voided in Field 2 (Predetermination/Preauthorization Number).

**General Division Billing Rules**

Most of the rules for billing the Division follow those observed by Medicare and other third party payers. However, the following requirements are emphasized by the Division:

A. Billing must follow completion of service delivery. A claim may cover a time span over which service was provided, but the last date of service billed must be prior to or the same date that the claim is signed.

B. Billing Multiple Units:

If the same procedure is provided multiple times on the same date of service, the procedure code must be entered **only once** on the claim form.

The unit’s field is used to specify the number of times the procedure was performed on the date of service.

The total billed charge is the unit charge multiplied by the number of units.

C. Medicare and Third Party Payments

By law, the Division has liability for payment of benefits after all other third party payers, including Medicare.

The provider must determine the extent of third party coverage and bill all third party payers **before** to billing the Division.

D. Age, Gender, and Frequency-Based Service Limitations:

1. The Division imposes some limitations on services based on member age and/or gender.

2. Some procedures have a limit on the number of units that can be provided to a member during a given time span.

3. The Division may revise these limits as appropriate.

E. All claims are considered non-emergent and subject to applicable prior authorization requirements unless the provider identifies the service(s) billed on the claim form as an emergency.

1. UB-04 Claim Form

   a. On the UB-04 claim form, the Admit Type (Field 14) must be “1” (emergency), “5” (trauma), or “4” (newborn) on all emergency
inpatient and outpatient claims.

b. All other Admit Types, including a “2” for urgent, designate the claim as non-emergent.

2. CMS 1500 Claim Form

On the CMS 1500 claim form, Field 24 C must be marked to indicate that the service billed on a particular claim line was an emergency.

3. American Dental Association (ADA) Claim Form

The Division staff will review ADA 2012 dental claims for adults to determine if the service provided was emergent.

**Overpayments**

A provider must notify the Division of any claim overpayments. The provider can notify the Division by submitting a replacement claim, which will allow recoupment of the overpayment to occur.

A. If an adjustment is needed then providers should attach documentation substantiating the overpayment, such as an EOB if the overpayment was due to payment received from a third party payer.

B. If it is necessary to void a claim, the entire payment will be recouped and documentation is not required.

C. The claim will appear on the Remittance Advice showing the original allowed amount, and the new (adjusted) allowed amount.

*Note: Do NOT send a check for the overpayment amount. The claim must be adjusted, and the overpaid amount will be recouped.*

**Recoupments**

A.R.S. §36-2903.01 L. requires the Division to conduct a post-payment review of all claims and recoup any monies erroneously paid. Under certain circumstances, the Division may find it necessary to recoup or take back money previously paid to a provider.

A. Overpayments and erroneous payments are identified through reports, medical review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments. Upon completion of the recoupment, the Remittance Advice will detail the action taken.

B. Payments recouped for a reason other than third party recovery (e.g., no medical documentation to substantiate services rendered), you will be afforded additional time to justify for re-payment for recoupments, as outlined below.

1. The time frame for submission of a clean claim differs from the time frames described earlier in this chapter.

2. The time span allowed for resubmission of a clean claim will be the greatest
if:

a. Twelve months from the date of service.

b. Twelve months from the date of eligibility posting for a retro-eligibility claim.

c. Sixty days from the date of the adverse action.

**Additional Billing Rules**

A. Multiple Page Claims

1. Do not submit double-sided, multiple-page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.). To ensure an UB-04 claim is processed as a single claim, all the pages must be numbered.

2. Keep all pages together, back-to-back. All pages should be paper-clipped or rubber-banded together. Do not staple.

3. Totals should not be carried forward onto each page, and each page can be treated as a single page. The total should be entered on the last page only.

B. Zero Charges

The Division will key revenue and procedure codes billed with zero charges. The Division will not key revenue, and procedure codes billed with blank charges. When submitting zero charges, $0.00 must be listed and it cannot be left blank.

Revenue codes with zero charges will not be considered for reimbursement.

C. Changes in Member Eligibility

If the member is ineligible for any portion of a service span, those periods should not be billed to the Division. If a member’s eligibility changes, then each eligible period should be billed separately to avoid processing delays.

D. Changes in Reimbursement Rate

It is not necessary to split-bill for an inpatient hospital claim when:

1. The claim dates of a service span change in the inpatient hospital reimbursement rates.

2. If a hospital outpatient claim is submitted with dates of service that span a change in the hospital outpatient reimbursement rates, then the claim must be split.
Documentation Requirements

Medical review is a function of the Division Claims Department and determines if services were provided according to the Division policy as it relates to medical necessity and emergency services. Medical review and adjudication also are performed to audit the appropriateness, utilization, and quality of the service provided.

A. To conduct a medical review, providers may be asked to submit additional documentation for AIHP Acute Service CMS 1500 claims, which are identified in the Division claims processing system as near duplicate claims. The documentation is necessary to allow the Division Medical Review staff to determine whether it is appropriate to reimburse multiple providers for the same service on the same day.

   1. Near-duplicate claims are claims for the same procedure, on the same day, for the same member, for different providers.

   2. Near-duplicate claims for certain E&M codes (for example, emergency room visits, critical care visits, newborn care, and hospital visits) may pend for review. If the documentation substantiates the services, adjudication staff will release the claim for payment, assuming that the claim has not failed any other edits.

B. If medical documentation is not submitted, the adjudication staff will deny the claim with a denial reason specifying what documentation is required. Providers will not receive a letter requesting documentation because the denial codes are very specific as to what is required.

C. It is expected that certain E&M codes such as 90491 (Critical care, evaluation and management) and 90431-90433 (Subsequent hospital care) will frequently fail the near-duplicate edit because it is feasible that a member could be seen by more than one provider on the same day. However, each provider must submit documentation substantiating the necessity for his or her services.

Example:

Provider A, a pulmonologist, and Provider B, a cardiologist, both see Mr. Jones in ICU on April 22. Both providers bill the Division for CPT Code 90491 for April 22. Either claim may fail the near-duplicate edit and pend to Medical Review. The Medical Review nurse will review the documentation submitted with the claim. In this case, the nurse would expect to find a critical care progress note from the provider.

If no medical documentation is provided, the claim will be denied.

Note: The Division requires all claims related to hysterectomy and sterilization procedures to be submitted with the respective consent forms.

D. While it is impossible to offer specific guidelines for each situation, the following table is designed to give providers some general guidance regarding submission of documentation. Also, not all Fee-For-Service claims submitted to the Division are subject to Medical Review.
### CMS 1500 Claims

<table>
<thead>
<tr>
<th>Billing For</th>
<th>Documents Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical procedures</td>
<td>History and physical, operative report, and emergency room report</td>
<td></td>
</tr>
<tr>
<td>Missed abortion/Incomplete abortion Procedures (all CPT codes)</td>
<td>History and physical, ultrasound report, operative report, and pathology report</td>
<td>Information must substantiate fetal demise.</td>
</tr>
<tr>
<td>Emergency room visits</td>
<td><strong>Complete</strong> emergency room record.</td>
<td>The billing physician’s signature must be on ER record</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Anesthesia records</td>
<td>Include “begin and end” time</td>
</tr>
<tr>
<td>Pathology</td>
<td>Pathology reports</td>
<td></td>
</tr>
<tr>
<td>E&amp;M services</td>
<td>Progress notes, history and physical, office records, discharge summary, &amp; consult reports</td>
<td>Documentation should be specific to code(s) billed</td>
</tr>
<tr>
<td>Radiology</td>
<td>X-ray/Scan reports</td>
<td></td>
</tr>
<tr>
<td>Medical procedures</td>
<td>Procedure report, history and physical</td>
<td>Examples: Cardiac catheterizations, Doppler studies, etc.</td>
</tr>
</tbody>
</table>

### UB-04 Claims

<table>
<thead>
<tr>
<th>Billing for</th>
<th>Documents Required</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
<td>Refer to AHCCCS FFS Chapter 11 Hospital Services for required documentation.</td>
<td>If labor and delivery, send labor and delivery records</td>
</tr>
<tr>
<td>Missed abortion/Incomplete abortion abortion</td>
<td>All documents required by statute, ultrasound report, operative report, and pathology report.</td>
<td>Information must substantiate fetal demise.</td>
</tr>
<tr>
<td>Outlier</td>
<td>Refer to AHCCCS FFS Chapter 11, Hospital Services, and to Exhibit 11-4, the Outlier Record Request, for information on the required documentation.</td>
<td></td>
</tr>
</tbody>
</table>

1. Unless specifically requested, Providers should not submit the following:

   - Emergency admission authorization forms
   - Patient follow-up care instructions
   - Nurses notes
   - Blank medical documentation forms
- Consents for treatment forms
- Operative consent forms (Exception: bilateral tubal ligation and hysterectomy)
- Ultrasound/X-ray films
- Medifax information
- Nursing care plans
- DRG/Coding forms
- Medical documentation on prior authorized procedures/hospital stays (Exception claims that qualify for outlier payment.)
- Entire medical records

**Social Determinants**

Beginning with dates of service on and after **April 1, 2018**, the Division will monitor all claims for the presence of social determinant ICD-10 codes.

**A.** As appropriate within the scope of practice, providers should be routinely screening for, and documenting, the presence of social determinants. Information about social determinant should be included in the member’s chart.

**B.** Any social determinant ICD-10 diagnosis codes that are identified should be included on the submitted claims for the Division members, to comply with state and federal coding requirements.

*Note: Social determinants are not the primary ICD-10 code. They are secondary ICD-10 codes.*

**C.** Dental providers will be exempt from the use of social determinants.

**D.** For a list of ICD-10 codes relevant to social determinants of health, please see Exhibit 4-1, Social Determinants of Health ICD-10 Code List in the AHCCCS Fee-For-Service Provider Billing Manual. The list of social determinants of health codes may be added to or updated on a quarterly basis. Providers should remain current in their use of these codes

**Claim Submission and Provider Registration**

According to the 42 CFR 455.410 of the Affordable Care Act, **the State Medicaid agency (AHCCCS)** must 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 must be registered with AHCCCS in order to be reimbursed for covered services provided to AHCCCS members.
Effective January 1, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider the Division will deny the claim.
CHAPTER 13 - UTILIZATION MANAGEMENT

REVISION DATE: 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 American Indian Health Program (AIHP). 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. American Indian Health Program (AIHP) Providers

All AIHP 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 AIHP providers.

For Division members enrolled with AIHP, prior authorization is required before rendering any service. The Division’s Chief Medical Officer (CMO) or Medical Director will review any denials for the AIHP 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 AIHP 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

EFFECTIVE DATE: March 29, 2013

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-OMB) Dual - A person who qualifies to receive both Medicare and Medicaid services, but does not qualify for the QMB program as outlined in

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 AHCCCS 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 month of application 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**

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE DIVISION MUST PAY: (Subject to the limits outlined in this Policy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Medicare copayments, coinsurance and deductible</td>
</tr>
<tr>
<td>Medicaid Only</td>
<td>The provider in accordance with the contract</td>
</tr>
<tr>
<td>By both Medicare and Medicaid (See Examples Below)</td>
<td>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.</td>
</tr>
</tbody>
</table>

**FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES**

Services are covered by both Medicare and Medicaid

*Subject to the limits outlined in this Policy*

<table>
<thead>
<tr>
<th>EXAMPLE 1 (b. In Table 1 above)</th>
<th>EXAMPLE 2 (b. In Table 1 above)</th>
<th>EXAMPLE 3 (b. In Table 1 above)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider charges</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td>Medicare rate for service</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>
Division of Developmental Disabilities
Provider Manual
Chapter 16
Remittance Advice, Eligibility, & Cost Sharing

<table>
<thead>
<tr>
<th>Medicaid rate for Medicare service (The Division’s contracted rate)</th>
<th>$100</th>
<th>$90</th>
<th>$90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare deductible</td>
<td>$0</td>
<td>$0</td>
<td>$40</td>
</tr>
<tr>
<td>Medicare paid amount (80% of Medicare rate less deductible)</td>
<td>$80</td>
<td>$80</td>
<td>$40</td>
</tr>
<tr>
<td>Medicare coinsurance (20% of Medicare rate)</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td><strong>THE DIVISION PAYS</strong></td>
<td>$20</td>
<td>$10</td>
<td>$50</td>
</tr>
</tbody>
</table>

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>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE DIVISION MUST NOT PAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Medicare copay, coinsurance or deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE DIVISION MUST PAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Only</td>
<td>The provider in accordance with the contract</td>
</tr>
</tbody>
</table>

Table 2: NON-QMB DUALS (IN NETWORK)
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>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE DIVISION Subject to the limits outlined in this Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>Medicaid only and the Division <strong>has not</strong> referred the member to the provider or has not authorized the provider to render services and the services are not emergent</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>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</td>
<td>Must pay in accordance with A.A.C. R9-22-705.</td>
</tr>
<tr>
<td>By both Medicare and Medicaid and the Division <strong>has not</strong> referred the member to the provider or has not authorized the provider to render services and the services are not emergent</td>
<td>Has no responsibility for payment.</td>
</tr>
</tbody>
</table>
| 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

EFFECTIVE DATE: March 29, 2013
REFERENCES: AHCCCS Medical Policy Manual

The Division of Developmental Disabilities (Division) adheres to the prior authorization guidelines and timelines available in the AHCCCS Medical Policy Manual. The Division will no longer process requests for prior authorization of medical services after the services are rendered. The Division will process standard authorization requests within 14 calendar days of the physician’s order. The Division will process expedited authorization requests within three working days of the physician’s order. When the standard time frame could seriously jeopardize the member’s life, health, or ability to attain, maintain or regain maximum function, the expedited process is implemented.

To receive prior authorization for acute care services for a member of the Division who is enrolled with an acute care health plan, providers should contact the prior authorization department of the member’s acute care Health Plan.

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

Health Care Services/Prior Authorization Unit
3443 North Central Avenue, Suite 600
Site Code 795M
Phoenix, Arizona 85005

(602) 771-8080 phone
(800) 624-4964 toll-free
(602) 238-9294 fax

The following services require prior authorization for members of the Division who are enrolled with AIHP.

A. Hospital Inpatient Services

Hospital inpatient services include:

1. Routine (regular) hospital care
2. Intensive care and coronary (heart) care
3. Intensive care for newborns
4. Maternity care, including labor, delivery and recovery rooms, and birthing centers
5. Nursery for newborns and infants
6. Surgery, including anesthesiology
7. Emergency mental health or addiction services
8. Medical supplies and equipment
9. Chemotherapy (cancer treatment)
10. Dialysis
11. Laboratory services
12. Pharmacy services and medicines
13. Radiological and medical imaging services
14. Total parenteral nutrition (feeding tube or intravenous feedings).

B. Medication

The AIHP may pay for medicines prescribed by a doctor (if the medicine is on the formulary).

Members of the Division who are enrolled in the AIHP can go to the following three places to get their medications:

1. Indian Health Service (IHS) facilities
2. 638 Tribal Facilities
3. Pharmacies that are part of the Med Impact Pharmacy Program.

Physician, dentist, or other health care provider may provide the prescription. Members are encouraged to fill the prescription at the same pharmacy each time. Some medicines require prior authorization (obtaining Med Impact approval first). The AHCCCS Fee-for-Service formulary is a list of approved medications for which the Division will pay; the Division will not pay for medicines that are not on the list.

C. Long Term Care Services

The Division provides care for members who are enrolled with the AIHP. Institutional care and home and community based services are provided to members of the Division who are enrolled with the AIHP who are at risk of institutionalization.

The following services are covered:

1. Medical services
2. Institutional services including:
   a. Nursing Facilities (NFs) and Intermediate Care Facilities (ICFs)
   b. Inpatient psychiatric facilities (RBCs) for members under age 21
c. Home and Community Based Services (refer to the Service Approval Matrix on the Arizona Department of Economic Security website)

d. Hospice services

e. Mental health and substance abuse services

f. Medical equipment and medical supplies

g. Speech, physical, occupational therapies (in nursing facilities and alternative residential facilities and as part of HCBS).

D. Other Covered Services

Other covered services include:

1. Cancer treatment, including chemotherapy and radiation

2. Cardiovascular (heart and blood vessel) exams, tests, treatment, and surgery

3. Consultations

4. Critical care (intensive care units)

5. Emergency treatment

6. Female genital exams, treatment and surgery

7. Gastroenterology (intestinal tract and liver) exams, treatment, and surgery

8. General medical care and services

9. Hearing exams and services

10. Home services and home health services

11. Immune system exams and testing and treatment of immune disorders

12. Laboratory tests

13. Male and females genital system exams, treatment, and surgery

14. Medical/surgical supplies and equipment

15. Musculoskeletal (bone, joint, and muscle) exams, treatment and surgery

16. Nursing services

17. Nutrition therapy

18. Office visits

19. Orthopedic shoes and orthotics
20. Osteopathic treatment
21. Pulmonary (lung and breathing) exams, treatment, surgery, and rehabilitation
22. Radiology (ultrasound, x-rays, other scans)
23. Respite care
24. Speech testing and services
25. Surgical procedures
26. Telehealth services
27. Urinary system exams, treatment, and surgery.

E. Dental Services
The Division covers dental services provided by a licensed AHCCCS-registered dentist.

1. Covered dental services for children include:
   a. Check-ups and sealants (prevention against cavities)
   b. Emergency dental services
   c. All medically necessary therapeutic dental services, including fillings.

2. Covered services for adults include medical and surgical services furnished by a licensed AHCCCS registered dentist only to the extent that such services:
   a. May be performed under state law by either a physician or by a dentist (Adult dental services including anesthesia up to $1,000 from October 1st through September 30th, starting CYE 2017) and
   b. Would be considered physician services if furnished by a physician.

F. Dialysis Services
The AIHP pays for dialysis at certain Medicare-certified hospitals and Medicare-certified End Stage Renal Disease (ESRD) facilities and includes all medically necessary services, supplies, and testing (including regular laboratory testing).

G. Vision Services
The AIHP pays for vision services provided by ophthalmologists and optometrists. There are limits based on the member’s age and eligibility.
H. Transportation for Medical Appointments

The AIHP pays for non-emergency medical transportation to and from covered medical appointments. A doctor or other health care provider may need to obtain approval (prior authorization) from the Division before transport.

I. Transportation From a Hospital to Another Facility

Prior authorization is required for round-trip ground ambulance transportation for members who require a transfer to another facility for special services if:

1. Use of any other type of transportation may be unsafe
2. Unable to obtain the needed services at the hospital where a member is currently located.

AHCCCS-contracted behavioral health providers must identify, and communicate to their subcontracted providers and eligible members, any behavioral health services that require authorization and the relevant clinical criteria required for authorization decisions.

The Service Approval Matrix for prior authorizations for Home and Community Based Services can be found on the Arizona Department of Economic Security website. Provider claims cannot exceed the hours documented on the ALTCS Member Service Plan (DDD 1500A). Providers must deliver services/tasks based on the member’s Planning Document including the Service Evaluation.
CHAPTER 18 - CLAIMS MEDICAL REVIEW

REVISION DATE: 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Mercy Care Plan; Care 1st; Arizona Physicians, IPA

The Division reserves the right to review any and all claims for eligible members who were provided covered services for which a provider is requesting or has requested payment from the Division. The Division’s acute care health plans may employ their own claims medical review processes. Providers may refer to the appropriate acute care health plan’s website for further information.
CHAPTER 19 CONCURRENT REVIEW

REVISION DATE: 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

EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 455.2; A.R.S. §§ 46-451 and 13-3623

Overview

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 prevention, detection, and reporting of FWA.

Policy Objectives

A. Prevent or detect fraud, waste, and abuse
B. Delineate reporting requirements
C. Describe training requirements
D. Specify policy requirements for providers

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 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.


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 FCA.

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)

1. An act of fraud has been committed when a member or provider:
2. Knowingly presents (or causes to be presented) to the Federal Government a false or fraudulent claim for payment.
3. Knowingly uses (or causes to be used) a false record or statement to get a claim paid by the Federal Government.
4. Conspires with others to get a false or fraudulent claim paid by the Federal Government.
5. 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. **Internal Audit Administration (IAA)** – 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.

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

Division Monitoring

The Division:

A. Reviews all participating providers during the credentialing/certification process (including re-credentialing)

B. Monitors providers for non-compliance with Division contracts, rules, policies and procedures, in addition to AHCCCS policies

C. Verifies as part of Prior Authorization:
   1. Member eligibility
   2. Medical necessity
   3. Appropriateness of service being authorized
   4. Service being requested is a covered service
   5. An appropriate provider referral.

The Division’s electronic claims processing application executes over 150 pre-payment edits ensuring payment accuracy and guarding against fraud, 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 reviews 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 to referred to the Corporate Compliance Unit for review and potential referral to the AHCCCS OIG.

**Provider Requirements**

A.  **Training and Education**

As a condition for receiving payments, 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:

1. Detailed information about the Federal False Claims Act,
2. The administrative remedies for false claims and statements,
3. Any State laws relating to civil or criminal liability or penalties for false claims and statements, and
4. The whistleblower protections under such laws.

B.  **Reporting Fraud, Waste and Abuse**

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

1. Call the toll free DES/DDD Hotline at 877-822-5799.
3. Mail to:

   DES/DDD
   Attention: Corporate Compliance Unit,
   1789 W. Jefferson Street
   Phoenix, AZ 85007
4. Email: DDDFWA@azdes.gov

5. Contact AHCCCS through their website: https://www.azahcccs.gov/Fraud/AboutOIG/
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.
The formulary or Preferred Drug List (PDL) is a list of all the preferred medications covered by a health plan. Any authorized provider may prescribe prescription drugs. Prescriptions should be written to allow for generic substitution whenever possible for cost effectiveness. Providers can cover more drugs than are listed but not less. When the Division receives formulary updates from AHCCCS, they are reviewed and sent to the Division’s Pharmacy Benefits Manager for eligible American Indian members. The Division’s subcontracted health plans receive formulary updates from AHCCCS and post updates to formulary information on their websites. For medications not found on the formulary, the prior authorization process should be followed.

A. The Division of Developmental Disabilities delegates the medical services to the subcontracted health plans. Subcontracted health plans’ formularies are found at:

B. The Division uses MedImpact for eligible American Indian members. Refer to the formulary:
   https://www.azahcccs.gov/PlansProviders/Pharmacy/

C. To receive pharmacy updates directly from AHCCCS, subscribe at:
   https://www.azahcccs.gov/PlansProviders/Pharmacy/

D. A list of medication by classification and brand/generic names can be found at:
   https://www.azahcccs.gov/PlansProviders/Pharmacy/
CHAPTER 23 - APPOINTMENT STANDARDS

REVISION DATE: 1/16/2019, 5/13/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 438.206.

The Division monitors and reports appointment accessibility and availability to ensure compliance with Division standards set forth in contract, Division Operations Policies 415 and 417 and 42 CFR 438.206.

Medical/Dental/Behavioral Health Appointments

A. Appointment Scheduling

1. For PCP appointments, members must be provided:
   a. Emergency appointments the same day or within 24 hours of the member’s phone call or other notification, or as medically appropriate
   b. Urgent care appointments as quickly and efficiently as the member’s health condition requires but no later than two business days of request
   c. Routine care appointments within 21 calendar days of request.

2. For specialty provider appointments, members must be provided:
   a. Emergency appointments within 24 hours of referral
   b. Urgent care appointments as quickly and efficiently as the member’s health condition requires but no later than three business days from the request
   c. Routine care appointments within 45 days of referral.

3. For behavioral health:
   a. 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 request for service
         • The first behavioral health service following the initial assessment as quickly and efficiently as the member’s health condition requires but no later than 23 calendar days after the initial assessment
         • 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.

b. For psychotropic medications:
   i. The urgency of the need is assessed immediately.
   ii. 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.

4. For dental appointments, members must be provided:
   a. Emergency appointments within 24 hours
   b. Urgent appointments as quickly and efficiently as the member’s health condition requires but no later than three business days of request
   c. Routine care appointments within 45 days of request.

5. For maternity care appointments, members must be provided initial prenatal care appointments:
   a. In the first trimester within 14 days of request
   b. In the second trimester within seven calendar days of request
   c. In the third trimester within three business days of request
   d. High risk pregnancies as quickly and efficiently as the 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.

B. Office Wait Times

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

C. Transportation

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

1. Arrives on time but no sooner than one hour before the appointment
2. Is not picked up prior to the completion of the appointment
3. Is not required to wait more than one hour after the conclusion of the appointment for transportation home.

**Critical Services**

Critical services are Attendant Care (ATC), Homemaker (HSK) and Respite (RSP).

A. **Provision of Critical Service**

Qualified Vendors must provide critical services:

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

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

B. **Gaps in Critical Service**

A gap in critical service is the difference between the number of hours of home care scheduled in each member’s planning document and the hours of the scheduled type of critical service that are actually delivered to the member. See Chapter 62 Qualified Vendor Management of Gaps in Critical Services for additional information on Gaps in Critical Service.
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

REVISION DATE: 6/10/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: Civil Rights Act of 1964 Public Law § 88-352

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

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

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

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

The Division acts in accordance with contractual obligations, state and federal codes and laws, including the Civil Rights Act of 1964 Public Law § 88-352 which prohibits discrimination in government agencies.
CHAPTER 27 - PEER REVIEW AND INTER-RATER RELIABILITY

REVISION DATE: 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013

This policy defines 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. 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.

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 essentially 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 will be included in the credentialing and contracting process for providers.

The provider receives documentation of the findings and recommendations of the peer review. A provider may dispute findings or recommendations that could include an action that affects the provider’s credentials or contract with the Division. 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. 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 final outcome.

Inter-rater reliability ensures consistency with which individuals involved in decision-making apply standardized criteria in accordance with adopted practice guidelines. The Division ensures that data is collected by more than one qualified person and has validity as established by inter-rater reliability process of random audits and other methods.

The Division delegates medical services including the peer review process pertaining to medical services to the subcontracted health plans. 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.
CHAPTER 28 - MEMBER RIGHTS

EFFECTIVE DATE: March 29, 2013

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

      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: 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR 438.100(B)(2), 42 CFR 438.100(B)(2)(iv), 42 CFR 438.102

Pursuant to 42 CFR 438.102, the Division of Developmental Disabilities 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 his or her patient for the following:

A. The member’s health status, medical care, or treatment options including any alternative treatment that may be self-administered

B. Any information the member needs in order to decide among all relevant treatment options

C. The risks, benefits, and consequences of treatment or no treatment

D. The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
CHAPTER 30 – CLINICAL PRACTICE GUIDELINES

EFFECTIVE DATE: March 29, 2013

The Division of Developmental Disabilities (Division) has developed guidelines for its providers, members, and staff, to use. The Division reviews these guidelines at least annually and uses them when determining medical necessity.

Links to the clinical practice guidelines (CPGs) used by the Division and the Division’s contracted health plans are provided on the Individuals & Families page and the Providers & Vendors/Resources page of the Division’s website.
CHAPTER 31 - CHANGE OF CONTRACTOR

REVISION DATE: 5/26/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: A.R.S. § 36-2944

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

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

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.

Members may have extenuating circumstances that necessitate changing contractors outside of the member’s annual enrollment choice. If it becomes necessary to change the Acute Care Health Plan outside of the open enrollment timeframe, the member/responsible party must contact the Division’s Liaison for the current health plan or the Division’s Member Services Unit.

AHCCCS Contractor Operations Manual (ACOM) Policy 402 documents and delineates the rights, obligations and responsibilities of:

A. The member
B. The member’s current health plan
C. The requested health plan
D. The Division.

This includes facilitating continuity of care, quality of care, efficient and effective program operations, and in responding to administrative issues regarding member notification and errors in assignment.
**CHAPTER 32 - SEPARATION OF CHILDREN AND ADULTS IN CENTER-BASED PROGRAMS**

**REVISION DATE:** 3/25/2016, 8/1/2014  
**EFFECTIVE DATE:** April 16, 2014  
**INTENDED USER(S):** Network staff, Quality Assurance staff, and Qualified Vendors

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

**Definitions**

Children - any member 17 years of age or younger.

Adults - any member 18 years or older.

**Requirements**

A. Separation of children and adults is required to ensure the health and safety of Division members at all times.

B. Each site must have one area designated solely for children and one area designated solely for adults to prevent any interaction between the two age groups.

C. Each site shall provide a physical and visual barrier separating the two areas. Separate areas shall include:

1. Bathrooms, and
2. Any interior space used for instruction, play, or similar activities.

D. The site may have common areas (e.g., kitchens, hallways, storage areas, reception areas, building entrances) accessible by both children and adults.

E. The Qualified Vendor shall provide the Division with written policies that include efforts to minimize contact between children and adults in a manner that will maintain the health and safety of all members.

F. During the delivery of the service, transportation of children must be provided separately from transportation of adults.

G. District Network and/or Quality Assurance staff will work collaboratively with Qualified Vendors to review service sites and offer technical assistance to meet these requirements.

H. Qualified Vendors shall meet these requirements.
Requests for Change in Process or Policy

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

The request will include:

1. The reason(s) for the request; and,
2. The proposed means by which the following will be met:
   i. The health and safety of members and/or staff; and,
   ii. The intent of the contract.

B. Approval shall be made at the sole discretion of the Division and may include a site visit.

C. Upon approval of the request, the Qualified Vendor will provide the Division a template “Letter of Notification” to be sent to all current and prospective members/legally responsible person(s) informing them of the change in process or policy regarding the separation of children and adults.

1. When substantial changes to the physical location or member participation occur which may affect an approved request, the Qualified Vendor shall provide written notification to the Division of anticipated changes within five business days.

2. Qualified Vendors may exercise the remedy outlined in R6-6-2115 when in disagreement with a Division decision.
CHAPTER 33 - ASSESSMENT REQUIREMENTS FOR MEMBERS PLACED IN RESIDENTIAL SETTINGS

REVISION DATE: 10/9/2015, 4/1/2015
EFFECTIVE DATE: July 31, 1993
REFERENCES: A.A.C. R6-6-806(B)

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

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

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

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

In addition, the Planning Team (Individual Support Plan/Individualized Family Services Plan team) must ensure that additional evaluations and assessments are identified and obtained.
CHAPTER 34 – PROVIDER PUBLICATIONS

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

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

Qualified Vendor Responsibilities

A. Reports or publications requiring review by the Division include but are not limited to:
   1. Newsletters
   2. Flyers referencing the Division or Division services
   3. Fact Sheets
   4. Website Content
   5. Radio or TV Presentations

B. The following information does not require review by the Division:
   1. Changes to office locations, hours, or phone numbers
   2. Information regarding staff (Staff Profiles)
   3. Links to resources on website
   4. Daily/Weekly Emails

C. All submitted reports or publications must be in:
   1. Compliance with AHCCCS policy, Division policy, state laws, Provider Manual, and the Qualified Vendor Agreement.
   2. An editable word document, not pdf; and,
   3. 6th grade or below reading level.
   4. Must include the following statement on printed material:
Under Titles VI and VII of the Civil Rights Act of 1964 (respectively “Title VI” and “Title VII”) and the Americans with Disabilities Act of 1990 (ADA) Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975, (insert Qualified Vendor name here) prohibits discrimination in admissions, programs, services, activities or employment based on race, color, religion, sex, national origin, age, and disability. The (insert Qualified Vendor name here) must make a reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. Auxiliary aids and services are available upon request to individuals with disabilities. For example, this means that if necessary, the (insert Qualified Vendor name here) must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the (insert Qualified Vendor name here) will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy please contact: (insert Qualified Vendor contact person and phone number here) Para obtener este documento en otro formato u obtener información adicional sobre esta política, (insert Qualified Vendor contact person and phone number here)”.

D. Audio materials must include the script.

E. The Qualified Vendor shall submit each report or publication to (DDDProviderPublications@azdes.gov) a minimum of 30 calendar days prior to the anticipated date of delivery or publication. The submission will include the following:

1. Email address and phone number for the employee from the Qualified Vendor who can best answer questions regarding the publication.

2. The name of the Qualified Vendor agency as listed on its Qualified Vendor Agreement.

F. If the Qualified Vendor does not receive a response by the 30th calendar day following submission to the Division, the Qualified Vendor may move forward with the publication.

G. If the Division expresses concern(s) with the information provided on the submitted report or publication, the Division will explain the concern(s) and the Qualified Vendor shall not move forward with the report or publication until the Division and Qualified Vendor have agreed upon a resolution of the concern. If the Division and Qualified Vendor are unable to resolve the concern, the Qualified Vendor may pursue review as provided in A.A.C. R6-6-2117.
Division Responsibilities

A. Upon receipt of the draft report or publication from the Qualified Vendor, the designated Division employee will initiate the review as described above.

B. Failure of DDD to comment on any submitted report or publication does not waive any subsequent action or constitute approval of the report or publication.
CHAPTER 35 - PROGRESS REPORTING REQUIREMENT

EFFECTIVE DATE: July 1, 2013

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

Elements of Progress Notes

A. The Division of Developmental Disabilities (Division) does not have a required format to be used for progress reports (except as set forth below in Section D of Progress Reports and Reporting Requirements), but the following minimum elements must be included:

1. Overall progress specific to planning document outcomes
2. Performance data that identifies the member’s progress toward achievement of the established outcomes
3. Current and potential barriers to achieving outcomes
4. Written summary describing specific service activities
5. Additional requirements as specified below.

B. The Division does not require periodic progress reports for:

1. Attendant Care
2. Housekeeping
3. Respite
4. Transportation.

C. 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.

Progress Reports Submission Instructions

Progress reports will 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).
**Progress Reports Schedule and Reporting Requirements**

The required due dates for the progress reports by service are listed below.

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
   
   Submit reports to Health Care Services with a copy to the Support Coordinator.

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, disclose any calendar month when the member is not engaged in paid work for at least 75% of the scheduled work hours for that member.

2. Day Treatment and Training, Adult
3. Day Treatment and Training, Child (After School)

4. Employment Support Aide

   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 in regard to 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. Therapies (Occupational Therapy, Physical Therapy, Speech Therapy)

   In addition to the minimum requirements of the progress report, the reports must also include: the Division’s therapy reporting requirements as identified on the Division’s Quarterly Therapy Progress/Discharge Report form.


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
D. Quarterly Progress Reports (Specialized Habilitation Services)

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
      i. Name
      ii. AHCCCS ID
      iii. DOB
      iv. Developmental Disability diagnosis or diagnoses
      v. Behavioral Health diagnosis or diagnoses
      vi. 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?

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:
Division of Developmental Disabilities
Provider Policy Manual
Chapter 35
Progress Reporting Requirement

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:
a. Individualized discharge criteria developed with specific, realistic, and timely follow-up care coordination recommendations
b. Plan for maintenance and generalization, including how and when this service will be transitioned to other lesser intensive services
c. 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

   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.

3. Group Supported Employment

4. Individual Supported Employment.
CHAPTER 36 - FIRE SAFETY

REVISION DATE: 10/9/2015, 7/3/2015, 10/30/2014
EFFECTIVE DATE: January 15, 1996
INTENDED USER(S): Group Home Qualified Vendor
REFERENCE: A.A.C. R9-33-201; A.A.C. R9-33-202

FORM: Fire Risk Profile (DD-254)

Fire Risk Profile

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

Instructions for Completing the Fire Risk Profile

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

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

A. Social Adaptation - This factor rates the member’s willingness to assist others and to cooperate in the evacuation process.

   1. Positive - the member is generally willing to assist others as far as they are able and can participate in a "buddy system" - helping or alerting anyone close to them in a fire emergency that needs assistance to evacuate. The member’s physical ability to help shall not be considered for this item because it will be addressed under other factors. (Rating of 0)

   2. None - the member does not usually interact with others in everyday situations and, therefore, could not be expected to assist or alert others in a fire emergency. (Rating of 8)

   3. Negative - the member does not interact well with others and exhibits frequent disruptive behavior. They are likely to be uncooperative. (Rating of 16)
B. Mobility Locomotion- This factor rates the member’s physical ability to initiate and complete an evacuation.

1. Within Normal Range - the member is physically able to initiate and complete an evacuation. (Rating of 0)

2. Speed Impairment/Needs Some Assistance - the member may require some initial staff assistance, e.g., getting out of bed, getting into a wheelchair, but can continue an evacuation without further assistance and within the three (3) minute timeframe. (Rating of 50)

3. Needs Full Assistance - the member may require the full attention/assistance of a staff throughout the evacuation. (Rating of 100)

C. Response to Instruction - This factor concerns the extent to which a member can receive, comprehend and follow through with simple instructions from staff. Evaluate the amount of guidance required to be reasonably certain that members will follow through with instructions given during an evacuation. Consider only the member’s abilities to follow instructions; behavior under stress and sensory impairment are rated as separate factors.

1. Follows Verbal Instructions - the member reliably comprehends, remembers and follows simple, brief instructions stated verbally or in sign language. (Rating of 0)

2. Needs Physical Guidance - the member does not always understand and follow directions; therefore, the member may need to be guided, reminded, reassured or otherwise accompanied during the evacuation, but will not require the exclusive attention of a staff. (Rating of 12)

3. Does Not Respond to Instructions - the member does not respond to instructions or general guidance. The member may require considerable assistance and most of the attention of a staff during the evacuation. (Rating of 24)

D. Behavior Under Stress - This factor concerns the member’s ability to cope with stress in an emergency.

1. No Significant Change - the member will probably experience a level of stress that will not markedly interfere with their ability to evacuate. (Rating of 0)

2. Delayed Reaction - the member may react to a fire emergency with confusion, slowed reaction, poor adaptability to hazards or demonstrates a moderate risk for seizure activity that disables the member for no more than 30 seconds. (Rating of 8)

3. Significant Risk - the member may react to a fire emergency with physical resistance, unresponsiveness to evacuation or demonstrates a high risk for seizure activity that disables the member for longer than 30 seconds. (Rating of 16)
E. Fire Awareness - This factor concerns the member’s ability to appropriately respond to fire related cues. Fire related cues include smoke, flames, fire alarms, and warnings from others. Evaluate how well the member is likely to perform in response to such cues, assuming that no one may be available to give them instructions at the time of the emergency.

1. Will Evacuate When Signal is Present - the member will probably initiate and complete an evacuation in response to signs of an actual fire, warnings from others or a fire alarm. Also, the member will probably avoid the hazards of a real fire such as flames and heavy smoke. (Rating of 0)

2. Responds to Signals - Needs Assistance to Avoid Hazard - the member will probably respond to an actual fire, warnings from others or a fire alarm; however, the member may not satisfactorily avoid the hazards of a fire or probably cannot complete the evacuation without assistance. (Rating of 8)

3. No Fire Awareness - Needs Assistance - the member does not respond to signs of an actual fire, warnings of others; or a fire alarm. The member should be closely attended by staff during an emergency evacuation. (Rating of 16)

F. Hearing/Sight Impairment - This factor evaluates any sensory impairment which, without adaptations, limits the member's ability to evacuate.

1. Within Normal Limits/Impairment Doesn’t Impact Evacuation - the member may have a severe hearing or sight loss but requires no assistance in case of fire evacuation. Consider special features in the home such as a strobe light or bed vibrator alerting systems. When special features are in the home, a member may be able to evacuate without assistance. (Rating of 0)

2. Impairment Assistance Needed to Start Evacuation - the member has severe hearing and/or sight loss and needs to be alerted to the presence of the fire emergency, but otherwise could evacuate without assistance. (Rating of 10)

3. Impairment Assistance Needed Throughout Evacuation - the member has severe hearing and/or sight loss and needs guidance or other assistance in order to evacuate. (Rating of 20)

G. Medication - This factor evaluates the impact of any medication on a member’s ability to evacuate.

1. None - the member does not take medication which can affect their ability to evacuate. (Rating of 0)

2. Maintenance Medication - the member routinely takes medications which can have some effect on the central nervous system, e.g., seizure controlling, antihistamines, mild tranquilizers, stimulants. The primary purpose of these medications is not to induce sleep. The member may need some assistance to evacuate. (Rating of 4)

3. Medication For Sleep - the member routinely takes medication for the primary purpose of inducing or maintaining sleep. (Rating of 8)
Fire Safety Requirements

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

Level I Fire Safety Requirements

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

A. The facility’s street address is painted or posted against a contrasting background so that the group home’s address is visible from the street; and if posting is not possible, local emergency services have been notified of the location of the home on at least an annual basis.

B. Smoke detectors are working and audible at a level of 75db from the location of each bed used by a resident in the facility and/or capable of alerting all residents in the facility, including a resident with a mobility or sensory impairment. Smoke detectors are located in at least the following areas:
   1. Each bedroom;
   2. Each room or hallway adjacent to a bedroom, except a bathroom or a laundry room; and,
   3. Each room or hallway adjacent to the kitchen, except a bathroom, a pantry, or a laundry room.

C. A minimum of one working, portable, all-purpose fire extinguisher labeled as rated 2A-10-BC by Underwriters Laboratories, or two collocated working, portable, all-purpose fire extinguishers labeled as rated at least 1A-10-BC by Underwriters Laboratories installed and maintained in the facility as prescribed by the manufacturer or the fire authority having jurisdiction.
   1. The provider shall ensure that a fire extinguisher is either disposable and has a charge indicator showing green or ‘ready’ status; or has been serviced annually by a fire extinguisher technician certified by the National Fire Protection Agency, the International Code Council, or Compliance Services and Assessments.
   2. If serviced and tagged, the documentation must include date of purchase or the date of recharging, whichever is more recent and the name of the company or organization performing the service, if applicable.

D. All stairways, hallways, walkways and other routes of evacuation are free from obstacles that prohibit exit in case of emergency.

E. Each sleeping room has at least one operable window or door that opens onto a street, alley, yard or exit court for emergency exit.

F. Locks, bars, grilles, grates or similar devices, installed on windows or doors which are used for emergency exit, are equipped with release mechanisms which are operable from the inside without the use of a key or special knowledge or effort.
G. A floor plan of the setting is available which designates the routes of evacuation, location of firefighting equipment and location of evacuation devices.

H. The setting has a working non-cellular telephone that is available and accessible to staff and each resident at all times.

I. Emergency telephone numbers for fire, police and local emergency medical personnel, or 911, as appropriate for the local community, and the address and telephone number of the group home are posted near all telephones in the setting.

J. Electrical outlet plates are in good condition and cover the receptacle box.

K. Combustible and/or flammable materials are not stored within three feet of furnaces, heaters or water heaters.

L. As applicable, each operable fireplace in the setting is protected at all times by a fire screen or metal curtain.

M. The premises do not have an accumulation of litter, rubbish, or garbage that may be considered a fire hazard.

**Level II Fire Safety Requirements**

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

A. The setting is in full compliance with the Level I Fire Safety Standards.

B. The setting is equipped with back-up lighting designed to illuminate a path to safety in case of power failure (independent of in-house electrical power) and that this system is inspected at least annually by the manufacturer or an entity that installs or repairs emergency lighting systems.

C. The group home setting has one of the following:
   1. Sufficient staff on duty to evacuate all residents present at the facility within three minutes; or,
   2. An automatic sprinkler system installed according to the applicable standard by reference in A.A.C. R9-1-412 and installed according to NFPA 13, 13R, or 13D and that covers every room in the entire facility. The automatic sprinkler system is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs automatic sprinkler systems.

D. The group home setting is equipped with an early warning fire detection system that:
   1. Is safety approved.
   2. Shall either be hard wired or connected wirelessly, with battery back-up, and shall sound every alarm in the setting when smoke is detected.
3. Is installed in each bedroom, each room, or each hallway adjacent to a bedroom, and each room or each hallway adjacent to a kitchen.

4. Is inspected at least once every 12 months by the manufacturer or by an entity that installs and repairs early warning fire detection systems.

**Fire Inspection**

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

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

**Fire Drill Requirements**

A. An evacuation drill including all residents is conducted at least once every six months on each shift; and,

B. Documentation of an evacuation drill is available for review at the facility for at least two years that includes the date and time, duration (should be completed within three minutes) and a summary of the evacuation drill.

C. If a member of the group home setting has been identified as having a condition that could cause harm if the member participated in an evacuation drill, then:

1. The risk shall be identified in the member’s ISP and will be reviewed annually.

2. The provider will not include the member in the drill and will simulate evacuation of the member.

3. When this condition is identified, the simulation drill may be increased to five minutes.
CHAPTER 37 – RESPONSIBLE PERSON/CAREGIVER PARTICIPATION IN THERAPY SESSIONS

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

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

A. Division policy requires a parent/family member or other caregiver (paid/unpaid) to be present and participate in all therapy sessions in order to:

1. Maximize the benefit of therapy services including implementing a home program;
2. Improve outcomes; and,
3. Adhere to legal liability standards.

B. The member’s parent/family member and caregiver are expected to instruct all other caregivers regarding the therapeutic activities that comprise the home program.

C. If the parent/family member/caregiver does not participate in a therapy session:

1. The therapy session shall be cancelled;
2. The therapist shall contact the Support Coordinator to discuss the lack of parent/family member/caregiver participation prior to the next therapy session; and,
3. The therapist shall document the reason for the cancellation on quarterly progress notes.

D. When the therapist recommends that the parent/family member/caregiver participate in the therapy session by observing the session outside the eyesight of the member, the therapist shall submit this recommendation via the evaluation or quarterly progress notes. When this type of participation is used:

1. The parent/family member/caregiver shall observe (e.g., one way or two way glass) the therapy session.
2. The therapist must consult with the parent/family member/caregiver prior to the end of the therapy session to discuss the home program.

E. The reasons for the requirement set forth above include:

1. Avoiding the risk of sexual abuse and molestation; and,
2. Ensuring consultation between the therapist and the parent/family member/caregiver to facilitate implementation of the home program.
CHAPTER 38 – EMERGENCY COMMUNICATION WHEN TRANSPORTING A MEMBER

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

For the health and safety of each member, the Qualified Vendor shall ensure that all methods of transportation allow for emergency communication at any time during the delivery of the service. The method of emergency communication shall be appropriate to the geographic area (e.g., two-way radio, a cellular phone, or satellite based communication system).
CHAPTER 40 - INSURANCE

EFFECTIVE DATE: November 10, 2016
REFERENCES: RFQVA DDD-710000

Insurance Requirements

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


Reporting Requirements

Proof of continuous insurance must be provided to the Division:

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

Certificate of Insurance Requirements

A. The QV’s insurance provider is responsible for completing the COI.
B. The QV is responsible for informing the insurance provider of the following requirements:

1. The “Insured” box of the COI must reflect the name of the QV on the agreement and the address must be the same as the vendor address listed in Section 2 of the Qualified Vendor Agreement (QVA).

2. The description section of the COI must include the solicitation number “RFQVA DDD-710000”, and your contract or QVA number.

3. Each COI submitted must reflect the State of Arizona, Department of Economic Security as the “Certificate Holder”. One of the following addresses must be present in the Certificate Holder section of the certificate:

   a. State of Arizona
      Department of Economic Security
      Division of Developmental Disabilities
      Contract Management Unit
      Business Operations – Site Code 791A
b. State of Arizona  
Department of Economic Security  
Division of Developmental Disabilities  
P.O. Box 6123  
Phoenix, AZ 85005-6123  


c. State of Arizona  
Department of Economic Security  
Division of Developmental Disabilities  
1789 West Jefferson St  
Site Code 791-A  
Phoenix, AZ 85007  

4. The COI must include the policy number, effective date, and expiration date for each type of insurance.
CHAPTER 41 – TERMINATION OF THE QUALIFIED VENDOR AGREEMENT UPON REQUEST OF THE QUALIFIED VENDOR

REVISION DATE: 3/25/2016  
EFFECTIVE DATE: April 1, 2015  
INTENDED USER(S): Business Operations staff (Contract Unit and Fiscal Integrity), Network staff, Quality Assurance staff, Support Coordination, Qualified Vendors  
REFERENCES: A.A.C. 6-6-2100 et. seq., A.R.S. §36-2904.G, Division Provider Manual Chapter 34 Provider Publications

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

The Qualified Vendor shall:

A. Provide a 60 day written notice to the Division’s Contract Management Unit setting forth the reasons for requesting termination.

B. Submit a draft of the written notice for members/families and subcontractors, if applicable, regarding the termination to the District’s Network Manager/designee for review and approval. The written notification must:
   1. Be written in 6th grade or below reading level, as specified in Chapter 34 of the Division’s Provider Manual; and,
   2. Include assurance that the Qualified Vendor will assist with transitioning members to alternate providers.

C. Mail approved letter to members/families and subcontractors, if applicable, upon receipt approval of draft letter from the Network Manager/designee and of termination acceptance notification from the Contract Manager/designee.

D. Continue to perform in accordance with the requirements of the Agreement up to or beyond the date of termination as directed in the termination acceptance notice provided by the Contract Manager/designee.

E. Make provisions for continuing all management/administrative services until the transition of members is completed and all other requirements of the Agreement are satisfied.

F. Facilitate any medically-necessary appointments for care and services for members.

G. Assist in the training of personnel, at the Qualified Vendor’s own expense, as required by the Division.

H. Ensure distribution of Client Funds to appropriate parties.
I. Complete and submit copies of all final progress reports and other data elements to the assigned Division Support Coordinator.

J. Pay all outstanding obligations for care rendered to members.

K. Provide the following financial reports to the Division’s Business Operations Fiscal Integrity Unit:
   1. A monthly claims aging report by provider/creditor including *Incurred But Not Reported* (IBNR) amounts;
   2. A monthly summary of cash disbursements; and,
   3. Copies of all bank statements received by the Qualified Vendor in the preceding month for Qualified Vendor’s bank accounts.

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

L. Submit a final claim to the Division for payment, pursuant to A.R.S. §36-2904.G.

M. Upon termination, all goods, materials, documents, data and reports prepared by the Qualified Vendor under the Agreement shall become the property of and be delivered to the State on demand.

N. Retain records as specified in the Agreement.

O. Be liable to the State for any excess costs incurred by the State in procuring materials or services in substitution for those due from the Qualified Vendor.

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

A. The Contract Management Unit will provide written notice of acceptance of such termination and the proposed termination date.

   1. The notification will be issued by the Contract Management Unit and will include information informing the Qualified Vendor of its responsibility to notify members/families and subcontractors in writing of its intent to terminate the Agreement and outlining the transition process.

   2. The Contract Management Unit will send a copy of the termination acceptance notification and the *Transition Roster* to the Division’s Network Manager(s). The *Transition Roster* is for all services being provided by the Qualified Vendor and includes:

      A list of open authorizations by service, timelines for Division Network notification to members and, timelines for transition of members to alternate providers.
B. The Fiscal Integrity Unit will verify the following financial information from the Qualified Vendor:

1. A monthly claims aging report by provider/creditor including *Incurred But Not Reported* (IBNR) amounts.
2. A monthly summary of cash disbursements.
3. Copies of all bank statements received by the Qualified Vendor in the preceding month for Qualified Vendor’s bank accounts.
4. All reports in this section shall be due on the 15th day of each succeeding month for the prior month.

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

The Division’s District will:

A. Review/approve the Qualified Vendor’s written notice to members/families and subcontractors, if applicable, of the intent to terminate the Qualified Vendor Agreement.

B. The Network Manager or designee will notify members in writing of the network change as outlined in the *Transition Roster*.

C. Attend transition meetings with the Qualified Vendor to ensure the smooth transition of members to alternate providers.

D. Update the *Transition Roster* and track the authorizations for each member.

E. Coordinate the transition of authorizations to alternate provider.

F. Ensure all ISP documentation reflects changes.

G. Provide updates on the *Transition Roster* to the Contract Management Unit regarding the transition to its completion.

H. Remove the Qualified Vendor from all Directories.

I. Remove the Qualified Vendor from the Vendor Call Lists.

J. Resolve/close any open issues in the Resolution System, as appropriate.

K. Reconcile all Client Funds for which the Division is Representative Payee.
CHAPTER 42 – ELECTRONIC MONITORING/SURVEILLANCE SYSTEM IN PROGRAM SITES

REVISION DATE: 05/01/2015
EFFECTIVE DATE: April 1, 2015
REFERENCES: A.R.S. §12-2297, A.R.S. §36-551.01

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

The following requirements must be met:

A. Prior to installing or using surveillance and monitoring equipment, the Qualified Vendor must notify the District Network Manager and provide a copy of the policy/procedures/notices that demonstrate there are no violations of the rights of any member as set forth in A.R.S §36-551.01.

B. Electronic surveillance and monitoring equipment and/or service may be used in residential settings in which residing members and their legal representatives, if applicable, request or consent to such surveillance and monitoring.

C. Electronic surveillance and monitoring equipment and/or service may be used in common public settings including but not limited to workshops and employment programs.

D. A sign must be posted in a conspicuous place in each common area that is under surveillance.

E. The sign must indicate the days and hours of surveillance.

F. Surveillance may only be conducted in areas that do not extend to the member’s private space (e.g., bathroom, bedroom).

G. Surveillance records (e.g., tapes) will be maintained in accordance with A.R.S. §12-2297 (Retention of Records) and must be produced upon request of the member or responsible person, the Division, law enforcement, protective agencies, and to other persons and entities entitled to access to public records under the law.
CHAPTER 43 – RESPITE PROVIDED AT CAMP TO ALTCS MEMBERS

REVISION DATE: 3/25/2016
EFFECTIVE DATE: April 15, 2015
INTENDED USERS: Support Coordinators, Qualified Vendors, Network Staff, and Business Operations

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

Definitions

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

Utilization of Respite for Camp

A. Respite begins when the care and custody of the member is transferred to the Qualified Vendor from the primary caregiver.

B. Respite ends when the care and custody is transferred from the Qualified Vendor to the primary caregiver.

C. When the member is transported to camp by the Qualified Vendor, transportation is part of the Respite service.

Number of Units of Respite for Camp

A. The service authorization is determined based on the number of hours the member is in the care and custody of the Qualified Vendor.

B. When the member is receiving 12 or more hours of Respite in a calendar day, the service authorization reflects one unit of Respite Daily. One unit of Respite Daily equals 12 hours of Respite.

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

Friday: 1p.m. – Midnight = 11 hours Respite Hourly
Saturday: All Day = One unit Respite Daily
Sunday: All day = One unit Respite Daily
Monday: Midnight to 10 a.m. = 10 hours Respite Hourly

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

A. Any site used to provide Respite services to ALTCS members must be inspected by the Division’s Office of Licensing, Certification and Regulation (OLCR) as required by the Qualified Vendor Agreement (QVA), Section 7 Service Specification, Respite Service Requirements and Limitations and Title 6, Chapter 18. Article 7 of the Arizona Administrative Code (A.A.C.). [http://www.azsos.gov/public_services/title_06/6-18.htm#Article_7](http://www.azsos.gov/public_services/title_06/6-18.htm#Article_7)

B. Any direct care staff working with Division members must meet all training and background requirements as outlined in the Qualified Vendor Agreement and A.A.C. Title 6, Chapter 6, Article 15. [http://www.azsos.gov/public_services/Title_06/6-06.htm](http://www.azsos.gov/public_services/Title_06/6-06.htm)

C. Staff-to-member ratio must comply with and be billed in accordance with the Division’s Rate Book.

D. All members attending the program must be included in the calculation of staff-to-member ratio.

Camp Related Activity Fees

A. The Qualified Vendor may request activity fees for special camp activities (e.g., horseback riding).

B. Qualified Vendors must offer an alternative activity or may provide scholarships for members who cannot or do not want to pay an activity fee.

C. Ability for a member to pay an activity fee cannot be used to determine program participation.
CHAPTER 44 – QUALIFIED VENDOR RESPONSIBILITIES FOR PLANNING TEAM MEETINGS

REVISION DATE: 9/15/2014, 8/1/2014
EFFECTIVE DATE: October 31, 1993

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

A. Submit assessments, including recommendations, to the Support Coordinator at least five working days prior to the scheduled Planning Team meeting.

B. Write plans of care or teaching strategies necessary to implement assigned outcomes and submit as required in the specific Service Specifications.

C. Submit progress reports as required in the Provider Manual.

D. Participate in the Planning Team meeting:
   1. In person at the location selected by the member;
   2. By phone; or,
   3. By submitting required documents prior to meeting.

E. Complete action items as determined by the Planning Team.

F. Contact the Support Coordinator to suggest a team meeting when the Qualified Vendor becomes aware of significant changes in the member’s condition or status.
CHAPTER 45 - AFTER-HOURS TELEPHONE SURVEY

EFFECTIVE DATE: April 28, 2017

Department of Economic Security/Division of Developmental Disabilities (Division) Network staff conduct telephone testing of Qualified Vendors (QVs) contracted to provide “critical services” (i.e., Attendant Care, Homemaker, or Respite services) to ensure calls made to the QV after business hours are answered immediately or returned within 15 minutes.

Survey Process

A. Division Network staff randomly select the QV to participate in the After-Hours Telephone Survey and call the QV, using the QV’s after-hours telephone number(s) identified in Focus.

Note: All calls conducted Monday through Friday are made between the hours of 8 p.m. and 5 a.m. Calls can be made on the weekends, regardless of time.

B. If the QV answers the call immediately or returns the call within 15 minutes, the Division requires no additional survey-related action from the QV.

C. If the QV does not answer the call and does not return the call within 15 minutes:
   1. Corrective Action Plan (CAP) Submission
      a. Division Network staff will send a CAP request letter to the QV, requiring the QV to submit a CAP to the Division within 14 calendar days from the date of the CAP request letter.
      b. If the QV does not submit a CAP to the Division within 14 calendar days from the date of the CAP request letter, Division Network staff will send a second CAP request letter to the QV, requiring that the QV respond to the Division within five calendar days from the date of the second CAP request letter.
      c. If the QV does not respond to the Division within five calendar days from the date of the second CAP request letter, the Division Contracts Compliance Unit reviews the noncompliance and may follow progressive contractual action as necessary.
   2. CAP Review and Implementation Verification
      a. Division Network staff reviews the CAP and sends a letter to the QV, accepting or rejecting the CAP.
      b. If the CAP is not accepted, Division Network staff will request a meeting with the QV and offer technical assistance if needed.
c. If the CAP is accepted:

i. Division Network staff will conduct three follow-up calls to the QV on different dates/times over three consecutive months.

ii. If the QV answers each after-hours follow-up phone call within 15 minutes as a result of implementing the CAP, Division Network staff will mail a letter to the QV indicating:

- QV is in compliance with the obligation to answer after-hours phone calls within 15 minutes
- CAP is closed.

iii. If the QV is not successful in answering the follow-up after-hours calls, the Division Contracts Management Unit reviews the noncompliance and may follow progressive contractual action as necessary.
CHAPTER 46 – AGENCY WITH CHOICE

REVISON DATE: 4/3/2019
EFFECTIVE DATE: April 1, 2015
REFERENCES: AMPM Chapter 1300 Member Directed Options
FORMS:
Agency with Choice: Individualized Representative (DDD-1658A)
Agency with Choice: Individual Representative (Spanish) (DDD-1658S)
Agency with Choice: Partnership Agreement (DDD-1659A)
Agency with Choice: Partnership Agreement (Spanish) (DDD-1659S)
ALTCS Service Model Options (Decision Tree) (DDD-1626A)
ALTCS Service Model Options (Decision Tree) (Spanish) (DDD-1626S)

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

Division Provider Policy Manual Appendix A QVADS Agency with Choice Selection instructions provides guidance to “Opt-In” as an AWC vendor.

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


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

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

For questions about Opting-In to AWC in QVADS, please call 844-770-9500.
For questions about DDD Policy for AWC, please contact DDDPolicy@azdes.gov.
For questions about AWC billing, please contact DDDClaims@azdes.gov.
CHAPTER 47 MANAGING VENDOR CALL LISTS, PROVIDER DIRECTORIES, SCOPE OF SERVICES AND REPORTING REQUIREMENTS

REVISION DATE: August 21, 2019
EFFECTIVE DATE: April 28, 2017
REFERENCES: A.A.C. R6-6-2103–2106

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.

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 the Qualified Vendor.

A. Background

1. The Division maintains vendor call lists and provider directories for each District to help match members needing service with available providers.

2. The provider directories must identify the provider’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 provider; 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; or
   c. Reducing the amount capacity of service provided or changing the geographical area served. A reduction in the service offered and/or the specific geographical region to be served is referred to as “Diminishing Scope of Service.”

B. Adding a New Service

1. To add a new service to an existing Qualified Vendor Agreement/contract,
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 (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 provider directories to include the service type(s) and geographical area(s) in which the services will be made available by 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’s provider directories and vendor call lists. The notice will include the new vendor, service(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 form.

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 delivery to 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 provider 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’s provider directories and vendor call lists. The notice will 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 Provider 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 informing them of the changes made to the District provider 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. Home and Community Based Services (HCBS) Provider Search

1. The online Provider Search application is located on the DDD website.

2. Qualified Vendors must update and maintain the HCBS Provider 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 located in the Qualified Vendor Application and Directory System (QVADS) Provider Instructions – Provider Search Maintenance (DDD-PS-000-002).

F. 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 provider directories, including changes in linguistic capabilities and special accessibility features; and

2. Update the HCBS Provider Search on the Division’s website within 10 calendar days prior to a change in scope of services.
CHAPTER 48 - CREDENTIALING OF CONTRACTED PROVIDERS

EFFECTIVE DATE: May 26, 2017
REFERENCES: AHCCCS AMPM Policy 950

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, and this policy pertains specifically to them.

A. Initial Credentialing

Initial Credentialing occurs after 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 the “good to go” criteria.

2. 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.

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, via letter, that the vendor has been approved and that recredentialing will occur at least every three years thereafter.

B. Provisional Credentialing

If a provider is immediately needed 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 start to provide authorized services.

3. The vendor’s credentialing information will be presented at the next Credentialing Committee meeting for final approval.
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 meet
   h. A 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

EFFECTIVE DATE: May 26, 2017

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.

Vendor Requirements

The Division requires vendors to develop and implement policies and procedures, regarding responsible driving and transporting members, that ensure:

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

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

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

The Division’s Quality Management Unit periodically reviews vendors’ policies and procedures to ensure inclusion of all components.
CHAPTER 50 – VENDOR CALL REQUIREMENTS FOR QUALIFIED VENDORS

EFFECTIVE DATE: February 5, 2018
REFERENCES: A.A.C. R6-6-2101 et seq.; Qualified Vendor Agreement

Responding to Vendor Calls

A. Qualified Vendors must maintain at least one email address on file with the Division of Developmental Disabilities (Division) to receive vendor calls. The Division may send vendor calls to the designated email address. (See Provider Policy Manual Chapter 47, Maintenance of Vendor Call Lists.)

B. Qualified Vendors must designate staff to respond to vendor calls.

C. Interested Qualified Vendors that have qualified staff available to provide service as outlined in the vendor call must respond using the Division’s vendor call system.

D. Qualified Vendors may request additional information about the member prior to the vendor call closing.
   1. If the Division has a signed HIPAA release, Division staff will send a secure email with the member’s additional information. If not, the Division will send a secure email with the member’s personal identifiable information redacted.
   2. Once the Qualified Vendor has reviewed the additional information and available staff have the necessary qualifications based on the member’s needs, the Qualified Vendor must send a response as directed in the vendor call, by the close date.
   3. The vendor response, at minimum, must include the following in order to be considered:
      a. Date provider can start services
      b. Name of Qualified Vendor
      c. Contact Name
      d. Contact Phone Number
      e. Contact Email
      f. Confirmation that the vendor can meet the member’s needs as outlined in the vendor call.

E. Vendor calls will be open for up to five calendar days.
Random Auto-Assignment

A. All vendor responses received by the Division may be used in random auto-assignment, as necessary. Qualified Vendors should not express interest to vendor calls if they do not have staff currently available that are qualified to provide the identified services.

B. If a member/member’s responsible person has not chosen a vendor, the Division will randomly auto-assign a Qualified Vendor from the vendor responses received.
   1. Vendor responses will be entered into a randomizer and one will be identified. The Division uses RAT-STATS 2010 V4: a statistical program designed and used by the U.S. Department of Health & Human Services Office of Inspector General or Focus.
   2. Support Coordination will notify the member/member’s responsible person and the qualified vendor of the selection within one business day.
   3. If the Qualified Vendor determines, subsequent to its selection, that it cannot meet the member's needs, the Qualified Vendor must follow the release process outlined in A.A.C. R6-6-2107(P). Selecting a Provider - Individual Consumers.

Direct Referrals (Calls)

A. When there are no responses to a vendor call, the Division will send Direct Referrals to Qualified Vendors.

B. The Division will contact Qualified Vendors that provide the service in the geographic area of the member and may extend the search to proximal areas or statewide solely at the discretion of the Division.

C. If there is no answer to the telephone call, the Division will send a voicemail and email to the Qualified Vendor. The Qualified Vendor must return the voicemails and emails to the Division within one business day.

D. The Division may continue to call the Qualified Vendor until contact has been made and the Division has verified the vendor’s availability to provide the service.

Vendor Selection

A. The Division must notify the responding Qualified Vendors within 14 calendar days after the due date for Vendor Call Responses as to whether the response meets the needs of the member.

B. The selected vendor must contact the member/member’s responsible person within one business day.

C. The Vendor must acknowledge the service authorization in Focus prior to providing services.
CHAPTER 51- OVERSIGHT AND MONITORING OF DEVELOPMENTAL HOME SERVICES

REVISION DATE: 12/26/2018
EFFECTIVE DATE: August 08, 2018
REFERENCES: ARS 36-591, 36-592; AAC R6-6-1001, R6-6-1101

PURPOSE: To outline the roles, responsibilities, and requirements of the Division, Qualified Vendors, and licensees in the provision of Developmental 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.

Roles and Responsibilities

The Division

The Division reviews, 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 pays Qualified Vendors as outlined in the Division’s Rate Book.

The Division monitors/audits Qualified Vendors at least annually to ensure that they have systems in place to provide oversight for compliance to licensing rules, Division Policies and Procedures, Qualified Vendor Agreement, and best practices. New Qualified Vendors are monitored/audited within six (6) months after implementing the service and annually thereafter. The Division issues corrective actions plans as necessary when issues of non-compliance are identified through its monitoring/auditing system. 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.

Prior to initial licensure and every three years thereafter, the Department conducts a life-safety inspection. A new inspection must be completed if the licensee moves to a new address or completes remodeling.

The Qualified Vendor Agency

Through its licensing staff, the Qualified Vendor is responsible to recruit, train, and provide technical assistance and oversight to applicants and licensed providers of Developmental Home services. 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. The Qualified Vendor also makes payment(s) to the licensee for direct Developmental Home services.

The Qualified Vendor is responsible to review vendor calls and facilitate appropriate placements in Developmental Homes. Only Division members or child siblings of members may be placed in Developmental Homes. Children deemed likely to be eligible for Division
services may be placed upon approval by the Division staff. Qualified Vendors must ensure new placements are not assigned 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.

**Education and Experience**

A licensing worker must have one or more of the following:

- A bachelor’s degree in a related human services field
- Two (2) years of post-secondary education in a related human services field and two (2) years of directly related work experience
- A minimum of five (5) years of directly related work experience. Directly related work experience includes work in the field of developmental disabilities, family home licensing, or child welfare.

A licensing supervisor must meet the requirements of licensing worker and have two (2) years of supervisory experience or demonstrated leadership experience.

A licensing supervisor who is completing the duties of both the supervisor and the licensing worker, it is necessary to meet the higher requirements of the supervisor.

All existing licensing staff must be in compliance with the required education and experience within 24 months of the effective date of this policy.

**Case Load Ratio**

A full-time licensing worker may not be responsible for more than twenty (20) licensed homes for training, technical assistance, and oversight.

**Training**

A licensing worker or supervisor must have a current level I fingerprint clearance card and within the first ninety (90) days of employment complete all of the following training areas:

1. Article 9 *(Requires a certified instructor)*
2. Articles 10 & 11
3. Mandated reporting
4. Incident reporting
5. Cultural Competency
6. HIPAA
7. *Provider Manual Chapter 51; Oversight and Monitoring of Developmental Home services*
8. Prevention & Support *(Requires a certified instructor)*
9. The Placement Process
10. The Planning Process
11. Introduction to the Four Developmental Disabilities
12. Licensing forms & Quick Connect
13. Record keeping
14. Behavior treatment planning
15. Positive Behavior Support
16. Medication management
17. Life safety rules
18. Member fund management
19. Investigations
20. Guardianship and Legal issues
21. The Child and Family Team Process

Licensing workers and supervisors are required to attend the Division’s licensing and home assessment seminar within six (6) months of being assigned to a licensee. In addition, a licensing worker or supervisor is required to complete a minimum of ten (10) hours of training per year.

**Records**

The Qualified Vendor must create an organized system to maintain all licensing documents. The licensing file includes training certificates, Department of Economic Security (DES) forms, and documentation to verify licensing compliance where applicable. The licensing file must be kept in locked storage or secure electronic storage when not in use and made available to the Division upon request. When a licensed provider transfers from one Qualified Vendor to another Qualified Vendor the sending agency must provide a copy of the provider’s licensing file, as outlined in this Chapter. The receiving Qualified Vendor must update any missing items within thirty (30) days of the transfer.

A. The licensing file must include the following DES forms:

1. LCR-1056A: DES Applicant Statement of Understanding
2. LCR-1040A: Health Self-Disclosure/Physician Statement
3. LCR-1034A: Criminal History Self-Disclosure
4. DD-289 or DD-281: Child or Adult Developmental Home Agreement
5. LCR-1031B: Child or Adult Developmental Home Caregiver Assessment Guide (for persons licensed after implementation of this policy).
6. LCR-1054A: Signed Initial Application
7. LCR-1053A: Signed Renewal Application
8. Third Party Agreement

9. LCR-1078A: Developmental Home Application Cover Page

B. The licensing file must include the following documents, as applicable:

1. Training Certificates
2. Fingerprint Clearance Documentation
3. Interstate Central Registry clearance (For Child Developmental Homes; for applicants and household members who have resided outside of Arizona within the prior five (5) years)
4. Three References
5. Marriage License
6. Divorce Decree(s) for the current 10-year period prior to application
7. Birth Certificates (or proof of legal residency)
8. Valid driver’s License for any individuals providing transportation
9. Current Vehicle Registration for any vehicles regularly used to provide transportation
10. Current Vehicle Insurance for any vehicles regularly used to provide transportation
11. Verification of income
12. Immunization records for children
13. Interview Documentation, pre-licensure and renewal
14. OLCR inspection report
15. Evacuation plan
16. Rabies vaccinations for dogs
17. Copy of the actual license
18. Monitoring Forms
19. Incident Reports
20. Licensing investigations and any corrective action plans
21. 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)
Potential Applicants for Developmental Home Licensure

A Qualified Vendor must 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 Department for a developmental home license.

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

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

Applicants for licensure may be married or unmarried persons. No more than two single individuals may be licensed at the same address if they both plan on providing care. This could include a cohabiting couple, a set of adult siblings, or a parent and adult child, or roommates who wish to be licensed together. Married applicants must 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.

C. Medically or physically incapacitated to the degree that the spouse is unable to provide care for a member.

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-placement orientation to each member’s needs and planning documents.

Home Study, Home Visits, and Technical Assistance

Prior to licensure, the applicant and household members must participate in interviews and assist the licensing worker to evaluate the applicant with respect to character, family stability, and the ability to care for persons 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.

The licensing worker must 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 must document all visits in the Division’s licensing data system, Quick Connect (QC). If there are no members placed in the home, only quarterly visits are required.
The licensing worker must perform quarterly license monitoring visits. For the quarterly monitoring visits, the licensing worker must use forms approved by the Division and ensure all forms are filed in the Qualified Vendor’s licensing files.

*Note: New placement visits must be completed within 7 days. For licensees providing care for the first time, a licensing worker must visit the home once per week during the first four weeks of placement.*

A comprehensive licensee visit must 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 ensure compliance with the licensing and life-safety rules.
C. A review of the file (progress reports, medication logs etc.).
D. A discussion of any placement challenges including methods used for managing inappropriate behaviors.
E. A discussion about the progress of the member on his or her 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’s social and recreational activities
M. Interaction or observation of the member in the home setting

Quarterly visits are based on the calendar year. Quarterly visits must be completed by March 31st, June 30th, September 30th, and December 31st. At least one unannounced home visit must be completed each calendar year using the *Abbreviated Developmental Home Compliance Review* (form LCR-1079B).

Visits must be documented in *Quick Connect* within ten (10) business days of the visit. Documentation must include:

A. Date of the visit
B. Type of visit (scheduled or unannounced)
C. Length of the visit
D. Location
E. Individuals contacted during the visit
F. A general visit summary which includes:

1. A summary of key discussion points during the visit
2. A statement identifying the monitoring tool used during the visit
3. 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
4. A statement of any corrective actions needed including a notation of any repeat issues
5. A summary of any items requiring follow-up
6. Verification that the follow up was completed from the last review

Annual renewal is an annual reassessment of character, family stability and the ability to care for persons with developmental disabilities. The annual renewal may be combined with a quarterly monitoring visit. A renewal visit includes interviews with licensees and a setting inspection. During the renewal visit, the licensing worker collects, or reviews documents needed for the renewal application. Renewal applications must be submitted through Quick Connect at least 30 days prior to the expiration of the license.

If a licensing investigation is requested by the Division due to a complaint or significant compliance concern, The Qualified Vendor must contact the licensee and initiate an investigation within ten (10) days. The Qualified Vendor must submit a report to OLCR within 21 days using the Licensing Investigation Template (form LCR-1080A).

At all visits, a Notice of Inspection Rights (form LCR-1005A) must be reviewed and completed. The licensee must receive a copy of any monitoring forms completed during the visit.

**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 must submit to the Division no later than the last day of the reporting month a census of each developmental home it has an agreement with. The census must be submitted on the Division’s approved Census form via secure methods to DDDDevelopmentalHomeCensus@azdes.gov.

Additionally, the Qualified Vendor must notify the Division of all changes in member placement including internal moves (within the agency) or external moves (to another vendor). The moves must be reported on the same form as the monthly Census and to the same email address within two business day of the member moving. The Qualified Vendor must highlight the members who have moved to identify the placement changes.

Finally, using the Census form, the Qualified Vendor must report changes that impact the capacity of a home due to bed holds. A bed hold means that the provider has capacity on the license but plans not to accept a new member placement for a time-limited basis. The Qualified Vendor shall review extended bed holds to determine if a recommendation to reduce the licensed capacity should be made the Division. The bed hold categories include the following and must include and anticipated duration of hold:

A. The developmental home provider identifies family or personal reasons.
B. The home had a recent member disruption.
C. There is an open licensing issue
D. The developmental home provider is currently on a corrective action

The bed hold information must be reported in the comment section of the Developmental Home census form.

**The Licensee**

The licensee is required to maintain a license issued by the Division and ensure that he or she 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.

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 90 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.

A licensee must comply with all home visits conducted by the licensing worker or the Division.

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*
   1. DDD Mission Statement
   2. Individual and family involvement in making choices and expressing preferences.
   3. Equal access to quality services and supports for all individuals.
   4. Individuals as welcomed, participating and contributing members in all aspects family and community life.
   5. The rights of all individuals and the preservation of their worth, value and dignity.
C. Introduction to the Four Developmental Disabilities *
   1. What are the Four Developmental Disabilities?
      a. Cognitive/ Intellectual Disability
      b. Epilepsy
      c. Cerebral Palsy
d. Autism

2. Diagnostic Criteria
3. Functional Criteria
4. Substantial Functional Limitation(s)
5. Treatment

D. The Planning Process and skill building*

1. The planning process
2. Components of a plan
3. Long and short-term goals
4. Measurable objectives
5. Data collection procedures and systems
6. Progress reports
7. Assessing strengths and needs
8. Methods of teaching
9. Types of reinforcement
10. The use of teaching strategies/plans

E. Medication Administration*

1. Medication storage
2. Medication container and label
3. The medication logs
4. Correct dosage
5. Forms of medication
6. Routes of medication administration
7. Medication error procedures

F. Incident Reporting and Reporting Abuse, Neglect, or Exploitation*

1. Understanding the incident reporting process
2. Identifying emergency situations and signs of abuse
3. Understanding mandatory reporting requirements
4. Demonstrating how to complete an incident report
G. Confidentiality/HIPPA*
   1. Limits to access to member records and personally identifiable information
   2. Agency procedures designed to protect/safeguard member confidentiality
   3. Procedures for obtaining consent prior to the release of information.
   4. Review of ARS 36-568.01

H. Choking and Aspiration*
   1. Preventing aspiration and choking
   2. Common issues
   3. Assessment
   4. Intervention and prevention strategies

I. Principles of Positive Behavior Support
   1. Prevention vs. intervention
   2. Recognizing cues
   3. Reinforcing appropriate behavior
   4. Redirection
   5. Consistency
   6. Clear communication
   7. Evaluating the environment
   8. Defensive positioning
   9. Providing opportunities for choices and decision making

J. Cultural Competency (covered for CDH applicants in the ADCS/Foster Parent College Based Pre-Service Training Program)

K. Client Funds Training*

L. Documentation and Progress Reporting Requirements and vendor polices with signed and dated verification of the review.

M. Review of Article 10 or 11 with signed and dated verification of the review.

N. Review of the Child or Adult Developmental Home Third Party Agreement with signed and dated verification of the review.

O. Supporting positive relationships with family members, schools, or day programs and professional communication (covered for CDH applicants in the ADCS/Foster Parent College Based Pre-Service Training Program).
In addition to the DDD specific training noted above:

A. Applicants for a Child Developmental Home license are required to complete the ADCS/Foster Parent College Based Pre-Service Training Program.

B. If required in a member’s planning documents, training in *Prevention and Support* Licensees are additionally required to complete ten (10) hours of training annually.
CHAPTER 52 – DAILY HABILITATION STAFFING SCHEDULE – GROUP HOMES AND INDIVIDUALLY DESIGNED LIVING ARRANGEMENTS

EFFECTIVE DATE: April 3, 2019
REFERENCES: RFQVA #DDD 710000; AHCCCS Medical Manual Chapter 1620-C

This policy describes the process for preparing and submitting a Daily Habilitation Staffing Schedule for approval for Group Homes and Individually Designed Living Arrangements (IDLA) unless otherwise noted.

Criteria

The Qualified Vendor must:

A. Maintain staffing ratios that are determined based on the collective needs of all members at that site.

B. Document, and submit, all Staffing Schedules to the Division for review and approval as follows:

1. For Group Homes, submit the Staffing Schedule through the Program Staffing Application in Focus.

2. For Individualized Designed Living Arrangement – Daily (IDLA – HID):
   b. Submit the Habilitation IDLA Staffing Schedule (DDD-1951A) via email to the appropriate District Network Manager or designee.

Creating and Submitting the Staffing Schedule

The Qualified Vendor must:

A. Create and submit all Staffing Schedules to the District Network following the timelines below:

1. Five business days before:
   a. Members move into an Expansion Home (new Group Home setting approved by the Division) or IDLA – HID setting
   b. All known or planned events (e.g., members moving in/out, school breaks, holidays)

2. Within two business days of all unplanned events (e.g., member hospitalized; unexpected illness or vacation).

B. Submit a new schedule for:

1. Changes in:
a. Occupancy (number of Division members or other individuals (i.e. Department of Child Safety [DCS]) who currently live in the home)

b. Capacity (requires Network pre-approval), for Group Homes only

c. Address

d. Modifiers for Group Homes only

e. Behavioral or medical status (including short term illness) that results in a modification to the staffing range

2. School/holiday breaks and results in a modification to the staffing range

3. Inability of member to attend a day or work program and results in modifications to the staffing range


C. If there is an emergency:

1. Staff the home as appropriate for the immediate circumstance.

2. When the emergency event modifies the staffing range, notify:

   a. Network Manager and/or designee by the next business day, and submit a revised Staffing Schedule with a detailed explanation.

   b. Members’ Support Coordinator as soon as possible, but no later than the next business day.

D. Complete Summary Comments:

1. Identify the member(s) by first and last name.

2. Indicate member(s) who:

   a. Have an approved Behavior Treatment Plan (BTP).

   b. Are eligible for a modifier (nutritional and/or incontinence) for Group Homes only.

   c. Have a work and/or Day Program schedule.

   d. Need additional staffing supports, as outlined in the Planning Documents, for needs including but not limited to:

      i. Behavioral Health

      ii. Medical

      iii. Community
iv. Overnight.

3. Explain the reason for the schedule change.

4. Provide specific details regarding the members’ staffing needs.

Example: “Jackie Doe is on a BTP for physical aggression, receives a nutritional modifier for Boost, which was denied by the Health Plan and requires a 1:1 staff from 4 p.m. to 8 p.m. to assist with mobility as she tends to fall in the afternoons. She works at Red Lobster on Monday, Wednesday, and Friday from 9 a.m. to noon.”

E. IDLA Staffing Schedules:

1. For any temporary changes to the IDLA Staffing Schedule, submit another schedule when the temporary schedule ends.

2. Submit IDLA Staffing Schedules at least annually for approval.

**Annual Daily Habilitation Staffing Schedule Review for Group Homes**

Annually, the Qualified Vendor must:

A. Meet with Network to review daily habilitation Staffing Schedules; the following will be reviewed:

1. **Vacancies and Placement Profiles**
   
   Review information regarding potential housemates

2. **Enhanced Ratios**
   
   a. Compare census to the schedule to ensure it is accurate.
   
   b. Review the information in the comment section regarding enhanced ratio.
   
   c. Verify documentation that enhanced ratio is approved by ISP team.

3. **Modifiers (nutritional and incontinent)**
   
   a. Compare census to the schedule to ensure it is accurate.
   
   b. Review the information in the comment section regarding modifiers.

4. **Capacity**

5. **Residents not funded through the Division, including individuals who are involved with DCS**

6. **Cost Effectiveness**

   The review should result in a mutually agreed upon, appropriate and cost-
effective supports that meets the medical, functional, social and behavioral health needs of the member in the most integrated and least restrictive setting.

7. Summary Comments.

B. Within 14 calendar days following the annual review, submit all agreed-upon updates to the Staffing Schedule to the Division.

C. Maintain all approved staffing schedules.

**Network Approval**

The Network Manager/designee:

A. May create or revise a Staffing Schedule

B. Will review Staffing Schedules with the Qualified Vendor when needed

C. Will approve each Staffing Schedule, as appropriate

D. Will, upon approval of an IDLA – HID Staffing Schedule:
   1. Keep the signed documents with original signatures.
   2. Provide a copy to the Qualified Vendor.
Chapter 57  Third Party Liability

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

REVISION DATE: April 25, 2018
EFFECTIVE DATE: August 5, 2016

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

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

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

“Cost avoidance” refers to the process of denying a claim and returning it to the provider for a determination of the amount of third-party liability.
CHAPTER 57-B  STATUTORY REQUIREMENTS FOR OTHER PAYOR (THIRD PARTY LIABILITY) CLAIMS

EFFECTIVE DATE: August 5, 2016

A. The Arizona Health Care Cost Containment System (AHCCCS) is, by Federal law, the “payor of last resort” in most instances. “Payor of last resort” means that AHCCCS only pays claims after all other forms of payment have been exhausted. According to 42 CFR 433.138, 42 CFR 433.139, and the Deficit Reduction Act (DRA) of 2005, AHCCCS is required to take measures to identify third party payers who are responsible for paying for services provided through AHCCCS and its program contractors.

B. Arizona Revised Statutes (A.R.S.) § 36-2923 requires that private health insurers provide AHCCCS with the enrollment information and respond to AHCCCS requests for claims data necessary to ensure the time period in which the AHCCCS-eligible person or his/her spouse or dependents may or may not have been covered by the health care insurer and the nature of that coverage.

C. Arizona Administrative Code (A.A.C.) R9-22-1002 requires AHCCCS to be the payor of last resort.

D. A.A.C. R9-22-1003 requires AHCCCS to apply the principles of cost avoidance and coordination of benefits.

E. According to A.A.C. R9-22-1001, “cost avoidance” is defined as “to deny a claim and return the claim to the provider for a determination of the amounts of first and third party liability.”

F. Pursuant to A.A.C. R9-22-1003(C), the responsibility to take reasonable measures to identify potentially legally liable first and third-party sources is bestowed upon AHCCCS or its program contractor, a provider, a non-contracting provider, and a member.

G. A.R.S. § 36-596 requires ADES/DDD to act as the payor of last resort unless specifically prohibited by law, and to establish a benefit recovery program for state-funded services for individuals who receive services pursuant to Title 36, Chapter 5.1 of the Arizona Revised Statutes which are covered wholly or partly by a first party health insurance medical benefit.

H. A.A.C. R6-6-1303 governs DD/non-Arizona Long Term Care System (ALTCS) Division-covered services and requires DDD to be the payor of last resort. It also requires service providers to submit Explanation of Benefits (EOB) for claim and payment processing in situations where a DDD member may have other medical benefits.
CHAPTER 57-C PAYMENTS AND DENIALS

EFFECTIVE DATE: August 5, 2016
REFERENCES: A.R.S. § 36-2904

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

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

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

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

EFFECTIVE DATE: August 5, 2016

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

Key Components of EOB

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

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

A. Provider’s Name: Name of the Qualified Vendor.

B. Claim Information: Includes the member/patient name, the member’s group and identification numbers, and the claim number.

C. Service Information: Identifies the health care facility or physician, dates of service and charges, and service or bill code for each specific service.

D. Coverage Information: Shows what was paid to whom, what discounts and deductions were applied, and what part of the total expense was not covered.

E. Information About Amounts Not Covered: Shows what benefit limitations or exclusions apply.

F. Information About Out-Of-Pocket Expenses: Shows an amount when a claim applies toward the deductible or counts toward out-of-pocket expenses.

G. Summary: Highlights the financial information and identifies the amount billed, total benefits approved, and the amount owed to the provider.

H. Reason Denial Codes/Remarks/Comments: Most insurance companies generally use a numbering-based system to reflect the denial reason followed by comments or number-based explanation. Explanation of the denial codes is required for the Division’s waiver process.
Important Considerations

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

B. If the EOB states “prior to the coverage effective date” or “termination of coverage,” the Qualified Vendor must verify the eligibility information with the insurance company. All insurance updates must be provided to the Division TPL Benefits Coordinators at TPLBenefits@azdes.gov.
CHAPTER 57-E DES/DDD WAIVER REQUESTS

REVISION DATE: April 25, 2018
EFFECTIVE DATE: August 5, 2016

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

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

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

Location of the Waiver Request Form

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

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

Required Documents

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

A. COBV Waiver Request (DDD-1651A) properly filled out (see below for more information), and

B. Each corresponding Explanation of Benefits (EOB).

If the EOB does not contain the procedure codes (CPT/HCPCS), include the CMS 1500 form (if applicable).
### Key Components of the COBV Waiver Request Form

The following is information regarding the required fields.

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

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

A. When a Qualified Vendor obtains a denied EOB listing an approved service code and appropriate remarks codes and explanation from the primary insurance or third party payor.

B. If a Qualified Vendor bills for services covered under Medicare Part B, the Qualified Vendor must follow the criteria below to obtain a waiver:
   1. Be a certified Medicare provider.
   2. Submit a *COBV Waiver Request (DDD-1651A)* and a Medicare Part B EOB.

   Note: The waiver requirement is only applicable for Medicare Part B. Billing pertaining to Medicare Parts A, C, and D does not require a waiver.

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

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

**Important Considerations**

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

B. Third Party Liability Exclusions

   The following accounts are not considered as liable third party resources and providers will not be required to bill these types of accounts:
   1. Medical Savings Account (MSA)
   2. Health Flex Spending Arrangement (FTA)
   3. Health Savings Account (HSA)

C. Health Reimbursement Arrangement (HRA), also known as Health Reimbursement Account or Personal Care Accounts, are a type of health insurance plan considered as a Third Party Liability resource, and providers shall bill this type of account.
CHAPTER 57-F DENIAL CODE EXPLANATION AND OTHER PAYOR / THIRD PARTY LIABILITY

EFFECTIVE DATE: August 5, 2016

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

<table>
<thead>
<tr>
<th>Error Description</th>
<th>What it Means</th>
<th>What Should the Qualified Vendor Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Waiver not found and reason code not supplied</td>
<td>The claim submitted does not have a COBV Waiver Request form on file and/or a TPL payment or deductible reported within the claim line of the Uniform Billing document.</td>
<td>Review Focus and ensure a waiver is on file for each active policy. Submit COBV Waiver Request form to <a href="mailto:TPLWaiver@azdes.gov">TPLWaiver@azdes.gov</a>. Submit eligibility information to DDD Claims for an insurance update, if a policy is no longer active.</td>
</tr>
<tr>
<td>2 Number of insurances does not match number of active insurances</td>
<td>There is discrepancy between Focus records and the claim lines provided in the Uniform Billing Document (based on EOB submitted on behalf of the member). Claim lines provided in the Uniform Billing Document have different information (more or less) than what is available in Focus.</td>
<td>Review member’s medical coverage and verify the insurances reported in Focus. If the insurance reported is not found in Focus, the Qualified Vendor should email <a href="mailto:TPLbenefits@azdes.gov">TPLbenefits@azdes.gov</a> for an insurance update. If there are two policies in Focus for the same insurance, the Qualified Vendor should email: <a href="mailto:TPLbenefits@azdes.gov">TPLbenefits@azdes.gov</a> for a review.</td>
</tr>
<tr>
<td>Error Description</td>
<td>What it Means</td>
<td>What Should the Provider Do</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>3 Invalid Insurance Company</td>
<td>The Master Carrier ID (MCID) reported on the claim line of the Uniform Billing Document does not match Focus records.</td>
<td>The Qualified Vendor should review Focus and ensure the Master Carrier ID (MCID) reported in Focus matches the claim lines of the Uniform Billing Document. If the MCID on the claim line does not reflect the MCID in Focus; claim will need adjustment. If the insurance reported is not found in Focus, the Qualified Vendor should email <a href="mailto:TPLbenefits@azdes.gov">TPLbenefits@azdes.gov</a> for an insurance review/update.</td>
</tr>
<tr>
<td>4 TPL amount greater than zero, no insurance on file</td>
<td>The claim line reports a TPL payment; members record shows no insurance on file</td>
<td>The Qualified Vendor should review the member’s medical coverage and verify the reported insurance found in Focus. If the insurance reported is verified, the Qualified Vendor should email <a href="mailto:TPLbenefits@azdes.gov">TPLbenefits@azdes.gov</a> for an insurance review/update.</td>
</tr>
<tr>
<td>5 Pay amount plus TPL amount does not equal rate times unit</td>
<td>This is an indication of the mathematical error. Rate times units minus TPL amount does not match the total amount due.</td>
<td>The Qualified Vendor should check the calculations of the rate times the units minus the TPL amount (if applicable) is equal to the total pay amount. (“Rate” x “Units” – “TPL amount” = “Total pay amount”)</td>
</tr>
</tbody>
</table>
CHAPTER 57-G RESPONSIBILITIES

EFFECTIVE DATE: August 5, 2016

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

Responsibilities for Other Payor (TPL) Documentation

A. The Qualified Vendor must report to TPLBenefits@azdes.gov any updates to the member-specific Other Payor (TPL) information within ten (10) business days of learning of the new information.

B. A Qualified Vendor who has been paid by the Division and subsequently receives reimbursement from an Other Payor (third party) must request a claim reversal and report TPL payment.

C. The Division/AHCCCS makes payments to Qualified Vendors on behalf of members for medical services rendered, but only to the extent that the member has a legal obligation to pay. This means that if a Division member has third party insurance, the Division’s payment will be limited to the member’s responsibility (usually the deductible, copay and/or coinsurance).

D. When a Qualified Vendor receives payment from an Other Payor (third party) in an amount that meets or exceeds the published rate, the Qualified Vendor must report the provision of service on the claim document indicating no amount due from the Division.

E. When a Qualified Vendor receives payment from an Other Payor (third party) in an amount that is lower than the published rate, the Qualified Vendor must report the provision of service on the claim document up to the Division’s contracted rate (the Qualified Vendor can bill the Division for the difference between the Other Payor (third party) paid amount and up to the Division’s contracted rate).
Time Frames - Initial Billing Submission and Resubmissions

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

Billing Codes

Qualified Vendors can only bill for service of categories for which they are approved from AHCCCS. It is the responsibility of the Qualified Vendor to be aware of the most updated CPT/HCPCS codes for billing purposes. CPT/HCPCS codes related with specific category of services may change. Information regarding this topic is available at [http://www.cms.gov/](http://www.cms.gov/) (Center for Medicare & Medicaid Services).
CHAPTER 57-H  PROCESS FOR UPDATING INSURANCE CHANGES IN FOCUS

EFFECTIVE DATE: August 5, 2016

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

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Required Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 New Insurance</td>
<td>• Insurance Card or</td>
</tr>
<tr>
<td></td>
<td>• Member Eligibility Page or</td>
</tr>
<tr>
<td></td>
<td>• Explanation of Benefits (EOB)</td>
</tr>
<tr>
<td>2 Termed Insurance (Policy expired)</td>
<td>• Member Eligibility Page or</td>
</tr>
<tr>
<td></td>
<td>• EOB and</td>
</tr>
<tr>
<td></td>
<td>• 4 Alpha Vendor Code and</td>
</tr>
<tr>
<td></td>
<td>• Service Codes for Billed Services</td>
</tr>
<tr>
<td>3 Duplicate Insurance</td>
<td>• 4 Alpha Vendor Code and</td>
</tr>
<tr>
<td>More than one policy reflected in the system</td>
<td>• Service Codes for Billed Services and</td>
</tr>
<tr>
<td>with similar:</td>
<td>• Details about the policy requested for removal (Policy</td>
</tr>
<tr>
<td>• Insurance company name</td>
<td>number plus Master Carrier ID [MCID])</td>
</tr>
<tr>
<td>• Effective/end dates</td>
<td></td>
</tr>
<tr>
<td>• Policy number</td>
<td></td>
</tr>
<tr>
<td>4 Invalid Insurance</td>
<td>• EOB with denial/rejection indicating member not enrolled</td>
</tr>
<tr>
<td>(Insurance policy does not exist)</td>
<td>(e.g., “member not found”) or</td>
</tr>
<tr>
<td></td>
<td>• The following information from the insurance company</td>
</tr>
<tr>
<td></td>
<td>contacted:</td>
</tr>
<tr>
<td></td>
<td>o Phone number of the insurance company</td>
</tr>
<tr>
<td></td>
<td>o Name of the representative spoken to</td>
</tr>
<tr>
<td></td>
<td>o Reference/confirmation number associated with the call</td>
</tr>
</tbody>
</table>

For all scenarios, member name and member ASSIST ID is required information.
CHAPTER 57-I  OTHER PAYOR (THIRD PARTY LIABILITY) BILLING SCENARIOS

EFFECTIVE DATE: August 5, 2016

Other Payor (TPL) Billing Scenarios

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

Group A - No waiver required, as discussed in Scenarios #1 through #4.
Group B - Waiver required, as discussed in Scenarios #5 and #6.

Group A - No Waiver Required

A. Scenario #1

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

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

2. Detail and Explanation

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

Legend - Uniform Billing Template

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>K</td>
<td>MCID number</td>
</tr>
<tr>
<td>L</td>
<td>Amount paid by insurance company</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

Sample Row - Uniform Billing Template

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>L</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.00</td>
<td>90655</td>
<td>$50.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
B. Scenario #2

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

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

2. Detail and Explanation

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

Legend - Uniform Billing Template

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>K</td>
<td>MCID number</td>
</tr>
<tr>
<td>L</td>
<td>Amount paid by insurance company</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

Sample Row - Uniform Billing Template

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>L</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>TplCode1</td>
<td>TplAmt1</td>
<td>Total Amt Due</td>
</tr>
<tr>
<td>$50.00</td>
<td>90655</td>
<td>$60.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
C. Scenario #3

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

<table>
<thead>
<tr>
<th>Insurance Paid Amount</th>
<th>Division Contracted Rate</th>
<th>Payment To Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>$30.00</td>
<td>$50.00</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

2. Detail and Explanation

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

Legend - Uniform Billing Template

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>K</td>
<td>MCID number</td>
</tr>
<tr>
<td>L</td>
<td>Amount paid by insurance company</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

Sample Row - Uniform Billing Template

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>L</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>TplCode1</td>
<td>TplAmt1</td>
<td>Total Amt Due</td>
</tr>
<tr>
<td>$50.00</td>
<td>90655</td>
<td>$30.00</td>
<td>$20.00</td>
</tr>
</tbody>
</table>
D. Scenario #4

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

1. Scenario: No Payment Issued
   a. If the insurance processes the claim and applies the claim towards the deductible, copay, or coinsurance and does **not** issue a payment. Provider submits monthly billing to Division and no waiver required.
   b. Detail and Explanation

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

   **Legend - Uniform Billing Template**

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>K</td>
<td>MCID number</td>
</tr>
<tr>
<td>M</td>
<td>Deductible Code 01</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

   **Sample Row - Uniform Billing Template**

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>M</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>TplCode1</td>
<td>TplReCode2</td>
<td>Total Amt Due</td>
</tr>
<tr>
<td>$50.00</td>
<td>90655</td>
<td>01</td>
<td>$50.00</td>
</tr>
</tbody>
</table>

2. Scenario: Payment Issued Greater than Division Rate
   a. If the insurance processes the claim and applies a portion of the claim towards the deductible, copay, or coinsurance and makes a payment that is more than the Division contracted rate.

   | Insurance Paid Amount = | $60.00 |
   | Division Contracted Rate = | $50.00 |
   | Payment To Provider = | $0.00 |
b. Detail and Explanation

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

Legend - Uniform Billing Template

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>K</td>
<td>MCID number</td>
</tr>
<tr>
<td>L</td>
<td>Amount paid by insurance company</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

Sample Row - Uniform Billing Template

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>L</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50.00</td>
<td>90655</td>
<td>$50.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

3. Scenario: Payment Issued Less than Division Contracted Rate

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

<table>
<thead>
<tr>
<th>Insurance Paid Amount</th>
<th>$30.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division Contracted Rate</td>
<td>$50.00</td>
</tr>
<tr>
<td>Payment To Provider</td>
<td>$20.00</td>
</tr>
</tbody>
</table>
b. **Detail and Explanation**

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

**Legend - Uniform Billing Template**

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>K</td>
<td>MCID number</td>
</tr>
<tr>
<td>L</td>
<td>Amount paid by insurance company</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

**Sample Row - Uniform Billing Template**

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>L</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>TplCode1</td>
<td>TplAmt1</td>
<td>Total Amt Due</td>
</tr>
<tr>
<td>$50.00</td>
<td>90655</td>
<td>$30.00</td>
<td>$20.00</td>
</tr>
</tbody>
</table>

**Group B - Waiver Required**

A. **Scenario #5**

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

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

**Legend - Uniform Billing Template**

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

**Sample Row - Uniform Billing Template**

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>M</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50.00</td>
<td>$50.00</td>
<td></td>
<td>$50.00</td>
</tr>
</tbody>
</table>

**B. Scenario #6**

1. **Primary insurance does not respond.**
   a. The Qualified Vendor is unable to obtain documentation or resolution from the insurance company, file a grievance with the insurance carrier as all other efforts to procure the documentation have failed.
   b. The Qualified Vendor applies for Waiver Request with the Division.
   c. The Division will use the grievance decision documentation to make appropriate determination regarding the finalization of the waiver process.
   d. The Division processes Waiver Request.
   e. If the Waiver Request is approved, the Division pays contracted rate.
2. Detail and Explanation

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

Legend - Uniform Billing Template

<table>
<thead>
<tr>
<th>Column Name</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Division rate for specific service</td>
</tr>
<tr>
<td>T</td>
<td>Total amount due</td>
</tr>
</tbody>
</table>

Sample Row - Uniform Billing Template

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>M</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>TplCode1</td>
<td>TplReCode1</td>
<td>Total Amt Due</td>
</tr>
<tr>
<td>$50.00</td>
<td></td>
<td></td>
<td>$50.00</td>
</tr>
</tbody>
</table>
CHAPTER 57-J RECOMMENDATIONS FOR WORKING WITH INSURANCE COMPANIES

EFFECTIVE DATE: August 5, 2016

A. Submit a claim to the insurance company as soon as possible after the delivery of service.

B. If no response has been received after 14 days, call the insurance company’s customer service department to determine the status of the claim.

C. If the insurance company has not received the claim, refile the claim.
   1. If sending by mail, stamp the claim as a repeat submission, or
   2. If sending by fax, use a cover note indicating as a repeat submission.

D. If the insurance company has received the claim but considers the billing insufficient:
   1. Supply all additional information requested by the insurance company.
   2. Confirm that all requested information has been submitted.

E. Allow seven (7) more days for the claim to be processed. If there is no response after seven (7) days and all information has been supplied as requested, contact the insurance company again. If the company acknowledges the receipt of the claim and considers the billing valid, but has not responded to the claim, make a note and follow-up with a written request for a response.

F. If there is no response after an additional seven (7) to eight (8) days, based on A.R.S § 20-3102, consider filing a grievance with the insurance carrier, as all other efforts to procure the documentation have failed. "Grievance" means any written complaint that is subject to resolution through the insurer’s system as discussed in A.R.S § 20-3101.

G. The Qualified Vendor may visit Arizona Department of Insurance’s website at www.azinsurance.gov to find information about the grievance process. Grievance documentation should include specific information regarding the claim in question, reason for the grievance, and any supporting information/documents.

H. The Division will require the grievance decision documentation in order to make the appropriate determination in reference to the finalization of the waiver process.
FREQUENTLY ASKED QUESTIONS - APPENDIX

REVISION DATE: April 25, 2018
EFFECTIVE DATE: August 5, 2016

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

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

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

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

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

3. When should a waiver request be submitted?

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

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

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

<table>
<thead>
<tr>
<th>J</th>
<th>K</th>
<th>L</th>
<th>N</th>
<th>P</th>
<th>T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>TplCode1</td>
<td>TplAmt1</td>
<td>TplCode2</td>
<td>TplReCode2</td>
<td>TotalAmtDue</td>
</tr>
<tr>
<td>$50.00</td>
<td>90655</td>
<td>$30.00</td>
<td>94940</td>
<td>01</td>
<td>20.00</td>
</tr>
</tbody>
</table>

**Primary Insurance Company**

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

**Secondary Insurance Company**

In the above example, column N is secondary insurance MCID number, column P is applied to deductible, and column T is total amount paid.
5. **What is the typical turnaround timeframe for waiver request approval?**

Waivers are generally approved within 2-3 business days.

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

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

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

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

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

A waiver is only required for Medicare Part B.

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

The Division issues waivers for Qualified Vendors that are certified Medicare providers. The Medicare Certified Provider must bill Medicare to obtain an EOB showing benefits were denied in order to request a waiver. Refer to the section “DES/DDD Waiver Request Process” for more information on this topic. The waiver request should show the type of services that is being billed and the start date.

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

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

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

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

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

For a detailed response, please refer to the section “Third Party Billing Scenarios - Scenario #4.”
13. **What is the Qualified Vendor’s responsibility if the primary insurance company refuses or fails to issue an EOB?**

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

14. **What is an “MCID”?**

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

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

For a detailed response on this topic, please refer to Chapter 57-H Process for Updating Insurance Changes in Focus of the Provider Manual.
Chapter 58 Medication Management Services

EFFECTIVE DATE: May 13, 2016

The Division allows Primary Care Providers (PCPs) to treat members diagnosed with anxiety, depression and Attention Deficit Hyperactivity Disorder (ADHD). For purposes of medication management, it is not required that the PCP be the member’s assigned PCP. PCPs who treat members with these behavioral health conditions may provide medication management services including prescriptions, laboratory and other diagnostic tests necessary for diagnosis, and treatment. The Division provides for these services both in the prospective and prior period coverage timeframes.
CHAPTER 59  BENEFIT COORDINATION AND FISCAL RESPONSIBILITY FOR BEHAVIORAL HEALTH SERVICES AND PHYSICAL HEALTH SERVICES

REVISION DATE: 10/1/2018, 5/30/2018, 5/26/17
EFFECTIVE DATE: May 13, 2016

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

This policy outlines the fiscal responsibility for physical and behavioral health services, for specific circumstances, and benefit coordination between physical and behavioral health services. Payment for covered behavioral health and physical health services is determined by the principal diagnosis appearing on a claim, except in limited circumstances as described in AHCCCS Contractor Operations Manual (ACOM) 432 Attachment A-Matrix of Financial Responsibility by Responsible Party.

This Policy does not apply to services provided through Indian Health Services (IHS) or Tribally owned and/or operated facilities.

This policy does not address all scenarios involving payment responsibility. For more information not found within this policy, refer to the Division contract (Amendment 62), ACOM 432, and ACOM 432 Attachment A.

Definitions

A. Acute Care Hospital - A general hospital that provides surgical services and emergency services

B. American Indian Health Program - 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. AIHP was formerly known as AHCCCS IHS.

C. Behavioral Health Diagnosis - Diagnoses listed in the Standard Service Set in AHCCCS Reference File (RF) 724.

D. Behavioral Health Entity - The entity, which may be a Contractor or TRBHA, with which the member is enrolled/assigned for the provision of and/or coordination of behavioral health services. Behavioral Health Entities are one of the following:

- Regional Behavioral Health Authority (RBHA)
- Tribal Regional Behavioral Health Authority (TRBHA)
E. **Enrolled Entity** - The entity, which may be a Contractor or AHCCCS FFS, with which the member is enrolled for the provision of physical health services. Enrolled Entities are one of the following:

- Division of Developmental Disabilities (DDD)
- Comprehensive Medical and Dental Program (CMDP)
- American Indian Health Plan (AIHP)

F. **Primary Care Provider (PCP)** - An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member’s health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

G. **Principal Diagnosis** - 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).

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.

**Policy**

A. **General Requirements**

The following apply for physical and behavioral health payments:

1. Regardless of setting, if physical health services are listed on a claim with a principal diagnosis of behavioral health, the Behavioral Health Entity is responsible for payment of covered physical health services and behavioral health services.

2. Regardless of setting, if behavioral health services are listed on a claim with a principal diagnosis of physical health, the AdSS is responsible for payment of covered behavioral health services and physical health services.

3. Payment responsibility for professional services associated with an inpatient stay is based on the principal diagnosis on the professional claim. Payment responsibility for the inpatient facility claim and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim must not be denied by the responsible entity due to lack of authorization/notifications of the inpatient stay regardless of the entity which authorized the inpatient stay.
4. 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, is the responsibility of the AdSS regardless of the Principal Diagnosis on the facility claim. Payment responsibility for professional services associated with the emergency department visit is determined by the principal diagnosis on the professional claim. Payment responsibility for the emergency department visit and payment responsibility for the associated professional services is not necessarily the same entity. Payment of the professional claim must not be denied by the responsible entity due to lack of notification of the emergency department visit.

5. All Division services must 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. The AdSS and Behavioral Health Entities may enter into contracts with providers that delineate other payment terms, including responsibility for payment.

B. Behavioral and Physical Health Responsibilities

1. The following apply to payment for Behavioral Health (BH) services:
   a. The AdSS must coordinate with the 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 must include, but is not limited to: communication/collaboration of authorizations, determinations of medical necessity, and concurrent reviews.
   b. When the Principal Diagnosis on an inpatient claim is a behavioral health diagnosis, the Behavioral Health Entity must not deny payment of the inpatient facility claim for lack of authorization or medical necessity when the AdSS authorized and/or determined medical necessity of the stay through concurrent review, such as when the admitting diagnosis is a physical health diagnosis.

The AdSS is responsible for reimbursement of services associated with a Primary Care Physician (PCP) visit for diagnosis and treatment of depression, anxiety and/or attention deficit hyperactive disorder including professional fees, related prescriptions, laboratory and other diagnostic tests. 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 AdSS is also responsible for payment of medication management services provided by the PCP while the member may simultaneously be receiving counseling and other medically necessary rehabilitative services from the Behavioral Health Entity. For purposes of medication
management, it is not required that the PCP be the member’s assigned PCP.

2. The following apply to payment for Physical Health (PH) services:

The AdSS must cover and pay for emergency services regardless of whether the provider that furnishes the service has a Contract with the AdSS. The AdSS must not deny payment for treatment obtained under either of the following circumstances [Section 1932(b)(2) of the Social Security Act; 42 CFR 438.114(c)(1)(i); 42 CFR 438.114(c)(1)(ii)(A) - (B)]:

   a. A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition 42 CFR 438.114.

   b. A representative of the AdSS (an employee or subcontracting provider) instructs the member to seek emergency medical services.

3. The AdSS must not:

   a. Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, based on diagnoses or symptoms [42 CFR 438.114(d)(1)(i)].

   b. Refuse to cover emergency services based on the failure of the emergency room provider, hospital, or fiscal agent to notify the AdSS of the member’s screening and treatment within 10 calendar days of presentation for emergency services. Claim submissions by the hospital within 10 calendar days of the member’s presentation for emergency services, constitutes notice to the AdSS. This notification stipulation is only related to the provision of emergency services [42 CFR 438.114(d)(1)(ii)].

   c. Require notification of Emergency Department treat and release visits as a condition of payment unless the AdSS has prior approval of the Division.

4. When members present in an emergency room setting, the AdSS is responsible for payment of all emergency room services and transportation for all members regardless of the principal diagnosis on the emergency room and/or transportation claim.

In the absence of a contract between the AdSS and the hospital, the AdSS must reimburse hospitals for inpatient and outpatient hospital services as required by A.R.S. §§ 36-2904 and 2905.01, and 9 A.A.C. 22, Article 7, which includes without limitation:
Reimbursement of the majority of inpatient hospital services with discharge dates on and after October 1, 2014, using the APR-DRG payment methodology in A.A.C. R9-22-712.60 through A.A.C. R9-22-712.81;

Reimbursement of limited inpatient hospital services with discharge dates on and after October 1, 2014, using per diem rates described in A.A.C. R9-22-712.61;

In Pima and Maricopa Counties, payment to non-contracted hospitals at 95% of the amounts otherwise payable for inpatient services.

5. The following apply to payment for Physical Health (PH) services for members residing in the Arizona State Hospital (AzSH):

a. The AdSS must reimburse for medically necessary physical health services under one of the two following arrangements:

i. A contractual agreement with Maricopa Integrated Health Systems (MIHS) clinics including Maricopa Medical Center (MMC) and MIHS physicians, to provide all medically necessary services. MIHS will be assigned to provide primary care services for all members residing in AzSH, or

ii. In the absence of a contractual agreement, the AdSS must be responsible for coordination of care, prior authorization processes, claims payments, and provider and member issues for all services delivered by MIHS. The AdSS must provide a seamless and obstacle-free process for the provision of services and payment.

a. Emergency services for AzSH residents will be provided by the MMC and must be reimbursed by the AdSS regardless of prior authorization or notification.

b. Physical health related pharmacy services for AzSH residents will be provided by AzSH in consultation with the AdSS. The AdSS is responsible for such payment.

iii. Benefit Coordination

The AdSS must coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and A.A.C. Title 9, Chapter 28, Article 9, so that costs for services otherwise payable by the AdSS are cost avoided or recovered from a liable third party [42 CFR 434.6(a)(9)]. The AdSS may require subcontractors to be responsible for coordination of benefits for services provided pursuant to this policy. The two methods that will be used for coordination of benefits are Cost Avoidance and Post-Payment Recovery. The AdSS must use these methods as described in A.A.C. Title 9, Chapter 28, Article 9, federal and state law, and the Division’s Provider Policy Manual Chapter 57 Third Party Liability. For the cost sharing responsibilities for members covered by both Medicare and Medicaid see the Division’s Provider Policy

The AdSS must cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. There are limited circumstances when cost avoidance is prohibited, and then the AdSS must apply post-payment recovery processes. See A.A.C. R9-22-1003.
CHAPTER 60 – PROVIDER NOTIFICATIONS

EFFECTIVE DATE: May 13, 2016

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

Material Change

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

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

Operational Change

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

B. If an overall operational change (e.g., policy, process, protocol) affects, or can reasonably be foreseen to affect, the Division’s ability to meet the performance standards of the Division’s contract with AHCCCS, the Division notifies AHCCCS, Division of Health Care Management, Operations and Compliance Officer at least 60 days prior to the proposed change.

Contract Notifications

The Division makes contract notifications:

A. In writing to provide the reason for declining any written request for inclusion in the network

B. To ensure contract compliance and to document progressive contract action, when necessary.
General Notifications

A. The Division provides notification via provider meetings, email (e.g., Vendor Blast), or US mail:

1. For routine changes and updates to AHCCCS Guidelines, Policy, Manual Changes, and any other information that AHCCCS may require the Division to disseminate on behalf of the Administration

2. For routine changes and updates to Division Guidelines, Policy/Provider Manual

3. For changes to the AHCCCS Minimum Subcontract, within 30 calendar days of the published change

4. To disseminate information designed to bring the providers into compliance with Disease/Chronic Care Management practice guidelines.

B. Qualified Vendors are required to maintain and update Primary Contract Contact information to receive provider notifications.

C. Communication with Independent Providers is via US mail.

D. Communication with Administrative Services Subcontractors (AdSS) is not duplicated if the AdSS is also contracted with AHCCCS.

E. The Division delegates notifications to acute care and behavioral health providers to its Administrative Services Subcontractors.
CHAPTER 61 - HOME AND COMMUNITY BASED SERVICES (HCBS) CERTIFICATION AND PROVIDER REGISTRATION

REVISION DATE: 08/21/2019, 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 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 (IP’s) are individuals that have an Independent Provider Agreement with the Division.
- Qualified Vendors (QV’s) are providers who 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 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 members needs
G. Possession of Cardio-Pulmonary Resuscitation (CPR) certification
H. Possession of First Aid certification (professionally licensed providers exempt)
I. Completion of Article 9 training
J. Submit to a Department of Child Safety Central Registry check
K. Submit 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, provider registration form, and a Provider Participation Agreement (AHCCCS form). 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. Provider Registration-OLCR-HCBS (LCR-1027A)
3. A Provider Participation Agreement (AHCCCS form)
4. 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
5. A copy of the *Criminal History Self Disclosure Affidavit (LCR-1034A)*
6. Applicant Statement of Understanding (LCR-1064A)
7. Statement of Lawful Presence (LCR-1075A)
8. Three reference letters
9. Proof of successful completion of training for CPR, First Aid, and Article 9
10. Declaration of Household Member 18 Year or Older (LCR-1024A) if services will be provided in the applicant’s home

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. An initial application includes:

The online HCBS Certification application includes:

A. A Provider Registration Form (LCR 1077A)

B. A Provider Participation Agreement (AHCCCS form)

C. Disclosure of Ownership/Control and Criminal Offenses Statement(s) (AHCCCS form)

D. A State of Arizona Substitute W-9 and Vendor Authorization form

E. A staff roster of all direct care employees or contractors, including the CEO/President/Owner. The roster must indicate compliance with all applicable HCBS training and background check requirements.

F. Criminal History Self Disclosure Affidavit (LCR-1034A) for the CEO/President/Owner(s) of the agency and all contract signatories.

G. 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.

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. The Life Safety Inspection must be completed every two years thereafter.
**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.

1. The required submission includes: 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.
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 Registration**

A. AHCCCS registration is mandatory. It is required for submission of encounter data to the AHCCCS Administration by the Division.

B. Providers of therapy services must contact AHCCCS directly for registration.

C. Most other HCBS providers (AHCCCS Provider Types 39 and 25) will be registered by OLCR upon completion of the HCBS certification process.

**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. Sign and return attestations found on the Provider Registration section of the AHCCCS website that are applicable to their individual practices or facilities.

C. Meet AHCCCS requirements for professional licensure, certification, or registration.
D. Complete all applicable registration forms.

Questions regarding HCBS certification may be directed to hcbscertification@azdes.gov.
CHAPTER 62 – QUALIFIED VENDOR MANAGEMENT OF GAPS IN CRITICAL SERVICES

EFFECTIVE DATE: September 22, 2017
REFERENCES: AMPM Policy 1620, ACOM 413

This policy applies to Qualified Vendors (QVs) of the Division of Developmental Disabilities (Division). This policy establishes requirements and timeframes for responding to, and reporting, gaps in critical services to Arizona Long Term Care (ALTCS) members receiving:

- Home and Community Based (HCBS) services (Attendant Care [ATC], Homemaker/Housekeeping [HSK] and Respite [RSP])
- Individually Designed Living Arrangement (IDLA) and Nursing services.

**Gaps in Critical Services**

The Division requires the reporting and tracking of gaps in critical services; critical services include:

- ATC, HSK, and RSP, including tasks such as bathing, toileting, dressing, feeding, transferring member to or from bed/wheelchair, and assistance with similar daily activities
- Individually Designed Living Arrangement (IDLA) and Nursing services. IDLA and Nursing services must be submitted as a separate report.

A gap in critical service is the difference between the number of hours of home care scheduled in each qualified member’s planning documents and the hours of the scheduled type of critical service that are actually delivered to the qualified member.

AHCCCS implemented a court order, under the Ball v. Betlach lawsuit, which covers the provision of critical services.

**Requirement to Implement Policies and Procedures**

All QVs that provide in-home ATC, HSK, RSP, IDLA and/or Nursing services must:

A. Implement policies and procedures to identify, resolve, and track gaps in critical services to ensure that appropriately trained additional staff is available within two hours of reporting when the primary staff person is unavailable.

B. Ensure that each member’s service preference level (back-up plan) is met as outlined in the member’s planning document.

**What QV Policies and Procedures Must Include**

The QV’s policies and procedures must, at a minimum, cover the following areas, and be made available to the Division upon request:

A. Information provided to members (verbally and in writing) regarding how to contact the QV when a critical service is not provided as scheduled.
B. Information provided to members (verbally and in writing) regarding their right to receive services as authorized, including the right to have:

1. Any gap(s) in critical services filled within two hours
2. A back-up caregiver to substitute when an unforeseeable gap in critical services occurs.

C. Processes for providing services in the event of a gap in critical services, including a description of the process used to ensure that the QV provides a back-up caregiver in the event of an unforeseeable gap in critical services as outlined in each members’ planning document.

D. System for tracking, trending, and analyzing, to identify when gaps in critical services occur. The results must lead to solutions that will prevent future gaps in critical services.

E. System to remediate identified trends with the support of the member’s planning team, as appropriate.

F. Maintenance of accurate documentation for all grievances that result from gaps in critical services.

Gaps in Critical Services Reporting Requirements

Regardless of whether a gap in critical services occurred during the reporting month, QVs with an open authorization for critical services must submit the following Gap in Critical Service Report Logs monthly:

- ATC, HSK, RSP (Log #1)
- IDLA and Nursing (Log #2).

A. By the 5th calendar day of each month, prepare and submit Gap in Critical Service Logs as follows:

1. Per the “Instructions for Completing the Gap in Critical Services Log” section (below), complete Gap in Critical Service Logs.

   Note: Current instructions and logs are located on the DDD Website, under “Help for Providers”; links are called:

   - Gap In Critical Service Log Instructions
   - Gap In Critical Service Log #1 (ATC, HSK, RSP)
   - Gap In Critical Service Log #2 (IDLA and Nursing)

2. Ensure accuracy in reporting and proper formatting (refer to instructions below) for the member’s and vendor’s identifying information (member AHCCCS ID, Provider Registration Number, Contractor ID).

B. Provide additional and/or clarifying information to the District’s Gap Lead, on the Gap in Critical Services Log, as requested.

**Instructions for Completing the Gap in Critical Services Log**

<table>
<thead>
<tr>
<th>Column Number</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>Contractor ID #</td>
<td>Contractor fills in column with identification number 110306, 110049, etc.</td>
</tr>
<tr>
<td>1.</td>
<td>Provider Registration Number</td>
<td>Provider’s AHCCCS Identification numbers. Column to be filled in by provider or contractor. Ensure that this column is completed.</td>
</tr>
<tr>
<td>2.</td>
<td>Date Called In</td>
<td>The date the agency was notified of the gap in critical service. Use the following format 00/00/00.</td>
</tr>
<tr>
<td>3.</td>
<td>Time Called In</td>
<td>The time the agency was notified. <strong>Use military time</strong> i.e., 08:00, 13:30, etc. Round to the nearest 15-minute increment.</td>
</tr>
<tr>
<td>4.</td>
<td>Gap Date</td>
<td>The date the gap in critical service occurs. This date may be the same as the date in Column 2 or the member may have waited to call. Use the following format 00/00/00.</td>
</tr>
<tr>
<td>5.</td>
<td>Time Service Scheduled to Begin</td>
<td>Insert the time the service was regularly scheduled to begin. <strong>Use military time</strong> i.e., 08:00, 13:30, etc. Round to the nearest 15-minute increment.</td>
</tr>
<tr>
<td>6.</td>
<td>County Code</td>
<td>The county of <strong>residence</strong> code from the following chart.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apache</td>
<td>01</td>
</tr>
<tr>
<td>Cochise</td>
<td>03</td>
</tr>
<tr>
<td>Coconino</td>
<td>05</td>
</tr>
<tr>
<td>Gila</td>
<td>07</td>
</tr>
<tr>
<td>Graham</td>
<td>09</td>
</tr>
<tr>
<td>Greenlee</td>
<td>11</td>
</tr>
<tr>
<td>La Paz</td>
<td>29</td>
</tr>
<tr>
<td>Maricopa</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mohave</td>
<td>15</td>
</tr>
<tr>
<td>Navajo</td>
<td>17</td>
</tr>
<tr>
<td>Pima</td>
<td>19</td>
</tr>
<tr>
<td>Pinal</td>
<td>21</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>23</td>
</tr>
<tr>
<td>Yavapai</td>
<td>25</td>
</tr>
<tr>
<td>Yuma</td>
<td>27</td>
</tr>
<tr>
<td>Column Number</td>
<td>Instruction</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>7.</td>
<td>Member’s Name</td>
</tr>
<tr>
<td>8.</td>
<td>Member’s Zip Code</td>
</tr>
<tr>
<td>9.</td>
<td>Member’s AHCCCS ID</td>
</tr>
<tr>
<td>10.</td>
<td>Select from the following authorized critical service type</td>
</tr>
</tbody>
</table>

**Log #1 ATC, HSK, RSP**

<table>
<thead>
<tr>
<th>Service Type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendant Care</td>
<td>A</td>
</tr>
<tr>
<td>Homemaker</td>
<td>B</td>
</tr>
<tr>
<td>Personal Care</td>
<td>C</td>
</tr>
<tr>
<td>Respite</td>
<td>D</td>
</tr>
</tbody>
</table>

**Log #2 IDLA, Nursing**

<table>
<thead>
<tr>
<th>Service Type</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>IDLA</td>
<td>A</td>
</tr>
<tr>
<td>Nursing</td>
<td>B</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Vendor must use two SEPERATE Gaps in Critical Services Logs:
- Log #1 report gaps in ATC, HSK, and RSP Services
- Log #2 report gaps in IDLA and Nursing.
<table>
<thead>
<tr>
<th>Column Number</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.</td>
<td><strong>Member Critical Service Preference Level at the time of notice (Agency)</strong></td>
<td>Insert the Member Critical Service Preference Level as indicated by the member/representative at the time the provider/agency either receives a call from member advising of a gap in critical service or the provider/agency contacts the member/representative to discuss the member’s current needs. Agencies must obtain from the member/representative the Member Critical Service Preference Level at time of critical service gap notification as a member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now. Column to be filled in by agency/provider.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Critical Service Preference Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs services within 2 hours</td>
<td>1</td>
</tr>
<tr>
<td>Needs services today</td>
<td>2</td>
</tr>
<tr>
<td>Needs services within 48 hours</td>
<td>3</td>
</tr>
<tr>
<td>Can wait until next scheduled day</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column Number</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.</td>
<td><strong>Member Critical Service Preference Level (Contractor)</strong></td>
<td>At time of last Support Coordinator’s visit - Insert the Member Critical Service Preference Level indicated by the member/representative during the initial or reassessment interviews. Column to be filled in by contractors.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Critical Service Preference Level</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs services within 2 hours</td>
<td>1</td>
</tr>
<tr>
<td>Needs services today</td>
<td>2</td>
</tr>
<tr>
<td>Needs services within 48 hours</td>
<td>3</td>
</tr>
<tr>
<td>Can wait until next scheduled day</td>
<td>4</td>
</tr>
</tbody>
</table>
### Column Number | Instruction | Explanation
---|---|---
13. | **Reason for Critical Service Gap** | List the reason the gap in critical service hours occurred. Use the corresponding numerical bullet only. **#4 should be used only when there is an ongoing gap in service.** Provide a brief explanation in Column 24, if “Other” is used.

<table>
<thead>
<tr>
<th>Reason for Critical Service Gap</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Cancelled</td>
<td>1</td>
</tr>
<tr>
<td>Caregiver Did Not Show</td>
<td>2</td>
</tr>
<tr>
<td>Caregiver Left Early</td>
<td>3</td>
</tr>
<tr>
<td>Replacement Caregiver Not Available</td>
<td>4</td>
</tr>
<tr>
<td>Reserved</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
</tbody>
</table>

### Column Number | Instruction | Explanation
---|---|---
14. | **Explain how critical service gap was resolved** | List how the critical service gap was met on the day of the gap. If critical services are not provided on the day of the gap regardless of the reason (i.e., member chose next scheduled visit), the column will be blank. Use the corresponding alphabetical bullet only. The unpaid community organization could be the member’s church or civic organization. The unpaid caregiver could be an unpaid family member, neighbor, friend, etc. who has been designated by the member/representative to assist in an emergency. If an unpaid caregiver is willing to stay with the member until the agency can get another caregiver to the home, use “H.” See scenario #2.

<table>
<thead>
<tr>
<th>Log # 1</th>
<th>Log # 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Explain how critical service gap was resolved</strong> (ATC, HSK &amp; RSP)</td>
<td><strong>Explain how critical service gap was resolved</strong> (IDLA &amp; NURSING)</td>
</tr>
<tr>
<td>Attendant Care</td>
<td>A</td>
</tr>
<tr>
<td>Homemaker</td>
<td>B</td>
</tr>
<tr>
<td>Personal Care</td>
<td>C</td>
</tr>
<tr>
<td>Respite</td>
<td>D</td>
</tr>
<tr>
<td>Unpaid Caregiver</td>
<td>E</td>
</tr>
<tr>
<td>Unpaid Community Organization</td>
<td>F</td>
</tr>
<tr>
<td>Other</td>
<td>G</td>
</tr>
<tr>
<td>Unpaid/Paid Caregivers</td>
<td>H</td>
</tr>
</tbody>
</table>

1. If an “E”, “F” or “H” is recorded in Column 14, then Column 23 must be completed.
2. If “G” is used, include an explanation of “Other” in Column 24. Do NOT use a “G” to indicate that no critical services were provided. **If no critical services are provided leave the column blank.**
<table>
<thead>
<tr>
<th>Column Number</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.</td>
<td><strong>Original Critical Hours Authorized</strong></td>
<td>Enter the amount of critical hours authorized by the Support Coordinator for the date of the gap in critical service.</td>
</tr>
<tr>
<td>16.</td>
<td><strong>Number of Critical Hours Not Replaced</strong></td>
<td>Enter the number of authorized critical hours that were not replaced. For example, the Support Coordinator authorized 4 hours of respite services and 0 hours were filled so a total of 4 hours should be recorded.</td>
</tr>
<tr>
<td>17.</td>
<td><strong>Unpaid hours provided to resolve gap in critical services on the day of the gap</strong></td>
<td>Enter number of unpaid hours provided by all entries in Column 14 above to meet member’s needs. For example, the Support Coordinator authorized 8 hours for attendant care services; agency was able to get a replacement caregiver to provide 6 hours and the unpaid caregiver provided 2 hours until replacement arrived so a total of 2 hours should be recorded. Note: If Column 17 is less than the number of hours authorized in Column 15, Column 20 must be completed.</td>
</tr>
<tr>
<td>18.</td>
<td><strong>Paid hours provided to resolve gap in critical services on the day of the gap</strong></td>
<td>Number of paid hours provided by all entries in Column 14 above to meet member’s needs. For example, the Support Coordinator authorized 4 hours of attendant care and the agency was able to get a replacement for 3 hours and 1 hour was not covered a total of 3 hours should be recorded. Note: If Column 18 is less than the number of hours authorized in Column 15, Column 20 must be completed.</td>
</tr>
<tr>
<td>Column Number</td>
<td>Instruction</td>
<td>Explanation</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 19.          | Length of time before critical services provided | Time to resolve gap in critical service hours, i.e., the time between the agency/contractor notification and the delivery of service. Record time to resolve gaps in hours – a half day as 12 hours; 1 day as 24 hours; next once a week scheduled visit as 168 hours. For example:  
A. The agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM scheduled critical service. The Member Service Preference Level indicated by the member/representative at the time of the call was 1 – Within 2 hours. The agency was able to get a substitute caregiver to the member’s home by 9:30 AM. Column 17 should record the length of time to resolve the gap in critical service as 1 hour.  
B. The agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM regularly scheduled Tuesday critical services. The Member Service Preference Level indicated by the member/representative at the time of the call was 3 – Within 48 hours. The agency is able to have a substitute caregiver there at 8:00 AM on Wednesday morning. Column 17 should record the length of time to resolve the gap in critical service as 23.5 hours.  
C. The agency was notified at 8:30 AM that the caregiver cancelled the 8:00 AM once a week Tuesday critical services. The Member Service Preference Level indicated by the member/representative at the time of the call was 4 – Next Scheduled Visit. Column 17 should record the length of time to resolve the gap in critical service as 167.5 hours. |
| 20.          | Was Member Critical Service Preference Level Timeline Met | Place a Y (Yes) or N (No) to indicate whether the critical service gap was met within the timeline indicated by the Member Service Preference Level at the time of the notice in Column 11.  
The clock on the critical service gap begins when the provider is notified by the member/representative or caregiver that the caregiver either will not or has not arrived to provide critical services.  
Note: If an “N” is recorded in Column 20, Column 21 must be filled out. |
<table>
<thead>
<tr>
<th>Column Number</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.</td>
<td><strong>If Member Critical Service Preference Level Timeline Not Met</strong></td>
<td>List the reason the Member Service Preference Level timeline was not met. Use the corresponding numerical bullet. Provide a brief explanation in Column 24, if “Other” is used.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Member Critical Service Preference Timelines are not met, explain why.</th>
<th>1</th>
<th>Reserved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Choice</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Unable to find replacement</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not alerted of critical service gap</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column Number</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.</td>
<td><strong>If total Authorized Critical Hours not replaced explain why</strong></td>
<td>List the reason the total critical authorized units not replaced on the day of the gap. Use the corresponding numerical bullet. Provide a brief explanation, if “Other” is used in Column 24.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If total critical hours were not replaced, explain why.</th>
<th>1</th>
<th>Full replacement hours not needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Choice</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Unable to find replacement</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not alerted of critical service gap</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Column Number</td>
<td>Instruction</td>
<td>Explanation</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23.</td>
<td>If an Unpaid Caregiver used, explain why</td>
<td>Use the corresponding number to indicate the reason an unpaid caregiver was used. Note if there is an “E”, “F,” or “H,” used in Column 14, Column 23 must be completed. For example, the agency is notified that the caregiver cancelled and the agency calls the member/representative to determine the Member Critical Service Preference Level and discusses getting another caregiver out to the member. The member refuses and states he/she wishes to use an unpaid caregiver. A number 1 would be recorded in Column 21. Provide a brief explanation if “Other” is used in Column 24.</td>
</tr>
</tbody>
</table>

### If an unpaid caregiver used, explain why.

<table>
<thead>
<tr>
<th>Column</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Member Choice</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>No Agency Staff Available</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Column Number</th>
<th>Instruction</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.</td>
<td>Explanation Column</td>
<td>Complete this column when an explanation is required.</td>
</tr>
</tbody>
</table>
Examples of Critical Service Gap Tracking Log for Recording of Scenarios

<table>
<thead>
<tr>
<th>Scenario 1:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td>J. Smith, with quadriplegia lives at home alone and requires services in the morning and evening. The member has limited to minimal informal support systems.</td>
</tr>
<tr>
<td><strong>Assessment/ Authorized</strong></td>
<td>The Support Coordinator has assessed and authorized a total of 6 hours of attendant care to be split 3 hours in the morning and 3 hours at night, to begin at 8:00 AM and 7:00 PM, seven days a week. Member Service Preference Level indicated by the member/representative was a Level 1 and the agency has been notified.</td>
</tr>
<tr>
<td><strong>Situation</strong></td>
<td>At 8:00 AM the caregiver calls the member and then calls the agency letting both know that they will be unable to work today. The agency calls the member to discuss the situation and the member indicates immediate priority needs. (Agencies must obtain from the member/representative the Member Service Preference Level at time of service gap notification as a member may have indicated a lower preference level previously but immediate circumstances indicate a higher preference level now).</td>
</tr>
<tr>
<td><strong>Resolution</strong></td>
<td>The agency is able to obtain another caregiver and has them at the member’s home at 10:00 AM and will provide 2 hours of personal care services. The replacement morning caregiver will also be able to cover the 3 hour evening shift therefore; a gap is not recorded for the evening shift because it was resolved before the scheduled time service was to begin.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scenario 2:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>History</strong></td>
<td>T. Jones is an elderly person with dementia who tends to wander and cannot be left alone. The member lives with his son. The son works outside of the home.</td>
</tr>
<tr>
<td><strong>Assessment/ Authorized</strong></td>
<td>The Support Coordinator has assessed and authorized a total of 9 hours of attendant care six days a week. The caregiver is scheduled to begin at 7:00 AM. The Member Service Preference Level indicated by the member/representative was a Level 1 and the agency has been notified.</td>
</tr>
<tr>
<td><strong>Situation</strong></td>
<td>At 7:30 AM the caregiver calls to say they will be unable to work today. The agency calls the member’s son to discuss the situation and the son indicates immediate priority needs. The son is not part of the Contingency Plan due to his employment outside of the home.</td>
</tr>
<tr>
<td><strong>Resolution</strong></td>
<td>The agency makes several calls to try and find another caregiver. At 8:30 AM the primary agency calls the contractor and informs them they cannot find a replacement caregiver. The contractor contacts another contracted provider within their network and makes arrangements for a replacement caregiver to be at the member’s home at noon. The son then stays with his father until the replacement caregiver arrives. Total number of service hours received from both paid and unpaid are 9 (5 by unpaid caregiver and 4 by paid caregiver); therefore, an “H” is recorded under Column 14.</td>
</tr>
</tbody>
</table>
**Scenario 3:**

<table>
<thead>
<tr>
<th>History</th>
<th>M. Brown is married and lives with his elderly spouse. The spouse is unable to assist with most personal care however, is able to assist with simple meals and the urinal. The Browns are a Spanish-speaking family who live 30 miles from town. The Browns would prefer Spanish-speaking caregivers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/Authorized</td>
<td>The Support Coordinator has assessed and authorized 2 hours of personal care 7 days a week and 2 hours of homemaker services Monday, Wednesday and Friday. Personal care hours are to begin at 7:30 AM and homemaker hours at 11:00 AM. Member Service Preference Level indicated by the member/representative was a Level 2 because of the Personal Care service. The spouse can get the member simple meals and is able to assist with the urinal. The member has indicated that when a Homemaker is not available the service can be delayed until the next scheduled visit.</td>
</tr>
<tr>
<td>Situation</td>
<td>The personal care worker called the agency at 7:30 AM on Wednesday and lets the agency know they won’t be in to work. The agency calls the member to discuss the situation pertaining to Personal Care services and member confirms his Service Preference Level as a Level 2. The Homemaker calls the agency at 11:00 AM on Wednesday to let the agency know they wouldn’t be in to work. The agency calls the member and discusses the Homemaker needs. The Member Service Preference Level is indicated by the member to be a Level 4 – Next Scheduled Visit.</td>
</tr>
<tr>
<td>Resolution</td>
<td>The agency only has a non-Spanish-speaking personal care worker available. That worker is sent to the member’s home at 10:30 AM for 2 hours of care. The family refuses the caregiver because of the language issue and calls the primary agency. The agency calls the contractor and informs them they cannot find a Spanish-speaking replacement caregiver. The contractor contacts another contracted provider within their network and makes arrangements for a replacement caregiver to be at the member’s home at 1:00 PM. The time recorded in Column 19 to resolve the gap in personal care services is 5.5 hours. On a separate line the hours recorded in Column 19 for the resolution of Homemaker services is 48 hours.</td>
</tr>
</tbody>
</table>

Note: As no Homemaker services were provided until the next scheduled visit Column 14 is blank. Column 20 now shows a “2” as member chose not to receive Homemaker services until the next scheduled visit.

**Scenario 4:**

<table>
<thead>
<tr>
<th>History</th>
<th>S. White is married and lives with her elderly spouse. The spouse is unable to do housework, shopping, laundry, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/Authorized</td>
<td>The Support Coordinator has assessed and authorized 2 hours of Homemaker services Monday, Wednesday and Friday beginning at 11:00 AM. Member Service Preference Level indicated by the member/representative was a Level 4 for Homemaker.</td>
</tr>
</tbody>
</table>
| Situation | At 11:30 on Wednesday the member calls the agency to report the homemaker has not shown up. While on the phone, the agency and the Whites discuss the situation. The Whites explain that the homemaker
always goes grocery shopping for them on Wednesdays and they can’t wait until Friday for the service. The Member Service Preference Level is currently indicated as Level 2.

<table>
<thead>
<tr>
<th>Resolution</th>
<th>The agency is able to have a homemaker out to the Whites at 4:30 PM the same day. The time recorded in Column 19 is 5 hours.</th>
</tr>
</thead>
</table>

**Scenario 5:**

<table>
<thead>
<tr>
<th>Situation</th>
<th>The member is to receive attendant care services 3 times a week for 6 hours a day. The caregiver shows up at the regularly scheduled time and the member did not answer the door. The caregiver made a reasonable attempt to verify that the member was not home (i.e. looked in windows, checked with a neighbor, called the member’s telephone number, etc.) The caregiver notified their agency who instructed them to wait 15 minutes before leaving.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resolution</td>
<td>The provider agency records this as a Non-Provision of Service because this is not a gap in services, contractors would not record this on the Gap In Service Log submitted to AHCCCS.</td>
</tr>
</tbody>
</table>

**Scenario 6:**

<table>
<thead>
<tr>
<th>History</th>
<th>J. Johnson lives with her son who works outside the home. The son performs her morning and evening care. All the member requires is assistance with housekeeping.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/Authorized</td>
<td>The Support Coordinator has assessed and authorized 2 hours of homemaker services twice a week. Services are scheduled Tuesdays and Thursdays beginning at 10:00 AM. Member Service Preference Level indicated by the member/representative was a Level 4.</td>
</tr>
<tr>
<td>Situation</td>
<td>At 10:15 AM on Tuesday the member calls the agency and states that the homemaker did not show up. The agency discusses the situation with the member who indicates the Member Service Preference Level is Level 4. The agency calls the homemaker and finds out the homemaker has been in an accident and is no longer available and they do not have another homemaker available today or in the foreseeable future. The agency calls the contractor and advises them of the situation.</td>
</tr>
</tbody>
</table>
## Resolution

The Contractor contacts other contracted providers in their network and is unable to find a replacement caregiver for today from any of them. All agencies will continue to look for a replacement caregiver for as soon as possible. On Friday, a provider agency (not the original agency) contacts the Contractor to report having found a replacement caregiver for this member to begin at 10:00 AM that day. This caregiver will only be available for one week while the member she usually takes care of is out of town. The Contractor contacts the original provider agency to advise them the non-provision of services has been temporarily resolved so this does not continue to be recorded. At the end of the week when the replacement caregiver is no longer available for the member neither the original nor any of the Contractor’s other provider agencies are able to find another replacement caregiver. One month later a replacement caregiver has still not been found. Contractor, Agencies continue to look for a caregiver. The Support Coordinator continues to discuss with the member alternative service/placement options to meet her needs. Member chooses to remain in her son’s home. The Support Coordinator and the member develop a Managed Risk Agreement.

---

### Scenario 7:

<table>
<thead>
<tr>
<th>History</th>
<th>Ms. Brown is a 48 year old member with MS who lives alone but has friends in her home frequently. The member has had numerous caregivers and agencies providing her care over the last several months. The current agency is the last of the contractor’s contracted providers who are willing to serve this member.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/Authorized</td>
<td>The Support Coordinator has assessed and authorized 5 hours per day of Attendant Care, 7 days/week. Member Service Preference Level is 2.</td>
</tr>
<tr>
<td>Situation</td>
<td>The member’s current caregiver arrives at the member’s home at the scheduled time and finds the member and a few friends actively using illegal drugs. This is not the first time this has occurred. The caregiver does not feel the situation is safe for her so she advises the member that she cannot stay to provide care. One of member’s friends becomes verbally aggressive towards the caregiver so she immediately leaves the home. She drives away from the home and calls her employer agency to inform them of the situation. The provider contacts the Contractor to inform them that they are no longer willing to send a caregiver into this unsafe setting.</td>
</tr>
<tr>
<td>Resolution</td>
<td>The Support Coordinator contacts the member to inform her that as a result of the drug activity in her home, they are unable to find a caregiver for the member today and it is not known when another caregiver will be found. The next day the Support Coordinator and her supervisor visit the member in her home to update her Managed Risk Agreement which outlines what the barriers to care are and the potential consequences if the member’s behaviors/choices continue. This is recorded as a Non-provision of service until a replacement caregiver is found. It is not a gap in service and therefore not recorded on the Gap In Critical Service Log.</td>
</tr>
</tbody>
</table>
CHAPTER 63 - WORKFORCE DEVELOPMENT

EFFECTIVE DATE: May 8, 2019
REFERENCES: ACOM 407; Division Operations Manual Policy 407

This policy describes the Qualified Vendor’s (QV) requirements to implement workforce development initiatives; these requirements include:

A. Monitoring and collection of information about the workforce
B. Collaborative planning of workforce development initiatives (including the recruitment and employment of members receiving services of the Division into healthcare roles)
C. Participation in Division directed initiatives, including surveys and technical assistance directed activities.

Definitions

A. Competency Requirement – A requirement mandating personnel to behaviorally demonstrate to a qualified staff member that they have acquired specific information or skill and/or that they are capable of routinely using the information or skill in the performance of their duties.

B. Training Requirement – A requirement mandating personnel to participate in a specific training course or program.

General

The Division, AHCCCS, providers, and Administrative Services Subcontractors (AdSS) work together to ensure members of the Division receive services from a workforce that is qualified, capable, and sufficiently staffed.

Providers must acquire, develop, and deploy a sufficiently staffed and qualified workforce that delivers services to members in an interpersonally, clinically, culturally, and technically effective manner.

Workforce Development Plan and Progress Report

Qualified Vendors must:

A. Develop and implement a Workforce Development (WFD) Plan that states short and long term strategic WFD capacity and capability requirements; the WFD Plan must include:
   1. Forecast of anticipated workforce capacity (e.g., size, job types) and capability (skills and workplace support) needs
   2. Specific WFD goals
   3. An explanation of how members, families, and any identified stakeholders will be involved in the development and implementation of the WFD Plan

B. Maintain a general assessment of the progress of the WFD Plan.
C. Formally assess overall progress, and submit to the Division a written WFD Progress Report that includes:
   1. An explanation of progress being made toward the achievement of the WFD Plan
   2. A metric summary on WFD initiatives focused on recruitment, retention, turnover, and time to hire.

**Monitor Workforce Development Activities**

The Division policies, guidance documents, manuals, and plans may include training and/or competency requirements. As part of the routine compliance monitoring process, the QV ensures that:

A. All required training content or competency descriptions are incorporated into the appropriate orientation, education, or training program and that evaluation processes are being made available to provider personnel.

B. There are processes for documenting training, verifying qualifications, skills, and knowledge of personnel, retention of required training, and competency transcripts and records.

C. All initiatives specified in the WFD Plan are routinely monitored and evaluated.

**Workforce Data**

The Qualified Vendor collects and analyzes required and ad hoc workforce data that:

A. Proactively identifies potential challenges and threats to the viability of the workforce

B. Conducts analysis of the potential impact of the challenges and threats to in accessing care for members

C. Develops and implements interventions to prevent or mitigate threats to workforce viability

D. Develops indicators to measure and monitor workforce sustainability that includes metrics focused on recruitment, retention, turnover, and time to hire.
Qualified Vendor Application and Directory System (QVADS)

Provider Instructions – Agency with Choice Option

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 ................................................................. 3
2 Updating the Agency with Choice Selection ................................ 3
1 How to Login to QVADS


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.
Table of Contents

1. Introduction .................................................................................................................................................................... 2
2. Changes in FOCUS Vendor Application ........................................................................................................................... 2
   2.1 Acknowledge within 3 business days
   2.2 Use U-7 Modifier for claims

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 business days. Unacknowledged AWC authorizations in this grid past the 3 business day rule will be automatically terminated.

Example:
Count for Authorizations awaiting acknowledgement/deny within 3 business days is displayed on the Service authorizations main screen require AWC Count
User will be able select members and Acknowledge/Deny the authorization.

2.2 Use U-7 modifier

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

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

Example:
Following are the ‘New Authorizations’ for HSK, ATC, MAH & HAI services that need to be acknowledged within 3 business days to be able to provide the services.

Message from webpage:

Please use UF Modifier for the claim when submitting the bill.

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

<table>
<thead>
<tr>
<th>Consumer Name</th>
<th>Service Code</th>
<th>DDD Code</th>
<th>Type</th>
<th>Status</th>
<th>Mfr/Not</th>
<th>Units Authorized</th>
<th>Units Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2021</td>
<td>DTA</td>
<td>ByPass</td>
<td>Open</td>
<td></td>
<td></td>
<td>1248.00</td>
<td>485.25</td>
</tr>
<tr>
<td>A0110</td>
<td>TRA</td>
<td>ByPass</td>
<td>Open</td>
<td></td>
<td></td>
<td>312.00</td>
<td>121.00</td>
</tr>
<tr>
<td>S5150</td>
<td>RSP</td>
<td>ByPass</td>
<td>Closed</td>
<td></td>
<td></td>
<td>336.00</td>
<td>179.25</td>
</tr>
<tr>
<td>S5130</td>
<td>HSK</td>
<td>ByPass</td>
<td>Closed</td>
<td></td>
<td></td>
<td>5.00</td>
<td></td>
</tr>
</tbody>
</table>
OPERATIONS POLICY MANUAL

Chapter 100 Administration
101 Marketing
103 Fraud, Waste and Abuse
104 Continuity of Operations/Emergency Preparedness Plan
106 Certification of Medicare Advantage Plans Serving Dual Eligible Medicare–AHCCCS Members
108 AHCCCS Security Rule Compliance
109 Institution for Mental Disease 15 Day Limit
110 Mental Health Parity

Chapter 200 Claims
201 Medicare Cost Sharing for Members Covered by Medicare and Medicaid
203 Claims Processing
205 Ground Ambulance Transportation Non-Contracted

Chapter 300 Financial
305 Performance Bond and Equity per Member Requirements
307 Alternative Payment Model Initiative - Strategies and Performance-Based Payments Incentive
311 CYE20 and Forward - Tiered Capitation Reconciliation
312 Children’s Rehabilitative Services Program Reconciliation
314 Auto-Assignment Algorithm
317 Change in Organizational Structure
320 Health Insurer Fee
321 Payment Reform E-Prescribing
325 Access to Professional Services Initiative and Reconciliation

Chapter 400 Operations
401 Change of DDD Health Plan and Administrative Services Subcontractors
402 Member Transition for Annual Enrollment Choice and Eligibility Changes
<table>
<thead>
<tr>
<th>Page</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>404</td>
<td>Contractor Website and Member Information</td>
</tr>
<tr>
<td>405</td>
<td>Cultural Competency, Language Access Plan and Family Member Centered Care</td>
</tr>
<tr>
<td>406</td>
<td>Member Handbook and Provider Directory</td>
</tr>
<tr>
<td>407</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>408</td>
<td>Sanctions</td>
</tr>
<tr>
<td>412</td>
<td>Claims Recoupment</td>
</tr>
<tr>
<td>414</td>
<td>Notices of Adverse Benefit Determination and Notices of Extension for Service Authorizations</td>
</tr>
<tr>
<td>415</td>
<td>Provider Network Development and Management Plan: Periodic Network Reporting Requirements</td>
</tr>
<tr>
<td>416</td>
<td>Provider Information</td>
</tr>
<tr>
<td>417</td>
<td>Appointment Availability, Monitoring and Reporting</td>
</tr>
<tr>
<td>418</td>
<td>Provider and Affiliate Advance and Loan Request</td>
</tr>
<tr>
<td>421</td>
<td>Contract Termination: Nursing Facilities and Alternate Home and Community Based Settings</td>
</tr>
<tr>
<td>423</td>
<td>Financial Responsibility for Court Ordered Treatment for DUI/Domestic Violence or Other Criminal Offenses</td>
</tr>
<tr>
<td>424</td>
<td>Verification of Receipt of Paid Services</td>
</tr>
<tr>
<td>425</td>
<td>Social Networking</td>
</tr>
<tr>
<td>426</td>
<td>Children’s Rehabilitation Services Application, Designation and Coverage</td>
</tr>
<tr>
<td>431</td>
<td>Copayment</td>
</tr>
<tr>
<td>433</td>
<td>Member Identification Cards</td>
</tr>
<tr>
<td>434</td>
<td>Coordination of Benefits and Third Party Liability</td>
</tr>
<tr>
<td>435</td>
<td>Telephone Performance Standards and Reporting</td>
</tr>
<tr>
<td>436</td>
<td>Network Standards</td>
</tr>
<tr>
<td>437</td>
<td>Financial Responsibility for Services After the Completion of Court-Ordered Evaluation</td>
</tr>
<tr>
<td>438</td>
<td>Administrative Services Subcontracts Evaluation</td>
</tr>
<tr>
<td>439</td>
<td>Material Changes: Provider Network and Business Operations</td>
</tr>
<tr>
<td>Page</td>
<td>Section Title</td>
</tr>
<tr>
<td>------</td>
<td>---------------</td>
</tr>
<tr>
<td>440</td>
<td>Managed Care Expiration or Termination of Contract</td>
</tr>
<tr>
<td>445</td>
<td>Submission of Requests for Hearing Documents</td>
</tr>
<tr>
<td>446</td>
<td>Grievances and Investigations Concerning Persons with Serious Mental Illness</td>
</tr>
<tr>
<td>448</td>
<td>Housing</td>
</tr>
<tr>
<td>449</td>
<td>Behavioral Health Services for Children in Department of Child Safety Custody and Adopted Children</td>
</tr>
<tr>
<td>470</td>
<td>Management and Maintenance of Records Related to Medicaid Line of Business</td>
</tr>
</tbody>
</table>
101 MARKETING

EFFECTIVE DATE: October 1, 2019


DELIVERABLES: Marketing Activities Report; Marketing Attestation Statement; Marketing Materials

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes guidelines and restrictions for an AdSS regarding marketing activities related to AHCCCS and the Division.

Definitions

A. Dual Eligible - A member who is eligible for both Medicare and Medicaid.

B. Dual Marketing - Marketing efforts specifically targeting a AdSS enrollee who is eligible for Medicare and Medicaid.

C. Financial Sponsor - Any monies or in kind contributions provided to an organization, other than attendance fees or table fees, to help offset the cost of an event.

D. Health Message - A slogan or statement on marketing materials to promote healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status, or methods or modes of medical treatment.

E. Marketing - Any communication from the AdSS to a member that can reasonably be interpreted as intended to influence the member to enroll with the AdSS, or to not enroll or disenroll with another Contractor’s Medicaid product in 42 CFR 438.104. Marketing does not include communication to any Medicaid member about a Qualified Health Plan, as defined in 45 CFR 155.20.

For the purposes of this policy, Marketing contrasts with Member Information found in Policy 404, which addresses guidelines and restrictions for the AdSS related to member and potential member information and activities.

F. Marketing Materials - Materials produced in any medium, by or on behalf of the AdSS that can reasonably be interpreted as intended for marketing purposes. This includes general audience materials such as general circulation brochures, AdSS web site and other materials that are designed, intended, or used to increase AdSS membership or establishing a brand. Examples include, but are not limited to: scripts or outlines for member services representatives, provider directories, brochures or leaflets that are distributed or circulated by any third party (including providers), and posters.

G. Member - A Medicaid recipient who is eligible for the Division and currently enrolled with a AdSS.
H. **Potential Enrollee** - A Medicaid-eligible recipient who is not yet enrolled with an AdSS; or an member during Annual Enrollment Choice (AEC).

I. **Promotion** - Any activity in which marketing materials are given away or displayed where the intent is to increase the AdSS’s membership.

J. **Social Networking Applications** - Web-based services (excluding the AdSS’s State mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as e-mail, comment posting, image sharing, invitation and instant messaging services.

**Marketing Activities**

AdSS marketing activities are limited to those defined by this policy. As required within 42 CFR 438.104, marketing materials may only be used if they are approved by the Division and comport to this policy. In addition to approval of advertising copy, approval of the publication in which the ad will be placed is also required.

The AdSS is responsible for ensuring its subcontractors comply with this policy. Failure of a subcontracted provider to adhere to this policy may result in penalties to the AdSS.

**Marketing Materials, Give-Always, Events, Sponsorships, Press Releases and AdSS and Division Logo and Name Use**

A. **Materials and Give-Aways**

Member materials that have been previously approved as member information under AdSS Operations Policy Manual, Policy 404 may be used during marketing activities only if they comply with the requirements of this policy.

The AdSS must submit marketing materials and marketing items (giveaways) for approval to the Division as required under this policy. If approved, the materials and giveaways may be distributed by the AdSS for a period of two years from the date of approval. The materials and giveaways must be resubmitted to the Division for approval if the AdSS makes a substantial change to the item. In addition to marketing materials and giveaways, the AdSS may submit templates for flyers or posters that advertise regular meetings or events where only the dates and times of the events change. If approved, these templates may be distributed by the AdSS for a period of two years from the date of approval.

The AdSS may distribute health educational materials without prior Division approval. The materials must be health-related and developed based on information from a recognized organization. For a list of approved recognized organizations see ACOM Policy 404, Attachment A. If these materials include AdSS specific information related to the Division Integrated Contract (e.g. enrollment, network or information on services) the materials must be submitted for approval.

The AdSS must ensure that:

1. The value of any marketing item (give-away) to the general public by the AdSS must not exceed $15.00.
2. Give-away items are health related (e.g. toothbrush, dental floss) or if non-health related (e.g. cups, key chains, buttons, t-shirts), include a health message (e.g. Don't Smoke, Get Your Flu Shot).

3. All materials identify the AdSS as a Division provider and are consistent with the requirements for information to members described in the contract and Division policies.

4. All materials that have been produced by the AdSS and refer to contract services must specify: "Contract services are funded in part under contract with the Arizona Department of Economic Security/Division of Developmental Disabilities".

5. Marketing materials that are distributed by the AdSS must be distributed statewide. Exclusion of any particular group or class of members would be considered to be a discriminatory marketing practice and subject to contract action.

6. The AdSS does not market directly to members eligible for the Division.

7. The AdSS does not encourage or induce a member to select a particular AdSS when completing the application and may not complete any portion of the application on behalf of the potential enrollee. This prohibition covers all situations, whether sponsored by the AdSS, their parent company, or any other entity.

B. Events

The AdSS may participate in health-related marketing events that are listed in Figure 1 in the “Pre-Approved” column. However, all events that are listed in this “Pre-Approved” column must either be health related or have a health education component (e.g., celebration events.). If the event is not listed as a “Pre-Approved” event, the AdSS must submit a request including the event name and date with the location and address to the Division for prior approval. The AdSS’s participation in events must be substantive; an unmanned booth with handouts is not acceptable. The AdSS is not required to obtain approval from the Division to attend pre-approved events listed in Figure 1 of this policy, with the following exceptions:

1. AdSS pays sponsorship fees,

2. AdSS donates benefits or items (e.g. raffle items, gift baskets, cash), and/or

3. AdSS distributes materials not previously approved by the Division within the last two years.

4. The AdSS may not attend events that are listed in the “Not-Approved” column in Figure 1 of this policy, or any event determined by the Division to not be in the best interest of the State of Arizona.
5. If the AdSS is not certain if an event would qualify as “Pre-Approved,” the AdSS must submit a request for approval to the Division prior to the event. The request must include the Name and date of the Event, the location and the address.

Example:

Roosevelt Shot Clinic (Name of Event)  
Phoenix Ranch Market (Location) 1602 E Roosevelt St (Address) Phoenix, AZ 85006  
9AM-1PM (Start and End Time) Flu Shots (Service)  
We will distribute the following:  
Tooth Brush Approved 12/10/17  
We will be handing out the tooth brush kits as the Roosevelt Clinic has been stressing dental hygiene this month.
Figure 1 – Pre-Approved and Not Approved Events

<table>
<thead>
<tr>
<th>PRE-APPROVED HEALTH RELATED EVENTS</th>
<th>NOT-APPROVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back to School Events</td>
<td>Events that are not health related or do not have a health education component</td>
</tr>
<tr>
<td>College/University Events</td>
<td>DES offices (except those listed on the approval list)</td>
</tr>
<tr>
<td>DES Health and/or Resource Events – if open to all AHCCCS plans</td>
<td>WIC Offices (except those listed on the approval list)</td>
</tr>
<tr>
<td>WIC Health and/or Resource Events – if open to all AHCCCS plans</td>
<td>Job Fairs</td>
</tr>
<tr>
<td>Events where health education is a component (e.g. Celebration events – Angeles Del Barrio, etc.)</td>
<td>County/State Fairs</td>
</tr>
<tr>
<td>Community Center/Recreational Events (e.g. Golden Gate, Boys and Girls Club, YMCA, parks and senior center)</td>
<td>Bi-national Health Events (e.g. Mexican consulate on their premises)</td>
</tr>
<tr>
<td>Community/Family Resource Events (e.g. Food banks, food distribution locations, homeless and/or women’s shelters)</td>
<td></td>
</tr>
<tr>
<td>Provider Events (e.g. Doctors, hospitals, and/or specialist) that the AdSS is contracted</td>
<td>Political Events</td>
</tr>
<tr>
<td>Faith Based Events</td>
<td>Pharmacy Events not open to all Contractors</td>
</tr>
<tr>
<td>Farmers Market Events</td>
<td>Swap Meets</td>
</tr>
<tr>
<td>Health Educational Forum (community sponsored) (e.g. Nutritional, health benefits, and prevention topics)</td>
<td></td>
</tr>
<tr>
<td>Safety Events (e.g. Sun safety, water safety, and fire safety)</td>
<td>AdSS Event that is created and sponsored by the AdSS or through its affiliates for Division’s members not enrolled with the AdSS, or for the general public</td>
</tr>
<tr>
<td>Immunization Clinics</td>
<td></td>
</tr>
<tr>
<td>Senior Events</td>
<td></td>
</tr>
<tr>
<td>Shopping Mall Events</td>
<td></td>
</tr>
<tr>
<td>AdSS Event that is created and sponsored by the AdSS for its own members only</td>
<td></td>
</tr>
</tbody>
</table>
C. Sponsorships

The AdSS may participate as a financial sponsor of health-related marketing events that are listed in Figure 1 of this policy in the "Pre-Approved" column. In addition to the information required to be submitted for events, the request must include the dollar amount of the participation, and either a copy or description of any materials (including websites) on which the AdSS name or logo will appear prior to production.

D. Press Releases

The AdSS may issue press releases or announcements about program innovations and events that promote the goals of the Division. Press releases that do not include AdSS-specific information related to the Division Integrated Contract (e.g. benefits, provider network) do not require prior Division approval. All other press releases must be submitted for Division prior approval.

E. Contractor Logos and Name Inclusion

The AdSS is responsible for preventing misuse of their name and logo. Upon receiving Division approval for an event, the AdSS logo can be included on event flyers or websites that are produced by hosting organizations without prior approval. The use of the AdSS name or logo is prohibited for television advertising of the event. If the AdSS is a financial sponsor for the event, event flyers or websites will require prior approval by the Division.

Restrictions

The following restrictions apply to all marketing activities (42 CFR 438.104).

A. The following must not be allowed:

1. Solicitation of any individual face-to-face, door-to-door, or over the telephone or other cold-call marketing activities

2. References to competing AdSS

3. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance
   a. For the purposes of this policy, Qualified Health Plans are not considered private insurance.
   b. The AdSS may discuss its affiliated Qualified Health Plan in promotional materials; however, the AdSS is a separate legal entity from all other affiliated health plans and is therefore subject to restrictions on the use of protected health information.

4. Television advertising

5. Direct mail advertising
6. Social Networking Applications (see AdSS Policy Manual, Policy 425 for requirements regarding social networking)

7. Marketing of non-mandated services

8. Utilization of the word "free" in reference to covered services

9. Listing of providers in marketing materials who do not have signed contracts with the AdSS

10. Use of the Arizona Department of Economic Security, Division of Developmental Disabilities, or AHCCCS logo

11. Inaccurate, misleading, confusing or negative information about the Division or the AdSS; and any information that may defraud members or the public


13. AdSS providing services where its enrollment is capped to prohibit members from selecting the AdSS may not engage in marketing activities, but may engage in outreach and retention activities with its current members.

B. Any activities, materials, or mediums in violation of this policy will be subject to sanction regardless of previous approval or terms of privately held contractual agreements

C. The Division will review the restrictions of the following activities on an annual basis:

1. Radio advertising

2. Billboard advertising

3. Bus advertisements (including bus stops and city and school busses).

D. The Division reserves the right to impose additional restrictions.

**Dual Eligible Marketing**

Dual marketing focuses on enrollment in the AdSS’s Medicare Dual Special Needs Plan (D-SNP). The state understands that the Medicare D-SNP is able to enroll any dual eligible member, but to increase alignment, encourages the AdSS to only market to individuals enrolled in its ALTCS plan. Marketing to dual eligible AdSS enrollees may include print advertisements, radio advertisements, billboards, bus advertising, and television.

A. In the case of marketing materials for dual eligible enrollees the process will be as follows:

The Division does not review for approval dual marketing materials that have been
approved by CMS and/or that do not include reference to Division benefits and/or service information. However, all dual marketing materials that have not been approved by CMS and/or include reference to Division benefits and/or service information require submission to the Division as specified in Section F3, Contractor Chart of Deliverables. While the Division may accept CMS approval of dual marketing materials as sufficient for distribution of materials, the Division retains and reserves the right to review before or after the fact, materials that have received CMS approval.

B. The AdSS must adhere to the following regarding use of billboards that use the terms ‘Medicaid’ or ‘AHCCCS’:

1. Limited to two in each urban county (Maricopa and Pima), and
2. Limited to one in each rural county.

**AdSS Responsibilities**

A. The AdSS is required to report their marketing costs on a quarterly basis as a separate line item in the quarterly financial statements. This requirement also applies to any marketing costs included in an allocation from a parent or other related corporation.

Additionally, any AdSS not in compliance with the Division viability criteria indicators, as defined in the contract, may be restricted from further marketing until the AdSS is in compliance with the viability criteria indicators.

The AdSS CEO (or designee) must sign and submit to the Division, ACOM 101, Attachment A, Marketing Attestation Statement, as adopted by the Division and as specified in Section F3, Contractor Chart of Deliverables. The AdSS’s Attestation Statement will address the compliance of its subcontracted health plans with the requirements of this policy.

B. The AdSS must review and revise all materials on a regular basis in order to reflect current practices. Any changes or amendments to previously approved materials (e.g., prior leaflet approved, but subsequently modified) must also be submitted in advance to the Division for approval as indicated above.

C. The AdSS must submit a Marketing Activities Report of the previous month’s marketing activities as specified in Section F3, Contractor Chart of Deliverables. This includes events in which the AdSS was a participant. Participation includes but is not limited to having a booth at the event, and/or having a presence at the event. The report must be submitted using the excel format in Attachment B, Marketing Activities Report of this policy. The DDD AdSS’s Report will address marketing activities of its subcontracted health plans.

The Division Marketing Committee will review the AdSS’s monthly submission to determine if the AdSS’ participation in the events was in compliance with this policy. If the Division determines a violation has occurred, the AdSS may be
subject to sanctions. Failure to disclose an event attended may also result in Administrative Action.

D. Submission Requirements

All Marketing materials including, giveaways, event requests, sponsorships and press releases, and dual eligible marketing materials must be submitted separately to the Division Marketing Committee for approval at least 21 days prior to dissemination as specified in Section F3, Contractor Chart of Deliverables. If 21-day notice is not possible, the AdSS may request an expedited review, but the request must be clearly marked as expedited and also indicate the reason for the shortened timeframe.

Division approval must only apply to the form of communication or specific date described with the submission. Any substantial modifications of previously approved marketing materials must be clearly identified and resubmitted.

The AdSS may contest the Division’s decision by filing a grievance in accordance with A.A.C. 9-34.

Sanctions/Penalties

Any violation of this policy may result in Administrative Action, including but not limited to, sanctions as described in Division Operations Policy Manual, Policy 408.
103 FRAUD, WASTE AND ABUSE

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2903, 2918 and 2957; A.A.C. R9-22-702; 42 CFR 438.608, 42 CFR 455.2, 12-23, 100-106, and 436; State Medicaid Director Letters 08-003 and 09-001; Section 6032 of the Deficit Reduction Act, Federal False Claims Act

DELIVERABLES: Attestation of Disclosure Information: Ownership and Control and Persons Convicted of a Crime; Change in Contractor Organizational Structure: Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime Information; Corporate Compliance External Audit Plan; Corporate Compliance Plan; Corporate Compliance: Executive Audit Summary; Corporate Compliance: External Auditing Schedule; Corporate Compliance: External Auditing Schedule-Changes; Exclusions Identified Regarding Persons Convicted of a Crime; Recovered Overpayment; Report Alleged Fraud/Waste/Abuse of the AHCCCS Program

Purpose

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (The Division or DDD). The purpose of this policy is to outline the corporate compliance requirements including the reporting responsibilities for alleged fraud, waste, and abuse, involving services funded by the Division. This policy also addresses additional responsibilities regarding compliance with broader program integrity, regulatory, and programmatic requirements.

Definitions

A. Abuse of the Program - Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the AHCCCS Program. 42 CFR 455.2.

B. Administrative Services Subcontract - An agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:
   1. Claims processing, including pharmacy claims
   2. Credentialing, including those for only primary source verification
   3. Management Service Agreements
   4. Service Level Agreements with any division or subsidiary of a corporate parent owner; providers are not AdSS.

C. Corporate Compliance Officer - The on-site management official designated by each AdSS to implement, oversee and administer the AdSS’ compliance program. The Corporate Compliance Officer must be available to all of the AdSS’s employees, and possess the authority to access and provide records, and make independent referrals to the AHCCCS Office of Inspector General (42 CFR 438.608).

D. Credible Allegation of Fraud - A credible allegation of fraud may be an allegation, which
has been verified by the State, from any source, including, but not limited to, the following:

1. Fraud hotline complaints
2. Claims data mining
3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis (42 CFR 455.2).

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

F. Managing Employee - A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency (42 CFR 455.101).

G. Provider - Any person or entity that furnishes Division-funded services.

H. Waste - Overutilization or inappropriate utilization of services. Misuse of resources, or practices that result in unnecessary costs to the Medicaid Program.

Policy

A. Authority

The AHCCCS Office of Inspector General (AHCCCS-OIG) is the division of AHCCCS that has the authority to conduct preliminary and full investigations, relating to fraud, waste, and abuse, involving the programs administered by AHCCCS. Pursuant to 42 CFR 455.12-23 and an Intergovernmental Agreement with the Arizona Attorney General’s Office, AHCCCS-OIG refers cases of suspected Medicaid fraud to the State Medicaid Fraud Control Unit for appropriate legal action. AHCCCS-OIG also has the authority to make independent referrals to other law enforcement entities.

1. Pursuant to A.R.S. § 36-2918, AHCCCS-OIG has the authority to issue subpoenas and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony, as the Inspector General deems relevant or material to an investigation, examination, or review undertaken by the Office.

2. Pursuant to A.R.S. §§ 36-2918 and 2957, AHCCCS-OIG has the authority to impose a civil monetary penalty of up to $2,000.00 for each item or service claimed, and/or an assessment of an amount not to exceed twice the amount claimed.

3. AHCCCS-OIG has been designated as a Criminal Justice Agency through the Federal Bureau of Investigations (FBI). This designation authorizes AHCCCS-OIG
to access the National Crime Information Center (NCIC) database as well as the Arizona Criminal Justice Information System. Additionally, OIG is authorized to receive and share restricted criminal justice information with other federal, state, and local agencies.

4. If AHCCCS-OIG determines that a credible allegation of fraud exists, AHCCCS-OIG may suspend payments to providers pursuant to 42 CFR 455.23.

B. AdSS Responsibilities

The AdSS must:

1. Have in place internal controls, policies, and procedures, to prevent, detect, and report fraud, waste, and abuse activities to the Division.

2. Have a Corporate Compliance Program that complies with the AdSS’s contract with the Division and with all state and federal laws. The program must be developed by a plan that includes:
   a. Program integrity goals and objectives
   b. Descriptions of internal and external controls employed by the AdSS
   c. The AdSS’s corporate compliance activities
   d. The roles and responsibilities of the AdSS’s staff, as they relate to the Corporate Compliance Program.

The Division has adopted Attachment B of the AHCCCS Operations Manual, Policy 103. The AdSS can use the sample provided under Attachment B for guidance on how to present such compliance activities. The AdSS’s written Corporate Compliance Plan must be submitted to the Division annually as specified in Section F3, Contractor Chart of Deliverables.

3. Have Corporate Compliance Plan that includes a program integrity audit/review program designed to identify fraud, waste, and abuse.

This program must ensure that the AdSS tracks inadequate billing practices and identifies emerging trends in an effort to provide technical assistance to contracted providers and avoid future occurrences of problematic billing.

4. Provide the external auditing schedule and executive summary of all individual provider audits to the Division as specified in Section F3, Contractor Chart of Deliverables.

   a. The External Audit Plan shall include the following information using Attachment C:
      i. Provider Name,
      ii. AHCCCS ID #,
      iii. Location,
iv. Provider Type,
v. Audit Type,
vi. Planned Audit Date,
vii. Audit Look-Back Period
viii. Total number of In-Network Providers, and
ix. Number of Providers to be audited

b. The External Audit Plan shall include the following information using Attachment C:
i. Location,
ii. Agency Name/Provider,
iii. Date(s) of Audit,
iv. AHCCCS ID,
v. Provider Type,
vi. Audit Type, and
vii. New/Follow-up Audit.

5. Obtain and disclose the information regarding ownership and control, and disclosure of information on persons convicted of crimes in accordance with 42 CFR 455.100-106, 42 CFR 455.436, State Medicaid Director Letters 08-003 and 09-001, and the contractual provisions contained in the contract.

The AdSS must also obtain and disclose the same information regarding its subcontractors. The results of the Disclosure of Ownership and Control and the Disclosure of Information on Persons Convicted of Crimes must be held by the AdSS. The AdSS must disclose to the Division the identity of any person excluded from participation in federal healthcare programs.
6. Submit annually Attachment A in the AHCCCS Operations Manual, Chapter 103, Attestation of: Disclosure of Ownership and Control and Disclosure of Information of Persons Convicted of a Crime, as specified in Section F3, Contractor Chart of Deliverables, attesting that the information has been obtained and verified by the AdSS, or upon request, provide this information to the Division.


8. Ensure all employees, subcontracted providers, and members receive adequate training and ongoing education on all of the following aspects of the Federal False Claims Act provisions:
   a. The administrative remedies for false claims and statements
   b. Any state laws relating to civil or criminal penalties for false claims and statements
   c. The whistleblower protections under such laws.

9. Ensure adequate training addressing fraud, waste, and abuse prevention, recognition and reporting, and encourage employees, contracted providers, and members to report fraud, waste, and abuse without fear of retaliation.

10. Ensure an internal reporting process that is well defined and made known to all employees.

11. Conduct research and proactively identify changes for program integrity that are relevant to their program, and periodically review and revise the fraud, waste, and abuse policies or guidance from the Division or AHCCCS to reflect such changes due to rules, regulations, or new initiatives.

12. Regularly attend and participate in Division work group meetings.

13. Respond promptly and no later than 30 days to requests for information from the Division.

14. Cooperate with the Division regarding any allegation of member billing in violation of A.R.S. §36-2903.01(L) and A.A.C. R9-22-702.

15. Have a method of verifying with Division members that the Division members received the services billed by providers, to identify potential service/claim fraud. The AdSS must perform periodic audits through member contact and to report the results of these audits to the Division as described in this Manual, Policy 424.

16. Be in compliance with all state and federal laws and regulations related to fraud, waste, and abuse, even if not directly detailed in this policy.

C. Reporting Responsibilities

1. Fraud, Waste, and Abuse
   a. If an AdSS discovers, or is made aware, that an incident of alleged fraud,
waste, or abuse has occurred, the AdSS must immediately report the incident to AHCCCS-OIG within ten business days, by completing and submitting the reporting form available on the AHCCCS-OIG webpage under Report Suspected Fraud or Abuse of the Program. All pertinent documentation that would assist AHCCCS in its investigation must be attached to the form.

b. If the AdSS identifies an incident that warrants self-disclosure, the incident must be reported within ten business days to AHCCCS-OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS-OIG webpage. All pertinent documentation that would assist AHCCCS in its investigation must be attached to the form.

c. Once the AdSS has referred a case of alleged fraud, waste, or abuse to AHCCCS-OIG, the AdSS must take no action to recoup or otherwise offset any suspected overpayments.

d. In the event AHCCCS-OIG feels it would be beneficial to seek additional and/or clarifying details regarding a referral from the AdSS, AHCCCS-OIG may first choose to request preliminary review work from the AdSS in order to expand the allegation and to obtain further documentation that will support an investigation by AHCCCS-OIG.

e. If AHCCCS-OIG chooses to seek additional and/or clarifying details regarding a referral from the AdSS, the AdSS will have 30 business days or more to provide the requested documentation, or provide an update as to the status of completing such request.

f. Once AHCCCS-OIG receives a referral, it will conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

g. AHCCCS-OIG will notify the AdSS when the investigation concludes in a manner that safeguards the integrity and confidentiality of the investigation.

h. If it is determined by AHCCCS-OIG not to be a fraud, waste, or abuse case, AHCCCS-OIG will return the matter to the AdSS for disposition in accordance with any applicable laws and/or contracts.

i. The AdSS agrees that AHCCCS has the sole authority to handle and dispose of any matter involving fraud, waste, or abuse. The AdSS assigns to AHCCCS the right to recoup any amounts overpaid to a provider as a result of fraud, waste, or abuse. If the AdSS receives anything of value that could be construed to represent the repayment of any amount expended due to fraud, waste or abuse, the AdSS must forward that recovery to AHCCCS-OIG within 30 days of its receipt. The AdSS relinquishes any and all claims to any monies, received by AHCCCS as a result of any program integrity efforts, that include, but are not limited to:

i. Civil monetary penalties and/or assessments

ii. Civil settlements and/or judgments
iii. Criminal restitution.

j. The AdSS must also report to AHCCCS, as specified in Contract, Division Medical Policy 950, any credentialing denials including, but not limited to:
   i. Those which are the result of licensure issues
   ii. Quality of care concerns
   iii. Excluded providers
   iv. Alleged fraud, waste, or abuse.

D. The Division’s Corporate Compliance Responsibilities Related to Fraud, Waste, and Abuse

1. Conduct pre-fact findings of viable allegations of member and provider fraud.

2. Oversee, monitor, and be the focal point for, the Division’s compliance program, with the authority to review all documents and functions as they relate to fraud, waste and abuse prevention, detection and reporting.

3. Maintain and monitor a tracking system of fraud, waste, and abuse investigations.

4. Ensure all employees, AdSS, providers, and members receive adequate training and information regarding fraud, waste and abuse prevention, identification and reporting. Assure employees, AdSS, providers, and members that they can report fraud, waste, and abuse without fear of retaliation.

5. Take contract action to include, but not be limited to, enrollment suspense of provider payments when there is a credible allegation of fraud.

6. Develop and maintain open channels of communication with AdSS to combat fraud, waste, and abuse at all levels in the system.

7. Develop and maintain open channels of communication with AHCCCS OIG in the prevention and detection of fraud, waste, and abuse.

8. Refer to AHCCCS OIG cases of potential member billing in violation of A.R.S. § 36-2903.01(L) and A.A.C. R9-22-702.

9. Perform all functions required by Section 6032 of the Deficit Reduction Act, including the auditing of AdSS and providers to ensure their compliance.

10. Ensure the Division is in compliance with its federal obligations regarding disclosure of ownership and control, managing employees database exclusion, and checks, and criminal convictions checks, and all other federal requirements related to provider screening and enrollment.
104 CONTINUITY OF OPERATIONS AND RECOVERY PLAN

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.207 and 42 CFR 438.208; Business Continuity and Recovery Plan Checklist (ACOM 104-Attachment A); Contract Section F, Deliverables
DELIVERABLES: Continuity of Operations and Recovery Plan Summary

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division requires in the contract that each of its AdSS have a Continuity of Operations and Recovery Plan to ensure restoration of business operations following unexpected events, or the threat of such events, which impact their ability to adequately serve members. The purpose of this policy is to outline the required components of the Continuity and Recovery Plan. Refer to the Resources section of this policy for more information in developing an emergency management plan.

Definitions

A. Administrative Services Subcontracts - An agreement that delegates any of the requirements of the contract with AHCCCS, including, but not limited to the following:
   1. Claims processing, including pharmacy claims
   2. Credentialing, including those for only primary source verification
   3. Management Service Agreements
   4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSS.

B. Continuity of Operations Programs (COOP) - An effort within the individual executive departments and agencies to ensure that essential functions continue to be performed during a wide range of emergencies.

The Division is mandated to provide health care benefits to its AHCCCS-eligible members. In order to provide benefits, the AdSS must be able to recover from any disruption in services as quickly as possible. This recovery can be accomplished by the development of a Business Continuity and Recovery Plan that contains strategies for recovery. The Continuity and Recovery Plan is part of the Federal Government’s Continuity of Operations Programs (COOP) requirements.

AdSS Responsibilities

The AdSS must develop, maintain, and update annually a Continuity and Recovery Plan that assures the Division that the provision of covered services will occur as stated in the contract (42 CFR 438.207 and 42 CFR 438.208). As specified in contract Section F, Deliverables, a comprehensive summary of the AdSS’s Continuity and Recovery Plan must be evaluated, updated, and submitted with a Continuity and Recovery Plan Checklist (AHCCCS Contractor Operations Manual Policy 104-Attachment A). The summary must be no longer than five pages and must address all Continuity and Recovery Plan requirements outlined below.
Continuity and Recovery Plan Requirements

A. The Continuity and Recovery Plan (Plan) must be reviewed and tested at least annually to manage unexpected events that may negatively and significantly impact the ability to deliver services to members and must be updated as needed by the AdSS.

B. The AdSS must ensure that all staff are trained and familiar with the Plan, and understand their respective roles.

C. The Plan must be specific to the AdSS’s operations in Arizona and reference local resources. Generic plans that do not reference operations in Arizona and the AdSS’s relationship to the Division are not acceptable.

D. The Plan must contain a listing of key customer priorities and key factors that could cause disruption and timelines for when the AdSS will be able to resume critical customer services when a disruption occurs.

E. These priorities include but are not limited to:
   1. Providers receipt of prior authorization approvals and denials
   2. Members receiving transportation
   3. Timely claims payments.

F. The AdSS must also include any additional priorities as identified by the AdSS to be critical key priorities or factors.

G. The Plan must contain specific timelines for resumption of services as well as the percentage of recovery at certain hours, and the key actions required meeting those timelines.

   Example: Telephone service restored to prior authorization unit within four hours, to Member Services within 24 hours, to all phones in 24 hours.

H. The Plan must contain, at a minimum, planning and training for:
   1. Electronic/telephonic failure
   2. Complete loss of use of the main site and any satellite offices in and out of State
   3. Loss of primary computer system/records
   4. Extreme weather conditions
   5. How the AdSS will communicate with the Division during a business disruption (the name and phone number of a specific contact in the Division of Health Care Management is preferred)

   The Plan must direct the AdSS staff to contact the Division at 602-542-0419 in the event of a disruption outside of normal business hours.
6. Periodic testing, at least annually. Results of the test must be documented.

I. The AdSS must designate a staff person as Continuity Planning Coordinator and furnish the Division with contact information as part of the Plan.

J. The AdSS must require its subcontractors to develop and maintain a Continuity and Recovery Plan.

**Resources**

The Federal Emergency Management Agency (FEMA) website contains more information on continuity planning, including checklists for reviewing a Plan. The Division encourages the AdSS to use relevant parts of these checklists in the evaluation and testing of its own Continuity Plan. The AdSS can also reference the Ready.gov website for supplementary information.
106  CERTIFICATION OF MEDICARE ADVANTAGE PLANS SERVING DUAL ELIGIBLE MEDICARE-AHCCCS MEMBERS

EFFECTIVE DATE: October 1, 2019
REFERENCES: Social Security Act §1876

This Policy applies to the Division’s Administrative Services Subcontractors (AdSS) pursuing and becoming Medicare Advantage/Prescription Drug/Special Needs Plans (MA/PD/SNP – hereafter MA Plan) serving dual eligible Medicaid and Medicare members. This Policy outlines the steps necessary to gain Medicare Advantage state certification by AHCCCS and the ongoing requirements to stay certified.

State certification is required as part of the CMS Medicare Advantage application. Under Arizona state law, certification of an AdSS serving persons who are eligible for Medicaid, including persons eligible for both Medicare and Medicaid (dual eligible members), can be completed by AHCCCS or through state licensure by the Arizona Department of Insurance (DOI).

AdSS serving dual eligible members can choose to be licensed by DOI, rather than certified by AHCCCS, if desired. However, if an AdSS does serve more than dually eligible Medicare and Medicaid members under its Medicare Plan, the AdSS must obtain certification by DOI and not AHCCCS. For current AdSS who have a MA Plan that serves members enrolled in the Arizona Long Term Care System Developmentally Disabled program, certification can be extended to include this population.

AHCCCS will only provide certification to AdSS if they are currently a Medicaid Contractor. However, due to the timing of the MA Plan application process, AHCCCS may provide a conditional certification that would allow an AdSS to start the process of becoming an MA Plan during the Division bid process for a new contracting cycle. The certification would be conditional upon being awarded a contract for the new contracting period. Likewise, conditional approval will be made final if the Offeror is awarded a contract.

Definitions

A. Dual Eligible Member (for Purposes of this Policy) - A member enrolled with a Division’s AdSS for Medicaid services who is also a Medicare beneficiary. These persons are considered full dual eligible members. A full dual eligible member does not include persons who are members of the Medicare Cost Sharing populations: Qualified Medicare Beneficiary only (QMB only), Specified Low-income Medicare Beneficiary only (SLMB only) or Qualified Individual-1 (QI-1).

B. Equity per Member - Net assets that are not designated or restricted for specific purposes divided by the number of Medicare Advantage Dual Eligible Members. Refer to the AdSS Operations Manual Policy 305 for further clarification.

C. Medicare Advantage Plan - An organization that provides Medicare services to Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act.
D. **Medicare Advantage**- Prescription Drug/Special Needs Plan (MA-PD/SNP) - An organization that provides the full Medicare benefit, including prescription drugs, to a very specific group of Medicare beneficiaries pursuant to a Medicare risk contract with CMS under §1876 of the Social Security Act. Specific groups served may include members eligible for Medicare and Medicaid (dual eligibles) and/or members residing in nursing facilities.

E. **Performance Bond** - In general, a performance bond is an instrument that provides a financial guarantee in an amount of one month’s capitation or an established amount per enrolled member.

**AdSS Responsibilities**

AdSS pursuing certification as an MA Plan serving only dual eligible members should submit the CMS State Certification Request form to the AHCCCS Division of Health Care Management (DHCM), Medicare Administrator, at least 30 days prior to the date the certification must be sent to the Center for Medicare and Medicaid Services (CMS). The State Certification Request form can be obtained from the Medicare Advantage application on the CMS website at [www.cms.gov](http://www.cms.gov).

In addition to the State Certification Request, AdSS must submit the following in narrative form:

A. Timing of start-up

B. Description of service area

C. Projected enrollment at start up and at the end of year one.

D. Projected amount and description of how equity per member requirements will be met initially and ongoing

E. Projected amount, and description of how performance bond requirements will be met initially and ongoing (refer to AdSS Operations Manual Policy 305 for performance bond requirements)

F. Statement of understanding regarding ongoing monitoring and reporting.

**AHCCCS Process**

A. Within two weeks of receipt of the State Certification Request, DHCM will notify the plan of the specific financial viability requirements and/or determine if additional information is necessary to approve the request.

B. Prior to the approval, DHCM will verify that the plan will be able to comply with the requirements by obtaining a specific plan of action addressing how the standards will be met.

C. Upon review and acceptance of the plan of action noted in B above, DHCM will forward a recommendation and the Certification Request to the AHCCCS Office of the Director for final signature and then back to the Contractor to be sent to CMS to continue the application process.
Financial Viability Standards and Reporting

To receive certification, the AdSS must be in compliance with current financial viability, claims, and administrative standards per the Division contract.

A. Performance Bond - The Division requires that the AdSS obtain and maintain a performance bond specifically for the purpose of the MA Plan in accordance with AdSS Operations Manual Policy 305.

B. Equity per Member - The Division requires that the AdSS maintain equity per MA Dual Eligible Member in accordance with AdSS Operations Manual Policy 305.

C. Ongoing Monitoring - The AdSS must self-monitor their compliance with the equity per member and performance bond requirements and to report to the Division when approaching non-compliance along with a corrective action plan. The Division reserves the right to investigate issues brought to the agency’s attention related to the MA Plan.

D. Financial Reporting - The AdSS will be required to submit quarterly financial statements and an annual audit report and supplemental financial schedules reporting on the MA Plan line of business separately.

The AdSS must report financial data to the Division using the appropriate Division Financial Reporting Guide for the line of business to which the MA Plan is related.
108  AHCCCS SECURITY RULE COMPLIANCE

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.100(d) and 42 CFR 438.208(b)(4); 45 CFR Parts 160, 162, and 164; Section F3, Contractor Chart of Deliverables
DELIVERABLES: AHCCCS Security Rule Compliance Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Definitions

A. Breach - An impermissible use or disclosure of protected health information is presumed to be a breach unless the covered entity or business associate, as applicable, demonstrates that there is a low probability that the protected health information has been compromised. As stated in Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act issued in August 2009.

B. Health Insurance, Portability and Accountability Act (HIPAA) - The Health Insurance Portability and Accountability Act; also known as the Kennedy-Kassebaum Act, signed August 21, 1996 as amended and as reflected in the implementing regulations at 45 CFR Parts 160, 162, and 164.

C. HIPAA Privacy Rule - The HIPAA Privacy Rule 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. The Rule requires appropriate safeguards to protect the privacy of individual health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients’ rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

D. HIPAA Security Rule - Established 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.

E. Health Information Technology for Economic and Clinical Health Act (HITECH) -

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.
F. **Protected Health Information** –

Individually identifiable health information as described in 45 CFR 160.103(5) about an individual that is transmitted or maintained in any medium where the information is:

- Created or received by a health care provider, health plan, employer or health care clearinghouse; or
- Relates to the past, present or future physical or mental health condition of an individual, provision of health care to an individual, or payment for the provision of health care to an individual.

Protected health information excludes information:

- In education records covered by the Family Educational Rights and Privacy Act as amended, 20 U.S.C. 1232g;
- In records described at 20 USC 1232g(a)(4)(B)(IV);
- In employment records held by a covered entity in its role as employer; and
- Regarding a person who has been deceased more than 50 years.

G. **Risk Analysis** - The assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic protected health information held by a covered entity, and the likelihood of occurrence.

H. **Risk Management** - The actual implementation of security measures to sufficiently reduce an organization's risk of losing or compromising its electronic protected health information and to meet the general security standards.

**Data Security Audit**

The AdSS must develop policies and procedures to ensure the privacy of protected health information, the security of electronic protected health information, and breach notification to members [42 CFR 438.100(d) and 42 CFR 438.208(b)(4)].

The AdSS must have a security audit performed by an independent third party annually. If an AdSS performs in multiple AHCCCS lines of business, one comprehensive audit may be performed covering all systems for all lines of business or separate audits may be performed.

The audit must include, at a minimum, a review of the following:

I. Compliance with all security requirements as outlined in ACOM Policy 108, Attachment A, AHCCCS Security Rule Compliance Summary Checklist.
2. AdSS policies and procedures to verify that appropriate security requirements have been adequately incorporated into the AdSS’s business practices, and the production processing systems. The AdSS’s Policies and procedures must include the requirements for the Breach Notification Rule.

Audits performed in the second and subsequent years of the contract will focus primarily on remediation of prior findings and system and policy changes identified since the prior audit.

**AHCCCS Security Compliance Report**

The AdSS must submit the AHCCCS Security Rule Compliance Report to the Division annually as described in Section F3, Contractor Chart of Deliverables. The timeframe audited may be calendar year, fiscal year, or contract year and must be noted in the report. The report must include all findings detailing any issues and discrepancies between the AHCCCS Security Audit Checklist requirements and the AdSS’s policies, practices and systems, and as necessary, a corrective action plan. In addition, the report must include written decisions regarding all addressable specifications.

The Division will verify that the required audit has been completed and the approved corrective action plan is in place and implemented as part of Operational Reviews.

The Division does not intend to release detailed audit reviews; however may, at its discretion, release a summary level of results.

**AHCCCS Security Rule Compliance Checklist**

A. Instructions

The AHCCCS Security Rule Compliance Checklist, located in the AHCCCS Operations Manual, identifies security rule requirements for administrative, physical, and technical safeguards. The Compliance Checklist must be signed and dated by the Chief Executive Officer or his/her designee verifying the information and must be submitted with the annual report.

B. Implementation Specifications

1. Required Specifications

   If an implementation specification is identified as “required” (indicated with an “R” on the checklist), the specification must be implemented.

   **Addressable Specification:** The concept of "addressable implementation specifications" was developed to provide covered entities additional flexibility with respect to compliance with the security standards. Addressable implementation specifications are indicated with an “A” on the checklist.

   In meeting standards that contain addressable implementation specifications, a covered entity must do one of the following for each addressable specification:
a. Implement the addressable implementation specifications.

b. Implement one or more alternative security measures to accomplish the same purpose.

c. Not implement either an addressable implementation specification or an alternative.

The covered entity must decide whether a given addressable implementation specification is a reasonable and appropriate security measure to apply within its particular security framework. For example, a covered entity must implement an addressable implementation specification if it is reasonable and appropriate to do so, and must implement an equivalent alternative if the addressable implementation specification is unreasonable and inappropriate, and there is a reasonable and appropriate alternative. This decision will depend on a variety of factors, such as, among others, the entity's risk analysis, risk mitigation strategy, what security measures are already in place, and the cost of implementation.

The decisions that a covered entity makes regarding addressable specifications must be documented in writing. The written documentation should include the factors considered as well as the results of the risk assessment on which the decision was based.

2. Risk Analysis

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(A), for Risk Analysis, requires a covered entity to, "conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity."

Risk analysis is the assessment of the risks and vulnerabilities that could negatively impact the confidentiality, integrity, and availability of the electronic PHI held by a covered entity, and the likelihood of occurrence. The risk analysis may include taking inventory of all systems and applications that are used to access and house data, and classifying them by level of risk. A thorough and accurate risk analysis would consider all relevant losses that would be expected if the security measures were not in place, including loss or damage of data, corrupted data systems, and anticipated ramifications of such losses or damage.
3. Risk Management

The required implementation specification at 45 CFR 164.308(a)(1)(ii)(B), for Risk Management, requires a covered entity to "implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR. 164.306(a) [(the General Requirements of the Security Rule)]." Risk management is the actual implementation of security measures to sufficiently reduce an organization’s risk of losing or compromising its electronic PHI and to meet the general security standards.

4. Compliance Status

If the covered entity complies with the requirement, insert a “C” in the column. If the requirement is not met insert “NC” for non-compliant.

5. Compliance Documentation

List policies, procedures and processes used to determine compliance with the Implementation Specification.
**109 INSTITUTION FOR MENTAL DISEASE 15 DAY LIMIT**

**EFFECTIVE DATE:** October 1, 2019

**REFERENCES:** 42 CFR 435.1010, 42 CFR 438.3(e)(2)(i) through (iii), 42 CFR 438.6(e)

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes processes and AdSS requirements for compliance with managed care regulation 42 CFR 438.6(e), “Payments to MCOs for and Prepaid Inpatient Health Plans (PIHPs) for enrollees that are a patient in an institution for mental disease.”

**Definitions**

A. **Day** - A calendar day unless otherwise specified.

B. **Institution** - An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services, to four or more persons unrelated to the proprietor.

C. **Institution For Mental Disease (IMD)** - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (including substance use disorders), including medical attention, nursing care, and related services. Whether an institution is an institution for mental disease is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases. [42 CFR 435.1010].

D. **IMD Stay** - The total number of calendar days of an inpatient stay in an institution for mental disease beginning with the date of admission through discharge, but not including the date of discharge unless the member expires.

**General**

Medically necessary IMD Stays are covered for individuals under the age of 21 (except as noted below under "Members Turning 21 or 65 Years of Age") and for adults 65 years of age and older. For adult members age 21 and older but under the age of 65 (referred to in this policy as “adult member age 21-64”) coverage is subject to the limitations and requirements outlined in this policy. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services or settings at 42 CFR 438.3(e)(2)(i) through (iii).

In accordance with 42 CFR 438.6(e), IMD Stays are covered, for adult members age 21-64, so long as the IMD Stay is no longer than 15 cumulative days during a calendar month.

The following provider types are considered to be IMDs subject to the limitations and requirements outlined in this policy:

A. **B1-Residential Treatment CTR-Secure (17+Beds)**
B. B3-Residential Treatment Center-Non-Secure
C. B6-Subacute Facility (17+Beds)
D. 71-Psychiatric Hospital

**AdSS Requirements**

A. Members remain enrolled and eligible for all medically necessary services during the entire IMD Stay whether or not the stay exceeds 15 cumulative days during a calendar month. The AdSS is responsible for payment of these services.

B. For any IMD stay which exceeds 15 days, neither the IMD Stay nor any other medically necessary services provided during the length of that IMD Stay may be paid with Title XIX funding including administrative funding for Title XIX services.

C. The AdSS responsible for behavioral health services must complete and submit *ACOM 109 Attachment A – IMD Placement Exceeding 15 days* to the Division, within one business day of identification of an IMD Stay greater than 15 days.

D. Submission of Attachment A will result in a change to the member’s physical and behavioral health enrollment/assignment with the AdSS resulting in an adjustment to the Capitation.

E. The AdSS must continue to submit encounters for all medically necessary services including the IMD Stay, regardless of the length of the IMD Stay, and regardless if the capitation payment is recouped by the Division from the AdSS for that month, that is, the AdSS is not permitted to recoup payments to providers. The Division will use encounters to audit AdSS compliance with this policy. Encounters related to the IMD Stay will not be considered in reconciliation and reinsurance processes.

F. The AdSS must maintain a network of providers adequate to provide members with adequate access to behavioral health services and to ensure the member is receiving care in the setting most appropriate for the member’s needs.

**Capitation Recoupment**

A. When an adult member’s IMD Stay is longer than 15 cumulative days during the calendar month, AHCCCS will recoup the AdSS’s entire monthly capitation payment for that member.

B. The change to a member’s enrollment/assignment to non-Capitated will trigger the recoupment.

C. If two different AdSSs are responsible for physical health services and behavioral health services for the member, AHCCCS must recoup the entire monthly capitation payment from both AdSSs.
D. The capitation recoupment will occur whether or not the AdSS pays the IMD.

E. This recoupment applies whether or not the member is dual eligible or the member has third party insurance coverage.

F. The AdSS will be notified of the contract type change/recoupment via the 834 and 820 files from AHCCCS.

G. After funds have been recouped, AHCCCS will make a capitation payment to the AdSS(s) equal to a pro-rated amount of the monthly capitation payment for each day the member is not in an IMD during the calendar month.

**Members Turning 21 Or 65 Years Of Age**

A. The IMD restriction does not apply for a member who is admitted prior to age 21 and turns 21 during the IMD Stay, until the member turns 22 years of age during the IMD Stay. The AdSS is not required to report an IMD Stay greater than 15 days when the member is admitted prior to age 21 even if the member turns 21 during the same IMD Stay as long as the member is discharged prior to age 22.

B. For members who turn age 65 during an IMD Stay, all the days of the IMD Stay while the member is age 64 must be counted against the 15 day limit and all the days of the IMD Stay when the member is 65 must not be counted against the limit.

The AdSS must report an IMD Stay greater than 15 days when the member is admitted prior to age 65 even if the member turns 65 during the same IMD Stay. After funds have been recouped, the Division will make a capitation payment to the AdSS(s) equal to a pro-rated amount of the monthly capitation payment for each day the member is age 65 or older during the IMD Stay.
110 MENTAL HEALTH PARITY

EFFECTIVE DATE: October 1, 2019

This Policy applies to the Division’s Administrative Services Subcontractors (AdSS). This Policy outlines the requirements to achieve and maintain compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

For Fee-For Service (FFS) members who are receiving part of their services through an AdSS, the Division will facilitate mental health parity requirements.

Definitions

A. **Aggregate Lifetime Dollar Limit** - A dollar limitation on the total amount of specified benefits that may be paid under a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP).

B. **Annual Dollar Limit** - A dollar limitation on the total amount of specified benefits that may be paid in a fiscal year 12-month period under a MCO, PIHP, or PAHP.

C. **Benefit Package** - A benefit package includes all benefits provided to a specific population group or targeted residents (e.g. individuals determined to have a serious mental illness) regardless of the Health Care Delivery System.

D. **Cumulative Financial Requirements** - Financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and included deductibles, and out-of-pocket maximums. Cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.

E. **Health Care Delivery System** - The health care delivery system refers to the structure and organization of covered services and benefit packages available to AdSS members. Delivery systems can be fully integrated (all covered services administered by a single AdSS) or partially integrated (Members enrolled with an AdSS may receive covered services by multiple AdSSs or via fee-for-service arrangements).

F. **Medical/Surgical Benefits** - Items or services for medical conditions or surgical procedures, as defined by the State and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits. Any condition defined by the State as being or not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice. Medical/surgical benefits include long-term care services.

G. **Mental Health Benefits** - Items or services for mental health conditions, as defined by the State and in accordance with applicable Federal and State law. Any condition defined by the State as being or not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice. Mental health benefits include long-term care services.

H. **Substance Use Disorder Benefits** - Items or services for substance use disorders, as defined by the State and in accordance with applicable Federal and State law.
disorder defined by the State as being or not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice. Substance use disorder benefits include long-term care services.

I. Treatment Limitations - Limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

Policy

A. MHPAEA Final Rule

The Centers for Medicare and Medicaid Services (CMS) issued the MHPAEA final rule on March 30, 2016. The regulation, in general, prohibits the application of more restrictive limits to Mental Health/Substance Use Disorder (MH/SUD) benefits than to Medical/Surgical (M/S) benefits. MHPAEA specifically:

1. Prohibits the application of annual or lifetime dollar limits to MH/SUD benefits unless aggregated dollar limits apply to at least one third of medical benefits;

2. Prohibits the application of financial requirements (e.g. copays) and quantitative treatment limitations (QTLs) (e.g. day or visit limits) on MH/SUD benefits that are more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all M/S benefits in that same classification; and

3. Prohibits the application of non-quantitative treatment limits (NQTLs) (e.g. prior authorization) on MH/SUD benefits in any classification unless the NQTL, as written and in operation, is applied to the MH/SUD benefits comparably and no more stringently than to M/S benefits in the same classification.

B. Mental Health Parity Analysis Requirements

If the AdSS is responsible for the delivery of all MH/SUD and M/S services in a benefit package, the AdSS is responsible for performing the initial and ongoing parity analyses. If some MH/SUD or M/S benefits are provided to members through another Health Care Delivery System, the Division is responsible for completing the parity analysis. The Division is responsible for ensuring compliance for all AdSSs.

1. Parity requirements apply to all MH/SUD benefits provided to members.

2. The parity analysis must be conducted and assessed annually for each Health Care Delivery System administering a benefit package.

3. The parity analysis must be conducted for each benefit package regardless of Health Care Delivery System.
a. The benefit package includes the covered services to a specific population;
b. A benefit package includes M/S and MH/SUD benefits, including long-term care benefits; and
c. A benefit package may be provided using one or more Health Care Delivery Systems.

C. Standard Parity Requirements

1. Benefit Packages

Benefit packages and Health Care Delivery Systems are defined as Title XIX adults and children; Title XXI adults and children; Title XIX SMI adults; Title XXI SMI adults; Title XIX DDD children and adults; EPD Title XIX adults and children; Medicare cost sharing; and members that are American Indians. Title XIX and XXI members up to the age of 21 are designated as children.

The AdSS must adhere to all applicable established benefit packages and service Health Care Delivery Systems when conducting the mental health parity analysis and assessing for ongoing compliance with parity requirements.

In addition to the established benefit packages and identified populations, the Division identified the following additional special populations applicable to the analysis that necessitated separate benefit packages:

a. Transitional Medical Assistance,
b. AHCCCS for Families with Children (1931),
c. Young Adult Transitional Insurance (YATI),
d. State Adoption Assistance for Special Needs Children who are being adopted,
e. Supplemental Security Income (SSI),
f. SSI Medical Assistance Only (SSI MAO), and
g. Freedom to Work (FTW).

2. Defining MH/SUD and M/S Benefits

MH/SUD benefits are items and services for MH/SUD conditions regardless of the type of AdSS or type of provider that delivers the item/service. The Division defines MH/SUD and M/S conditions using the ICD-10-Clinical Modification (ICD-10). For purposes of parity, MH and SUDs are those conditions in ICD-10, chapter 5, “Mental, Behavioral and Neurodevelopmental Disorders,” sub-chapters 2-7 and 10-11.
a. Sub-chapter 1, "Mental Disorders Due to Known Physiological Conditions," is excluded from the MH condition definition (and included in the M/S condition definition) because the physiological condition is primary for these diagnostic codes; and

b. Sub-chapters 8 and 9 (e.g., intellectual disabilities, specific developmental disorders of speech and language, specific developmental disorders of scholastic skills and pervasive developmental disorders) are excluded from the MH condition definition (and included in the M/S condition definition) because these are neurodevelopmental conditions, which are separate and distinct from mental and behavioral conditions, as indicated by the chapter title.

AdSSs must utilize the Division’s definitions for MH/SUD and M/S conditions when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

3. Mapping Benefits to Classifications

When conducting the parity analysis and when assessing for ongoing compliance with parity requirements, AdSS must apply the defined classifications outlined below.

In order to conduct the analysis, each service is assigned to one of four classifications: inpatient, outpatient, emergency care, and prescription drug. AdSSs must apply the established benefit mapping when conducting the parity analysis. Refer to AHCCCS Contractor Operations Manual (ACOM), Chapter 100, Policy 110, Attachment A for the benefit mapping for year 2016-2017. Each of the above classifications are defined based on the setting in which the services are delivered. General definitions for each of the classifications include:

a. Inpatient: Includes all covered services or items provided to a member in a setting that requires an overnight stay including behavioral health placement settings;

b. Outpatient: Includes all covered services or items provided to a member in a setting that does not require an overnight stay, which does not otherwise meet the definition of inpatient, prescription drug, or emergency care services;

c. Emergency care: Includes all covered emergency services or items to treat an emergency medical condition delivered in an emergency department (ED) setting; and

d. Prescription drugs: Covered medication, drugs, and associated supplies and services that require a prescription to be dispensed, which includes drugs claimed using the NCPDP claim forms.

Parity requirements for financial requirements, quantitative treatment limits,
and non-quantitative treatment limits apply by classification (e.g., as inpatient, outpatient, emergency, and pharmacy).

AdSSs must apply the defined classifications when conducting the parity analysis and when assessing for ongoing compliance with parity requirements.

4. Testing MH/SUD Financial Requirements, Quantitative Limits, Annual Dollar Limits, and Non-Quantitative Treatment Limits

a. When applicable, AdSSs must conduct limit testing as part of the initial parity analysis and must re-assess compliance when changes may impact parity compliance. Testing limits includes:

i. Identifying and evaluating financial requirements and quantitative treatment limits using a 2-part, claims-based test (if applicable). The Division determined that the 2-part, claims-based test is not necessary when performing or overseeing the initial MH parity.

ii. Identifying and testing aggregate lifetime and annual dollar limits (if applicable) using a multi-part claims-based test. The Division did not identify any of these limits applicable to any MH/SUD services and as a result, no review or testing is necessary.

iii. Identifying NQTLs and applying the NQTL information-based test to each NQTL.

b. Financial requirements include copays, coinsurance, deductibles, out of pocket maximums (does not include aggregate lifetime or annual dollar limits),

i. The AdSS must ensure that cumulative financial requirements (i.e. deductibles) do not accumulate separately for MH/SUD benefits.

ii. Individuals eligible for AHCCCS may be charged nominal copays, unless they are receiving a covered service that is exempt from copays or the individual is in a group that cannot be charged copays. Nominal copays are also referred to as optional copays. If a member has a nominal copay, then a provider cannot deny the service if the member states that the member is unable to pay the copay. There are specific populations that are exempt from any nominal copayments,

iii. During the initial MH parity analysis ((Contract Year (CY) 2017)) and presently ((Fiscal Year (FY) 2019)), the Division requires all outpatient office visits in all benefit packages to have a copayment, with the exception of members and services exempted from copayments. Because all outpatient office visits
have a copayment, the Division concluded without testing that these are the respective predominant limits. Similarly, for prescription drugs, a copayment applies to all prescription drugs for both M/S and MH/SUD conditions. This is considered the predominant limit, and

iv. The AdSS must adhere to ACOM Policy 431 regarding copayment requirements, including the populations subject to a copayment, the amount of the copayment, populations and services exempt from copayments, as well as the out-of-pocket maximum.

c. Quantitative treatment limits are numerical limits on benefits based on the frequency of treatment, number of days, days of coverage, days in a waiting period, or similar limits on treatment scope or duration. In accordance with this Policy, the AdSS must not apply quantitative treatment limits to any MH/SUD services in any classification in any benefit package, with the exception that hour limits currently applied to respite services (600 hours/year) and visit limits (15 visits per Contract Year) currently applied to occupational therapy services in the outpatient classification are permissible under the parity requirements.

d. NQTLs are limitations that are not expressed numerically, but otherwise limit the scope or duration of benefits.

i. Examples of NQTLs published in the Final MHPAEA Rule include:

(1) Medical management standards (e.g. medical necessity criteria and processes or experimental/investigational determinations);

(2) Prescription drug formulary;

(3) Admission standards for provider network;

(4) Standards for accessing out-of-network providers;

(5) Provider reimbursement rates (including methodology);

(6) Restrictions based on the location, facility type, or provider specialty;

(7) Fail-first policies or step therapy protocols; and

(8) Exclusions based on failure to complete a course of treatment.

ii. AHCCCS identified the following NQTLs as part of the initial MHPAEA compliance determination:

(1) Utilization management NQTLs,
(2) Medical necessity NQTLs,
(3) Documentation requirements NQTLs, and
(4) Out-of-network/geographic area coverage NQTLs.

iii. AdSSs must not impose NQTLs for MH/SUD services in any classification unless, under the policies and procedures of the AdSS as written and in operation, any processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the NQTL to M/S benefits in the classification, and

iv. Once NQTLs are identified, the AdSS must collect and analyze information about the processes, strategies, evidentiary standards and other factors applicable to each NQTL, in writing and in operation, relative to M/S and MH/SUD benefits in each classification.

D. Events Warranting a Parity Analysis and AdSS Specific Requirements

1. AdSSs responsible for administering a fully integrated contract must perform a parity analysis anytime a benefit package, utilization requirements, including both NTQL and QTL, Health Care Delivery System changes, or when there is a change in the AdSS’ operations that may impact parity compliance. AdSSs that are new or newly responsible for the delivery of integrated M/S and MH/SUD services in a benefit package must perform and document a comprehensive parity analysis prior to initiation of services. The results of the analysis must be submitted to the Division as specified in Contract.

2. In the event of a contract modification, amendment, novation, or other legal act changes, limits, or impacts compliance with the mental health parity requirement, the AdSS must conduct an additional analysis for mental health parity in advance of the execution of the contract change. Further, the AdSS must provide documentation of how the parity requirement is met, with the submission of the contract change, and how sustained compliance will be achieved. The AdSS must certify compliance with parity requirements prior to the effective date of the contract changes.

3. The AdSS must report mental health parity deficiencies as specified in Contract and develop a corrective action plan to be in compliance within the same quarter as the submission.

4. All financial requirements, AL/ADLs, QTLs, and NQTLs must be evaluated as part of the AdSS’ parity analysis.

5. The AdSS may utilize any data collection and documentation template for the parity analysis; however, the following elements must be clearly documented:
a. Methodology, processes, strategies, evidentiary standards and other factors applied;

b. All financial requirements, AL/ADLs, QTLs and identified NQTLs AdSSs must minimally report NQTL analysis results for prior authorization, concurrent review, medical necessity, outlier, documentation, and out of area criteria, but must also assess and document for the presence of other potential NQTLs):

i. Monitoring mechanisms and aggregated results as applicable (e.g. denial rates);

ii. Findings;

iii. Components of the analysis that are determined to be non-compliant with parity along with a detailed plan to resolve identified deficiencies; and

iv. The AdSS must analyze and document all delegated functions that may apply to limit MH/SUD benefits in policy and in operation.

6. If there have been no substantive changes to the AdSS’s benefit package, utilization, or Health Care Delivery Systems, the AdSS must submit an annual attestation (Attachment B) and NQTL Summary (Attachment C) along with documentation supporting compliance with mental health parity certifying ongoing compliance with parity requirements as specified in Contract.

7. The AdSS must make available upon request to beneficiaries and contracting providers the criteria for medical necessity determinations with respect to MH/SUD benefits. AdSSs must also make available to the member the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

8. The AdSS may be required to participate with and respond to inquiries from AHCCCS or an AHCCCS contracted consultant regarding AdSS policies and procedures requiring review to determine compliance with mental health parity regulations.
201 MEDICARE COST SHARING FOR MEMBERS COVERED BY MEDICARE AND MEDICAID

EFFECTIVE DATE: October 1, 2019


DELIVERABLES: AHCCCS Notification to Waive Medicare Part D Co-Payments

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The purpose of this policy is to:

- Define cost sharing responsibilities for members who 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.
- Maximize cost avoidance efforts by the AdSS and to provide a consistent reimbursement methodology for Medicare cost sharing as outlined in section 1905(p)(3) of the Social Security Act.

Definitions

A. Cost Sharing - The AdSS’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 member who is eligible for the Division and both Medicaid and Medicare services. There are two types of Dual Eligible members: Qualified Medicare Beneficiary (QMB) Duals and Non-QMB Duals (Full Benefit Dual Eligible [FBDE], Specified Low Income Medicare Beneficiary [SLMB], QMB)

C. Full Benefit Dual Eligible (FBDE) - An AHCCCS 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 AdSS 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 (RPOPs).

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 AdSS to provide services to its members.

K. 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.

L. 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.

M. For QMB Duals and Non-QMB Duals, the AdSS’s cost sharing payment responsibilities are dependent upon whether:

1. Service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid.

2. Services are received in or out of network (the AdSS only has responsibility to make payments to AHCCCS-registered providers).

3. Services are emergency services.

4. AdSS refers the member out of network.

Refer to sections A-B of this policy and to A.A.C. R9-29-301 et seq.

An exception to the AdSS’s cost sharing payment responsibility described below applies to days in a Skilled Nursing Facility. For stays in a Skilled Nursing Facility, the AdSS 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 AdSS has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

For AdSS responsibilities regarding coordination of benefits activities for members who have third-party coverage other than Medicare, refer to the Division’s Operations Manual, Policy 434.
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 AHCCCS 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. 9-22 or A.A.C. 9-28 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)

AdSS Payment Responsibilities

A. The AdSS 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 (see Division Medical Policy Manual Chapter 300). These services include:

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

B. The AdSS 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 AdSS’s network or prior authorization has been obtained.

D. The AdSS must have no cost sharing obligation if the Medicare payment exceeds the AdSS’s contracted rate for the services. The AdSS’s liability for cost sharing plus the amount of Medicare’s payment must not exceed the AdSS’s contracted rate for the service. There is no cost sharing obligation if the AdSS 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 AdSS must pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if the AdSS 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

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE AdSS MUST PAY: (Subject to the limits outlined in this policy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Medicare copayments, coinsurance and deductible</td>
</tr>
<tr>
<td>Medicaid Only</td>
<td>The provider in accordance with the contract</td>
</tr>
<tr>
<td>By both Medicare and Medicaid</td>
<td>The lesser of:</td>
</tr>
<tr>
<td>(See Examples Below)</td>
<td>a. The Medicare copay, coinsurance or deductible, or</td>
</tr>
<tr>
<td></td>
<td>b. The difference between the AdSS’s contracted rate and the Medicare paid amount.</td>
</tr>
</tbody>
</table>

Figure 1 – QMB DUAL Cost Sharing - Examples

<table>
<thead>
<tr>
<th>SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID</th>
<th>EXAMPLE 1</th>
<th>EXAMPLE 2</th>
<th>EXAMPLE 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider charges</td>
<td>$125</td>
<td>$125</td>
<td>$125</td>
</tr>
<tr>
<td>Medicare rate for service</td>
<td>$100</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>Medicaid rate for Medicare service (AdSS’s contracted rate)</td>
<td>$100</td>
<td>$90</td>
<td>$90</td>
</tr>
<tr>
<td>Medicare deductible</td>
<td>$0</td>
<td>$0</td>
<td>$40</td>
</tr>
<tr>
<td>Medicare paid amount (80% of Medicare rate less deductible)</td>
<td>$80</td>
<td>$80</td>
<td>$40</td>
</tr>
<tr>
<td>Medicare coinsurance (20% of Medicare rate)</td>
<td>$20</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>AdSS PAYS</td>
<td>$20</td>
<td>$10</td>
<td>$50</td>
</tr>
</tbody>
</table>

Non-QMB DUALS

A Non-QMB Dual eligible member who receives covered services under A.A.C. R9-22-201 et seq or A.A.C. R9-28-201 et seq from a provider within the AdSS’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. R9-22-201 et seq. 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.
AdSS 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. R9-22-201 et seq, the member is not liable for any balance of billed charges and the following applies (Table 2):

Table 2: Non-QMB Duals (In Network)

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE AdSS MUST NOT PAY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Medicare copay, coinsurance or deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE AdSS MUST PAY: Subject to the limits outlined in this Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Only</td>
<td>The provider in accordance with the contract</td>
</tr>
<tr>
<td>Both Medicare and Medicaid</td>
<td>The lesser of the following (unless the subcontract with the provider sets forth different terms):</td>
</tr>
<tr>
<td></td>
<td>a. The Medicare copay, coinsurance or deductible, or</td>
</tr>
<tr>
<td></td>
<td>b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (AdSS’s contracted rate).</td>
</tr>
</tbody>
</table>
AdSS 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-contracting provider the following applies (Table 3):

Table 3: NON-QMB Duals (Out of Network)

<table>
<thead>
<tr>
<th>WHEN THE SERVICE IS COVERED BY:</th>
<th>THE AdSS Subject to the limits outlined in this Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Only</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>Medicaid only and the AdSS has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>Medicaid only and the AdSS has referred the member to the provider or has authorized the provider to render services or the services are emergent</td>
<td>Must pay in accordance with A.A.C. R9-22-705.</td>
</tr>
<tr>
<td>By both Medicare and Medicaid and the AdSS has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent</td>
<td>Has no responsibility for payment.</td>
</tr>
<tr>
<td>By both Medicare and Medicaid and the AdSS has referred the member to the provider or has authorized the provider to render services or the services are emergent</td>
<td>Must pay the lesser of: a. The Medicare copay, coinsurance or deductible, or b. Any amount remaining after the Medicare paid amount is deducted from the amount otherwise payable under A.A.C. R9-22-705.</td>
</tr>
</tbody>
</table>

Prior Authorization

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

**Part D Covered Drugs**

For QMB and Non-QMB Duals, federal and state laws prohibit the use of AHCCCS monies to pay for cost sharing of Medicare Part D medications.
203  CLAIMS PROCESSING

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §§ 36-2903.01.G, 36-2904.G; 42 CFR 438.242(a), 45 CFR 160.101 et seq., 162.100 et seq., and 164.102 et seq., Section F3 Contractor Chart of Deliverables

DELIVERABLES: Claims Dashboard

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). It stipulates requirements for the adjudication and payment of claims. See Section F3, Contractor Chart of Deliverables.

Definitions

A. Administrative Services Subcontracts - An Administrative Services Subcontract is a contract that delegates any of the requirements of the Division’s contract with AHCCCS, including, but not limited to:
   1. Claims processing, including pharmacy claims
   2. Credentialing, including those for only primary source verification
   3. Management Service Agreements
   4. Service Level Agreements with any Division
   5. Subsidiary of a corporate parent owner claims process.

B. Clean Claim – A claim that may be processed without obtaining additional information from the provider of service or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.

C. Subcontractor –
   1. A provider of health care who agrees to furnish covered services to members
   2. A person, agency or organization with which the Administrative Services Subcontractor (AdSS) has contracted or delegated some of its management/administrative functions or responsibilities
   3. A person, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Division agreement.

Claims Processes and Systems

The AdSS must develop and maintain claims processes and systems that ensure the correct collection and processing of claims, analysis, integration, and reporting of data. These processes and systems result in information on areas including, but not limited to, service utilization, claim disputes, and appeals.
The AdSS must have a mechanism to inform providers of the place to send claims at the time of notification or prior authorization if the provider has not otherwise been informed of such information via subcontract and/or a provider manual.

**Receipt Date**

The receipt date of the claim is the date of the date stamp on the claim or the date on which the claim is electronically received. The receipt date is the day on which the claim is received at the AdSS specified claim mailing address, received through direct electronic submission, or received by the AdSS designated clearinghouse.

**Claim Submission Timeliness**

A. Unless a contract specifies otherwise, the AdSS ensures that, for each form type, 95% of all clean claims are adjudicated within 30 days of receipt of the clean claim and 99% are adjudicated within 60 days of receipt of the clean claim. The AdSS must track and report the following monthly:

1. Percentage of clean claims that reach PAID status on a provider’s first billing submission

   The AdSS will ensure that 95% of all clean claims reach PAID status on the provider’s first billing submission. *The AdSS will highlight field and provide an explanation if this falls below contract performance minimum.*

2. Percentage of claims that are DENIED

   i. *The AdSS will highlight field and provide an explanation if the total percentage reported is above 20% OR*

   ii. *The AdSS will highlight field and provide an explanation if there is a 15% increase from the previous reporting month.*

   *For example, if the previous month’s percent claims denied was 10%, the AdSS must provide an explanation if the current month’s percent is 11.5% or greater.*

   Percentage of claims denied:

   \[
   \text{Percentage of claims denied} = \frac{\text{Total number of claims denied in the month}}{\text{Total number of claims processed in the month}}
   \]

B. In addition, 95% of clean claims will be paid on first submission and less than 20% of second submission claims will be denied.

C. The AdSS must refer to ATTACHMENT B of the DDD Claims Dashboard Reporting Guide for additional information on reporting guidelines.

The AdSS must not pay:

A. Claims initially submitted more than six months after date of service for which
payment is claimed or after the date that eligibility is posted, whichever date is later; or

B. Claims submitted as clean claims more than 12 months after date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later.

When any payor recoups a claim because the claim is the payment responsibility of another payor (responsible payor), the provider may file a claim for payment with the responsible payor. The provider must submit a clean claim to the responsible payor no later than the latest of the following dates:

A. 60 days from the date of the recoupment
B. 12 months from the date of service
C. 12 months from date that eligibility is posted.

The payor must not deny a claim on the basis of lack of timely filing if the provider submits the claim within the timeframes above.

Claim payment requirements pertain to both contracted and non-contracted providers.

**Discounts**

The AdSS must apply a quick pay discount of 1% on hospital claims paid within 30 days of the date on which the clean claim was received.

**Interest Payments**

The AdSS must pay interest on late payments and report the interest as required.

For hospital, clean claims, the AdSS must pay slow payment penalties (interest) on payments made after 60 day of receipt of the clean claim. Interest must be paid at the rate of 1% per month for each month or portion of a month from the 61st day until the date of payment.

For authorized services submitted by a licensed skilled nursing facility, the AdSS must pay interest on payments made after 30 days of receipt of the clean claim. Interest is paid at the rate of 1% per month (prorated on a daily basis) from the date the clean claim is received until the date of payment.

For non-hospital clean claims the AdSS must pay interest on payments made after 45 days of receipt of the clean claim. Interest is paid at the rate of 10% per annum (prorated daily) from the 46th day until the date of payment.

The AdSS must pay interest on all claim disputes as appropriate based on the date of the receipt of the original clean claim submission (not the claim dispute).
Electronic Processing and Remittance Advices

A. The AdSS must accept and generate required HIPAA-compliant electronic transactions from or to any provider or their assigned representative interested in and capable of electronic submission. Accepted electronic submissions include eligibility verifications, claims, claims status verifications, and prior authorization requests.

B. The AdSS must make claim payments via electronic funds transfer (EFT) and accept electronic claim attachments.

C. The AdSS must generate an electronic remittance that includes:
   1. The reason(s) for denials and adjustments
   2. A detailed explanation/description of all denials and adjustments
   3. The amount billed
   4. The amount paid
   5. Application of Coordination of Benefits (COB) and copays
   6. Providers rights for claim disputes
   7. Instructions and timeframes for the submission of claim disputes and corrected claims.

D. The AdSS must send electronic remittance advice with the payment, unless the payment is made by EFT. The AdSS must either direct providers to the link where this information is explained or include a supplemental file where this information is explained. Any remittance advice related to an EFT is sent no later than the date of the EFT.

General Claims Processing

The AdSS must follow all general claims processing requirements as described below.

A. The AdSS must use nationally recognized methodologies to correctly pay claims; these methodologies include but are not limited to:
   1. National Correct Coding Initiative (NCCI) for Professional, Ambulatory Surgery Centers, and Outpatient Services
   2. Multiple Procedure/Surgical Reductions

B. The AdSS claims payment system must assess and apply data-related edits including but not limited to:
   1. Benefit Package Variations
2. Timeliness Standards
3. Data Accuracy
4. Adherence to Division and AHCCCS policy
5. Provider Qualifications
6. Member Eligibility and Enrollment
7. Overutilization Standards.

C. If a claim dispute is overturned, in full or in part, the AdSS reprocesses and pays the claim(s) in a manner consistent with the decision within 15 business days of the decision.

D. The AdSS claims payment system must not require a recoupment of a previously paid amount when the provider’s claim is adjusted for data correction (excluding payment to a wrong provider) or an additional payment is made. The AdSS must ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.

E. The AdSS must adhere to the following:
   1. COB and Third Party Liability requirements per contract, and Policy 201 and 434 in the Division’s Operations Manual
   2. Claims processing requirements per contract and the Claims Dashboard Reporting Guide
   3. All Health Insurance, Portability, and Accountability Act (HIPAA) requirements according to 45 CFR Parts 160, 162, and 164.

F. When the AdSS contractor cost avoids a claim, the following payment provisions apply:
   1. Claims from providers CONTRACTED with the AdSS: Unless a subcontract with the provider specifies otherwise, the AdSS must pay the difference between the AdSS Contracted Rate and the Primary Insurance Paid amount, not to exceed the AdSS Contracted Rate.
   2. Claims from providers NOT CONTRACTED with the AdSS: The AdSS must pay the difference between the AHCCCS Capped-Fee-For-Service rate and the Primary Insurance Paid amount, not to exceed the AHCCCS Capped-Fee-For Service.

**Claims Processing By AdSS Contractors**

A. The AdSS must obtain prior approval from the Division for subcontracts regarding claims processing to be performed by or under the direction of a subcontractor.

B. The AdSS remains responsible for the complete, accurate, and timely payment of...
all valid provider claims arising from the provision of medically necessary covered services to its enrolled members regardless of administrative service arrangements.

**C.** The AdSS must forward all claims received to the subcontractor responsible for claims adjudicating.

**D.** The AdSS must require the subcontractor to submit a monthly claims aging summary to the AdSS to ensure compliance with claims payment timeliness standards.

**E.** The AdSS must monitor the subcontractor’s performance on an ongoing basis and complete a formal review according to a periodic schedule.

   1. As a result of the performance review, any deficiencies must be communicated to the subcontractor in order to establish a corrective action plan.

   2. The results of the performance review and the correction plan must be communicated to the Division upon completion.

**F.** The AdSS must monitor encounters received from the subcontractor to ensure encounters are submitted in accordance with Division and AHCCCS standards and thresholds.
GROUND AMBULANCE TRANSPORTATION REIMBURSEMENT REQUIREMENTS FOR NON-CONTRACTED PROVIDERS

EFFECTIVE DATE: October 1, 2019

Purpose

This Policy applies to the Division of Developmental Disabilities Administrative Services Subcontractors (AdSS). The purpose of this Policy is to provide ground ambulance transportation reimbursement requirements. It is limited to AdSS and ambulance or emergent care transportation providers when a contract does not exist between these entities.

Definitions

For purposes of this policy the following definitions apply:

A. Advanced Life Support (ALS) - 42 CFR 414.605, describes ALS as either transportation by ground ambulance vehicle, that has medically necessary supplies and services, and the treatment includes administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer’s Lactate); or transportation, medically necessary supplies and services, and the provision of at least one ALS procedure:
   - Manual defibrillation/cardioversion
   - Endotracheal intubation
   - Central venous line
   - Cardiac pacing
   - Chest decompression
   - Surgical airway
   - Intraosseous line.

B. Ambulance - Ambulance as defined in A.R.S. §36-2201.

C. Basic Life Support (BLS) - Transportation by ground ambulance vehicle that has medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as described in 42 CFR 414.605.

D. Emergency Ambulance Services - Emergency ambulance services are as described in 9 A.A.C. 22, Article 2, 9 A.A.C. 25, and in 42 CFR 410.40 and 414.605.

E. Emergency Ambulance Transportation - Emergency ground and air ambulance services required to manage an emergency medical condition of an AHCCCS member at an emergency scene and transport to the nearest appropriate facility.

F. Emergency Medical Care Technician (EMCT) - As defined in A.A.C. R9-25-101(18).
G. **Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

H. **Emergency Medical Services** - Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition [42 CFR 438.114(a)].

**Policy**

Ambulance providers that have fees established by the Arizona Department of Health Services (ADHS) are reimbursed by AHCCCS at a percentage, prescribed by law, of the Ambulance provider’s ADHS-approved fees for covered services. These rates are contained in the AHCCCS Capped Fee for Service (FFS) Fee Schedule for Certificate of Necessity Providers and are used by the AdSS for reimbursement when no contract exists with the provider.

For Ambulance providers, whose fees are not established by ADHS, and no contract exists with the provider, the AHCCCS Capped FFS Fee Schedule is for Ground Transportation are used by the AdSS.

**Emergency Ground Ambulance Claims are Subject to Medical Review**

Claims are submitted with documentation of medical necessity and a copy of the trip report evidencing:

A. Medical condition, signs, symptoms, procedures, and treatment.

B. Transportation origin, destination, and mileage (statute miles).

C. Supplies

D. Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial. The AdSS processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the AdSS cannot be denied upon receipt. This claim is not subject to further medical review.

**Criteria and Reimbursement processes for Advanced Life Support (ALS) and Basic Life Support**

A. Advanced Life Support (ALS) level

   1. To reimburse Ambulance services at the ALS level, all the following criteria must be satisfied:

      a. The Ambulance must be ALS licensed and certified in accordance with A.R.S. §36-2202, A.R.S. §36-2204, and A.R.S. §36-2212.
b. Emergency Medical Care Technician (EMCT) are present and EMCT services/procedures are medically necessary, based upon the member’s symptoms and medical condition at the time of the transport.

c. EMCT services/procedures and authorized treatment activities were provided.

B. Basic Life Support (BLS) level

1. To reimburse Ambulance services at the BLS level, all the following criteria must be satisfied:

   a. The Ambulance must be BLS licensed and certified in accordance with A.R.S.§36-2212 and A.A.C. R9-25-201.

   b. EMCT are present

   c. EMCT services/procedures, are medically necessary, based upon the member’s symptoms and medical condition at the time of the transport.

   d. EMCT services/procedures and authorized treatment activities were provided.

Claims submitted without such documentation are subject to denial. The AdSS processes the claims within the timeframes established in 9 A.A.C. 22, Article 7. Emergency transportation ordered by the AdSS cannot be denied upon receipt. This claim is not subject to further medical review.

**Non-Emergent Ground Ambulance Transportation Payment Provisions**

A. Non-emergent Ambulance transportation is subject to review for medical necessity by the AdSS. Medical necessity criteria are based on the medical condition of the member. Non-emergent transportation by an ambulance is appropriate if:

1. Documentation supports that other methods of transportation are contraindicated.

2. The member’s medical condition, regardless of bed confinement, requires the medical treatment provided by the qualified staff in an ambulance.

   Non-emergent transportation ordered by the AdSS cannot be denied upon receipt. This claim is not subject to further medical review.

B. At the AdSS discretion, non-emergent ambulance transport may not require prior authorization or notification. This may include after-hours calls. An example is an ambulance company which receives a call from the emergency room to transport a nursing facility member back to the facility and the AdSS cannot be reached.

All hospital-to-hospital transfers are paid at the BLS level unless the transfer meets ALS criteria. This includes transportation between general and specialty hospitals.

C. Transportation reimbursement is adjusted to the level of the appropriate alternative transportation when circumstances do not necessitate an ambulance transport, or the services rendered at the time of transport are deemed not medically necessary. Ambulance
providers that have fees established by ADHS are reimbursed in accordance with A.R.S. § 36-2239(H).

Refer to AMPM Policy 310-BB for additional requirements for coverage of transportation.
305 PERFORMANCE BOND AND EQUITY PER MEMBER REQUIREMENTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 35-155
DELIVERABLES: Performance Bond or Bond Substitute, ACOM 305 Attachment A

This Policy applies to the Division’s Administrative Services Subcontractors (AdSS). The purpose of this Policy is to establish standards to meet the performance bonding and equity per member requirements. These standards will continue to ensure an AdSS ability to meet its claims payment obligations, while addressing the individual differences among AdSS and enrollment growth.

Definitions
A. **Equity** - Net Assets that are not designated or restricted for specific purposes.
B. **Performance Bond** - A cash deposit with the State Treasurer or a financial instrument secured by the AdSS in an amount designated by the Division to guarantee payment of AdSS claims.
C. **Surety Bond** - An agreement between the Division, the AdSS, and the Surety where the surety provides a financial guarantee to the Division.

Policy

The Division requires the posting of a Performance Bond or Bond Substitute in addition to the initial minimum capitalization and equity per member requirements as described below. This is to guarantee payment of the AdSS obligations under the Contract including, but not limited obligations or payments to providers and non-contracting providers and any other entity that subcontracts for the performance of the AdSS obligations under this Contract whether related to coverage for services to members or for the administration of this Contract.

The Division will inform the AdSS of the required initial amount of the Performance Bond or Bond Substitute, as determined by the Division, prior to or at the beginning of each contract cycle. This requirement must be satisfied by the AdSS no later than 30 days after notification by the Division of the initial amount required.

After the initial performance bond or Bond Substitute is satisfied, the Division will evaluate each AdSS enrollment statistics and/or monthly capitation payments and determine if adjustments are necessary in accordance with this Policy.

Annually on October 1, the AdSS provides a written attestation, consistent with 42 C.F.R. 438.604 and 42 CFR 438.606, that the documentation of the Performance Bond or Bond Substitute is accurate, complete, and truthful. See Attachment A.
Performance Bond Requirements and Bond Substitutes

A. The Performance Bond must be in a form acceptable to the Division as described in Section III B of this Policy. The AdSS must request an approval from the Division before a Bond Substitute is established.

B. The AdSS must not change the amount, duration, scope, or type of the performance bond of Bond Substitute without prior written approval from the Division’s Finance unit.

C. The AdSS must not pledge any Bond Substitute as collateral or security for any other loan, debt, or obligation of the AdSS or pledge the Bond Substitute as security to creditors.

D. The Performance Bond or Bond Substitute maintains after the contract term until outstanding and contingent liabilities greater are less than $50,000, or 15 months following the termination date of the contract with the Division, whichever is later and will be in the amount and for the term determined by the Division.

E. Any security agreement must be disclosed.

F. An AdSS that fails to maintain or renew the Performance Bond or Bond Substitute as required by the Contract with the Division and as outlined in this Policy, is considered in material breach of the Contract with the Division.

G. Following a merger/acquisition of an AdSS or an AdSS parent company, the Division reserves the right to require additional Performance Bond assurances on behalf of the new entity, including, but not limited to, expanding the Performance Bond or Bond Substitute to include service dates prior to the merger/acquisition.

H. In the event of a default by the AdSS, the Division will, in addition to any other remedies it may have under the Contract, obtain payment under the Performance Bond or Bond Substitute to remedy the breach, including but not limited to one or more of the following purposes:

1. Paying any damages sustained by providers, and other subcontractors because of a breach of the AdSS obligations under this Contract.

2. Reimbursing the Division for any payments made by the Division on behalf of the AdSS.

3. Reimbursing the Division for any administrative expenses incurred because of a breach of the AdSS obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract. Terminations pursuant to Section E, Termination for Convenience, of the Contract do not require reimbursement to the Division for administrative expenses.

4. Reimbursing expenditures incurred by the Division in the direct operation of the AdSS under Section E.

5. Paying any sanctions imposed under Section D, to the extent the sanctions
are not offset against payments due from the Division to the AdSS as provided for under Section G2, Right of Offset of the Contract.

**Performance Bonds and Types of Bond Substitute**

**A. Performance Bond**

1. **Establishment of Bond**
   
   a. The AdSS must send a copy of the completed Performance Bond form to the Division’s Finance Department, 30 days prior to the execution of the bond agreement. The Division will review the agreement and advise the AdSS in writing of the acceptance of the Performance Bond form to be executed or that changes are necessary. The Division review will only be for the sufficiency of the agreement to meet the Division Performance Bond requirements section.

   b. Performance Bond Form includes the following requirements

      i. Issued by a Surety

      ii. The Performance Bond must be in an amount that meets or exceeds the Performance Bond dollar requirement.

      iii. The Performance Bond guarantees performance by the AdSS for all obligations, including post-award obligations that precede the beginning of the first contract year and “wind down” obligations that follow termination of the contract.

      iv. The Performance Bond includes a statement that the Performance Bond cannot be changed in the amount, duration, or scope or discontinued without the written authorization of the Division Finance Department. Any changes in the Surety or the terms of the Performance Bond is approved in writing by the Division Finance Department at least 30 days prior to the anticipated change date.

      v. The Performance Bond includes a contact person at the financial institution issuing the Performance Bond and a contact phone number.

2. After the Performance Bond Form is executed, the Division sends the original completed Performance Bond Form to the Division Finance Department signed, and notarized by the AdSS and the Surety.

3. The Division will hold the original Performance Bond Form in safe keeping until the agreement ends or is terminated by the parties.

4. The AdSS is not required to submit a separate Surety Bond to support the Performance Bond Form. If a supporting Surety Bond exists, to the extent the
terms of a Surety Bond conflict with the terms of the Performance Bond Form, the terms of the Performance Bond Form are controlling.

5. Return of Performance Bond Form original

The original Performance Bond Form will be returned to the originators upon:

a. The later of 15 months after the termination of the Contract or when the AdSS actual and contingent liabilities after the termination of the Contract are less than $50,000.

b. Satisfying the Performance Bond requirement with a Bond Substitute(s) as outlined and approved by the Division.

B. Types of Bond Substitutes

With the prior written approval of the Division Finance Department, the AdSS may provide one or more of the following Bond Substitutes in lieu of a Performance Bond:

Cash Deposits, Irrevocable Letter of Credit, Certificate of Deposit, and any other type of security agreed to by the Division.

C. Cash Deposit

1. Deposit of Funds

a. Any funds to be deposited with the State Treasurer must be sent to the Division in the form of a check or a wire transfer of funds to the State Treasurer. Reference ACOM 305 Attachment A Instructions for Wire/ACH Transfers of Funds to AHCCCS via Arizona State Treasurer.

b. Additionally, a letter should be sent to the Division describing:
   i. The application of funds
   ii. A contact person at the AdSS and contact phone number, for any issues concerning the deposit, and a wire number if the funds were sent via a bank wire.

c. The Division will “claim” the funds by submitting a copy of the AdSS letter and a “Securities Safekeeping” form to the State Treasurer’s Office. After the funds, have been claimed, the Division will send a confirmation that the funds were received and claimed.

2. Withdrawal of Funds

a. To withdraw principal funds, send a letter to the Division requesting the withdrawal. The letter must include:
   i. The amount of the withdrawal
ii. The program from which the funds are being withdrawn

iii. The date that the funds should be withdrawn (allow a minimum of 10 working days)

iv. The manner the warrant from the State Treasurer’s office is to be handled:
   • Mailed by the US Postal Service
   • Courier pick-up (please include a phone number of the primary contact so prompt notice can be given)
   • Wiring instructions.

b. The Division will submit to the State Treasurer’s Office a copy of the AdSS letter and a “Securities Safekeeping” form to release the funds. The Division will forward the warrant to the AdSS in the manner requested in the withdrawal letter.

D. Irrevocable Letter of Credit

1. Establishment of Irrevocable Letter of Credit

a. Before a Letter of Credit can be accepted in lieu of performance bond it must be approved by the Division for form and amount. Requirements include:

   i. Be of standard commercial scope and issued by a bank, insured by the Federal Deposit Insurance Corporation, credit union insured by the National Credit Union Administration or savings and loans association insured by Federal Savings and Loan Insurance Corporation and authorized to do business in the State of Arizona.

   ii. For an amount that meets or exceeds the Bond Substitute dollar requirement.

   iii. Payable to the Division for the benefit of covered members, providers and certain third parties

   iv. A statement that the Letter of Credit cannot be changed in the amount, duration, or scope, or discontinued without the written authorization from the Division.

b. The AdSS must send a copy of the Letter of Credit to the Division Finance Department to 30 working days prior to the execution of the Letter of Credit. The Division will review the Letter of Credit and advise the AdSS in writing whether it is accepted or that changes are necessary including but not limited to, expiration date and amount. The Division review will only be for issues that are necessary for the
Division Letter of Credit. It will not include review for any other matters.

c. After the agreement is executed, the AdSS must send the original to the Division. The original will be held in safe keeping until the agreement ends or is terminated by the parties.

d. The AdSS must send notification of a contact person at the financial institution issuing the letter of credit and contact phone number to the Division Finance Manager.

2. Return of the original Letter of Credit

The original Letter of Credit will be returned to the originators upon:

a. Termination of the Letter of Credit
b. Termination of the Division Contract
c. Satisfying the Performance Bond or Bond Substitute requirement with another acceptable form as outlined by the Division.

Certificate of Deposits

Certificates of Deposit are acceptable only by a bank, savings and loan, or credit union that is insured by the appropriate Federal institution.

A. Types of Certificate of Deposits

1. Only Certificates of Deposit from banks
2. Savings and loans, or credit unions and insured by the appropriate Federal institution, are applicable for the performance bond.

B. Assignment to Arizona State Treasurer

C. All Certificates of Deposit must be assigned to the Arizona State Treasurer in compliance with A.R.S. §35-155. Division finance personnel completes this by submission of the "Assignment to Arizona State Treasurer" form.

D. Deposit of the Certificate of Deposit.

1. The AdSS must send or deliver the original Certificate of Deposit (or receipt for the Certificate of Deposit if a certificate is not issued) and the Assignment form to the Division. A letter should accompany the Certificate of Deposit describing the contract or line of business (e.g., Acute Care, DDD, CRS, ALTCS/EPD, or MA) the Certificate of Deposit is satisfying and a contact person.

2. After the Certificate of Deposit has been sent to the State Treasurer, the Division will send a copy of the State Treasurer’s "Securities Safekeeping” form to the Treasurer to record the deposit of the
Certificate of Deposit.

3. After the Certificate of Deposit has been deposited with the State Treasurer, the AdSS must monitor the maturity date. No notification should be expected from the State Treasurer’s office or the Division. Evidence of the renewal of each CD must be sent to the Division within five business days prior to the renewal date.

4. The AdSS must send notification of a contact person at the AdSS and contact phone number to the Division Finance Manager.

E. Withdrawal of a Certificate of Deposit

The AdSS must send a letter to the Division requesting the release of a specific Certificate of Deposit providing:

1. The name of the institution that issued the Certificate of Deposit
2. The certificate number
3. The amount of the Certificate of Deposit
4. The programs from which the Certificate of Deposit is being withdrawn
5. The manner the Certificate of Deposit is to be returned to the Plan
6. A contact person.

The Division submits to the State Treasurer’s Office a copy of the AdSS letter and a “Securities Safekeeping” form to release the funds. The Division forwards the warrant to the AdSS in the manner requested in the withdrawal letter.

F. Any Other Type of Substitute Securities

1. The Division may accept a substitute security or securities in lieu of the surety bond or bond substitute forms discussed above. The AdSS must obtain prior approval from AHCCCS for any Substitute Securities.
   a. The AdSS agrees to perform all acts and execute any and all documents including, but not limited to, security agreements and necessary filings pursuant to the Arizona Uniform Commercial Code, necessary to grant the Division an enforceable security interest in such substitute security to secure performance of the AdSS obligations under the Contract.
   b. The AdSS is solely responsible for establishing the credit-worthiness of all forms of substitute security.

2. The Division may, after written notice to the AdSS, withdraw its permission for a substitute security or securities, in which case the AdSS must provide the Division with Performance Bond or an alternate form of Bond Substitute
discussed above.

Performance Bond and Bond Substitute Requirement for a Terminated AdSS

A. The Performance Bond or Bond Substitute amount must be maintained after the contract term in an amount sufficient to cover the Terminated AdSS outstanding and contingent liabilities greater than $50,000, or 15 months following the termination date of their contract, whichever is later, to guarantee payment of the AdSS obligations to providers, non-providers, and other subcontractors and performance by the AdSS of its obligations under the Contract with the Division.

B. The Performance Bond or Bond Substitute must be in a form acceptable to the Division.

C. Annually, on October 1, the AdSS must provide a written attestation, consistent with 42 C.F.R. §§ 438.604 and 42 CFR 438.606, that the documentation of the Performance Bond or Bond Substitute is accurate, complete, and truthful.

D. A terminated AdSS may request a reduction in the Performance Bond or Bond Substitute amount sufficient to cover all outstanding liabilities, including liabilities greater than $50,000, subject to the Divisions’ approval. A Terminated Contractor AdSS may not change the amount, duration, scope, or type of the Performance Bond or Bond Substitute without prior written approval from the Division Finance. Any modification in the Performance Bond or Bond Substitute must be approved by the Division Finance at least 30 days before the revision of the Performance Bond or Bond Substitute has been executed.

Equity per Member Requirements

A. Formula

Unrestricted equity, less on-balance sheet performance bond or bond substitute, due from affiliates, guarantees of debts/pledges/assignments and other assets determined to be restricted by the Division, divided by the number of members enrolled at the end of the period.

B. Requirement

CYE2020: At least $450 per member
CYE2021: At least $500 per member
CYE2022 and thereafter: At least $500 per member

C. Division Certified Medicare Advantage Plan Requirement:

$350 per member upon commencement of the plan.

Remediation When an AdSS Fails to Meet the Equity per Member Requirement

If an AdSS equity per member falls below the requirement, the Division will review the
causes for the lack of compliance. The Division may require the AdSS to comply with one or more of the following measures:

A. Capital infusion, within 30 days of non-compliance, in an amount sufficient to not only bring equity into compliance, but also to maintain compliance.

B. Submission of corrective action plan to increase equity

C. Monthly financial reporting, if not already required

D. Increase the amount of the Performance Bond or Bond Substitute

E. Sanctions and/or Enrollment Cap, if applicable.

If the AdSS fails to comply with the above requirements, the Division may apply sanctions as delineated in AdSS Operations Manual, Policy 408.

**Restrictions on Equity**

The following asset types will constitute restricted assets, and therefore will be subtracted from AdSS equity when calculating the equity per member ratio:

A. Assets recorded as "due from affiliates." The AdSS may request a waiver from the Division to include the prorated portion of the due from affiliates balance resulting from Division approved cash/bank account sweep arrangements.

B. Goodwill and adjustments to other assets resulting from a purchase, including those resulting from purchases and revaluations recorded in accordance with FASB Accounting Standards Codification Topic 105 - Generally Accepted Accounting Principles and FASB Accounting Standards Codification Topic 350 - Intangibles — Goodwill and Other

C. Guarantees of debt, pledges, and assignments.

D. On balance sheet Performance Bonds or Bond Substitute

E. Other assets determined to be restricted by the Division.

**Requirements for AdSS with Restricted Equity**

If AdSS equity is not supported by unrestricted cash or investments, and the AdSS does not meet the equity per member requirements, then the AdSS may be required to maintain a Performance Bond or Bond Substitute in an amount greater than 100% of one month’s capitation to cover the amount of the equity necessary to meet the requirements.

**Fund Balance and Capitalization Requirements**

If the AdSS equity becomes a fund deficit, the AdSS and its owners must fund the deficit through capital contributions in a form acceptable to the Division. The capital contributions must be for the period in which the deficit is reported and must occur within 30 days of the financial statement due to the Division. The Division at its sole discretion may impose a different timeframe other than the 30 days required in this paragraph. The Division may,
at its option, impose enrollment caps and/or sanction the AdSS because of an accumulated deficit, even if unaudited.

**Division Monitoring Responsibilities**

A. The Division’s Finance Unit monitors compliance with equity per member requirements on a quarterly basis. Analyses will be performed to determine the equity per member. Deficiencies and requests for remediation will be communicated in writing to the AdSS. The AdSS will be required to submit a plan to increase the equity and/or capitalization within 30 days.

B. The Division’s Finance Unit monitors compliance with Performance Bond or Bond Substitute requirements on a monthly basis. Deficiencies and requests for remediation will be communicated in writing to the AdSS. The AdSS will have 30 days to comply with new requirements.
307 ALTERNATIVE PAYMENT MODEL INITIATIVE – STRATEGIES AND PERFORMANCE-BASED PAYMENTS INCENTIVE

EFFECTIVE DATE: October 1, 2019
REFERENCES: ACOM Policy 306, ACOM Policy 307, Attachments A and B
DELIVERABLES: Alternative Payment Model (APM) Strategies Certification (Final), Structured Payment File, and APM indicator; Alternative Payment Model APM Strategies Certification (Initial)

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The purpose of this Alternative Payment Model (APM) Initiative is to encourage AdSS activity in the area of quality improvement, particularly those initiatives that are conducive to improved health outcomes and cost savings, by aligning the incentives of the AdSS and provider through APM strategies.

Definitions

A. Alternative Payment Model Strategies (In LAN-APM Category Order) - A model that aligns payments between payers and providers to incentivize quality, health outcomes and value over volume, to achieve the goals of better care, smarter spending, and healthier people.

The APM strategies discussed in this initiative originate from the Learning Action Network APM Framework (LAN-APM), which include the following categories and strategies:

- Fee-For-Service – No Link To Quality & Value
- Fee-For-Service – Link To Quality & Value (Foundational Payments for Infrastructure & Operations, Pay for Reporting, Pay for Performance)
- APMs Built on Fee-For-Service Architecture (APMs with Shared Savings, APMs with Shared Savings and Downside Risk)
- Population Based Payment (Condition-Specific Population-Based Payment, Comprehensive Population-Based Payment, Integrated Finance & Delivery Systems).

See ACOM Policy 307, Attachment A to view the LAN-APM strategies.

B. Pay for Performance - Purchasing strategy in which providers are rewarded for performing well on quality metrics. It can also include penalties for providers who do not perform well on quality metrics. In this strategy, specific providers are responsible for the cost and quality associated with a particular set of procedures or services. Payments are not subject to rewards or penalties for provider performance against aggregate cost targets, but may account for performance on a more limited set of utilization measures. (LAN-APM Category 2C).
C. APMs Built On Fee for Service Architecture (LAN-APM Category 3)

1. **APMs with Shared Savings** - Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. (LAN-APM Category 3A).

2. **APMs with Shared Savings and Downside Risk** - Purchasing strategy where providers share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. In this strategy, multiple providers may be responsible for the cost and quality associated with a particular set of procedures or services. This strategy includes episode-based payments for procedures and comprehensive payments with upside and downside risk. (LAN-APM Category 3B).

D. Population Based Payment (LAN-APM Category 4)

1. **Condition-Specific Population-Based Payment** - Purchasing strategy of prospective, population-based payments, for all care delivered by particular types of clinicians structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within a defined scope of practice. This strategy includes per member per month payments, payments for specialty services, such as oncology or mental health, and bundled payments for the comprehensive treatment of specific conditions. (LAN-APM Category 4A).

2. **Integrated Finance and Delivery Systems** - Purchasing strategy of prospective, population-based payments structured to encourage providers to deliver well-coordinated, high-quality, person-centered care within a highly integrated finance and delivery system. This strategy includes global budgets or full/percent of premium payments in integrated systems. (LAN-APM Category 4C).

3. **Encounter** - For the purposes of this policy, all encounters must be in an adjudicated and approved status.

4. **Performance Based Payment** - A payment from an AdSS to a provider upon successful completion, or expectation of successful completion, of contracted goals/measures in accordance with the APM strategy selected for the contract. This is a non-encounterable payment and does not reflect payment for a direct medical service to a member. This payment usually occurs after the completion of the contract period, but could include quarterly or semi-annual payments if contract terms specify such payments in recognition of successful performance measurement.
General

The AdSS must meet the APM strategies qualifying criteria in “A” and “C” of AdSS Responsibilities (below), and certify as described in B.2. Failure to meet or certify to meeting the criteria in a particular contract year will result in

AdSS Responsibilities

A. A minimum percentage of total Title XIX payments (both APM and non-APM, whether contracted or non-contracted), must be governed by APM strategies for the contract year.

The Division intends that the minimum value threshold will grow each year according to the schedule below.

<table>
<thead>
<tr>
<th>CYE 19 Anticipated</th>
<th>35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYE 20 Anticipated</td>
<td>50%</td>
</tr>
<tr>
<td>CYE 21 Anticipated</td>
<td>60%</td>
</tr>
</tbody>
</table>

Strategies for this initiative may not include:

- Block Purchase Payment Arrangement Methodology with no link to quality and value
- Fee-For-Service Strategy with no link to quality and value (LAN-APM Category 1)
- Foundational Payments for Infrastructure & Operations strategy (LAN-Category 2A).

Strategies that incorporate the Pay for Reporting strategy (LAN-APM Category 2B) are considered by the Division to meet the qualifying criteria on a case-by-case basis, and prior approval is required:

- The Division only considers approval of LAN-APM Category 2B for expansion to services/service providers/provider types not traditionally used for APM arrangements.
- The Division expects to consider approval only on a short-term basis.

Strategies used must meet the definitions provided in the Definitions section of this policy. Strategies must be designed to achieve cost savings and quantifiable improved outcomes.
AHCCCS will have a requirement beginning in CYE19 for specific usage of strategies in LAN-APM Categories 3 and 4; this information will be determined based upon a review of contractor deliverables and will be released in a Public Notice published in or after January 2018. AHCCCS intends that the required percentage of strategies in LAN-APM Category 3 and Category 4 grow each year.

The AdSS is responsible for identifying which strategy applies to each APM contract and whether each contract applies to a limited cost of care, where the provider can only impact direct and limited costs attributed to members, or the total cost of care attributed to members. For example, a contract with a transportation provider which rewards the provider for improvement in on-time pick-ups would count as a limited cost of care contract since the provider has no impact on the members’ total medical costs and only directly affects transportation expense. Alternatively, a contract with a PCP which rewards the provider for reducing total medical expenses attributed to members, including those not directly provided by the PCP, would count as a total cost of care contract.

The same dollars must not be counted under multiple contracts. Additionally, one contract must not be counted under multiple strategies.

The AdSS may use quality measures other than the measures identified in this policy as part of the AdSS’s APM strategies.

To count towards meeting the qualifying criteria, strategies must be evidenced by written contracts. For those contracts executed before February 1 of each contract year, the Division counts the strategies for the time period in the contract year for which the contract is in effect. For those contracts executed after February 1 of each contract year, the Division counts the strategies for the time period from the execution date forward for which the contract is in effect.

B. The AdSS must certify to the Division that these requirements will be met, by submitting an executed copy and an electronic copy in an Excel format and through the Structured Payment File described in below under “Structured Payment File and Post Adjudicated/Post Submitted File.”

1. An initial APM strategies Certification as provided in ACOM Policy 307, Attachment B, to the Division Finance Manager within 60 days of the start of the contract year, and

2. A final APM Strategies Certification as provided in ACOM Policy 307, Attachment B, to the Division Finance Manager, and the Structured Payment File, due 270 days after the end of the contract year.

The Division will submit the APM Strategies Certifications on behalf of the AdSSs.

In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.
Failure to certify to the APM strategies qualifying criteria in a particular contract year will result in disqualification from the provisions of ACOM Policy 306 or the application of sanctions listed under General (above).

The Division reserves the right to request an audit of the Certifications included in ACOM Policy 307, Attachment B. The AdSS, upon the request of the Division, must provide documentation of APM contracts and payments to providers for performance based payments.

**Division Responsibilities**

A. The performance-based payments made by the AdSS to providers will be paid by the Division through a lump sum payment through a future monthly capitation payment. Upon receipt and review of the final APM Strategies Certification discussed in AdSS Responsibilities, The Division will perform testing of the performance-based payment amounts reported by the AdSS prior to payment of the incentive, including review of AdSS documentation of APM contracting and payments to providers for performance-based payments. The performance-based payment incentive will be adjusted for premium tax.

The AdSS must report the performance-based payments on an accrual basis. The Division reserves the right to perform a look-back and true-up of the previous year’s accrual in a subsequent year’s payment.

B. For any APM contract that is effective for a period other than the measurement year, The Division will allow performance-based payments to be included in the year to which the lump sum performance-based payments incentive is attributable. For example, a contract effective from April 1, 201X to March 31, 201Y will have six months (April 1, 201X – September 30, 201X) in the 201X lump sum payment and six months (October 1, 201X – March 31, 201Y) in the 201Y lump sum payment.

The AdSS is not required to meet the APM strategies qualifying criteria in AdSS Responsibilities in order for the performance-based payments incentive to be paid to the AdSS.

The Division will test the total amount of performance-based payments incentive due to the AdSS to ensure that the federal limit of 5% of annual prospective gross capitation is met. Any amount over the limit must be reduced to bring the final due payment within the federal requirement. Federal regulation requires that all incentive payments combined not exceed this 5% limit; thus the test of the 5% limit will include both the performance-based payment incentives included in this policy and the Quality Measure Performance Incentive payments described in ACOM Policy 306.

**Structured Payment File and Post Adjudicated/Post Submitted Files**

A. The Division has developed a Structured Payment File to automate the APM Strategies Certification Excel file. The AdSS must submit this file annually. (See AdSS Responsibilities)
B. To link encounters to the Structured Payment File, the AdSS must add an APM Indicator to encounters paid under an APM contract. If the AdSS knows upfront that the encounter is tied to a member/provider under APM contract, the AdSS should include the APM Indicator in the original encounter submission.

If the AdSS does not know upfront that the encounter is tied to a member/provider under APM contract, the AdSS must add the APM Indicator to the adjudicated encounter via the Post Adjudicated/Post Submitted File. The AdSS may choose to only use the post adjudication adjustment process to add the APM Indicator to adjudicated encounters, if desired.

All applicable encounters should have the APM Indicator included 270 days following the contract year end.
311 CYE 20 AND FORWARD – TIERED CAPITATION RECONCILIATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2905, AHCCCS Financial Reporting Guide; Section 9010 of the Patient Protection and Affordable Care Act, Section F3, Contractor Chart of Deliverables

This Policy applies to the Division’s Administrative Services Subcontractor (AdSS). The purpose of this Policy is to outline the process and AdSS requirements regarding the DDD Health Plan Tiered Prospective Reconciliation. The reconciliation applies to dates of service effective on and after October 1, 2019 and is based upon total medical expenses and net capitation as described in this Policy. The Division will recoup/reimburse a percentage of the AdSS profit or loss for all risk groups as described below using a tiered approach. All profit/loss sharing is based on adjudicated encounter data and subcapitated/block purchase expense reports. This reconciliation is performed annually on a contract year basis.

Definitions

A. Administrative Component - The administrative component is equal to the administrative Per Member Per Month (PMPM) awarded to the AdSS including any administrative adjustments deemed necessary by the Division during the capitation rate setting process multiplied by the actual prospective member months for the contract year being reconciled. For any rates that are not bid by the AdSS, but are set by the Division, the administrative component is equal to the administrative PMPM built into the capitation rates multiplied by the actual prospective member months for the contract year being reconciled.

B. Health Insurer Fee Capitation Adjustment - An amount equal to the capitation adjustment for the year being reconciled that accounts for the AdSS’s liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

C. Non-Capped Newborn Expenses - In accordance with the contract, AdSS must notify the Division of a newborn born to an ALTCS mother within one day of the date of birth. When notification is received timely, the AdSS receives capitation retroactive to the birth date. When notification is received late, the AdSS receives capitation beginning on the date of notification, but expenses must be covered by the AdSS back to the date of birth. Encounters for dates of services from the date of birth to the day before a tardy notification are considered non-capped expenses and are excluded from capitation rate development and reconciliations.

D. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. §36- 2905 for all payments made to AdSS for the contract year.

E. Prospective and Prior Period Coverage Medical Expense - Prospective expenses reported through fully adjudicated encounters and subcapitated/block purchase expense incurred by the AdSS for covered services with dates of service during the contract year (including expenses incurred during the Prior Period Coverage (PPC) time period) being reconciled.

F. Net Capitation – Prospective and PPC capitation, risk adjusted if applicable, plus Delivery Supplemental payments, less the administrative component, the health insurer fee capitation adjustment and the premium tax component.
G. **Reinsurance** - For purposes of this reconciliation, reinsurance means the actual reinsurance payments received by the AdSS as the result of prospective medical expense incurred by the AdSS for covered services with dates of service during the contract year being reconciled.

H. **Subcapitated/Block Purchase Expense** - Expenses incurred by the AdSS as payments to a provider under a subcapitated or block purchase arrangement. The subcapitated/block purchase expenses used in this reconciliation are reported by the AdSS through quarterly financial reports in the format required by the Division.

**General**

A. The tiered prospective reconciliation shall be based on net capitation less **prospective and PPC medical expense** plus reinsurance payments. The amount due from or due to the AdSS as the result of this reconciliation will be based on aggregated profits and losses across all of the tiered reconciliation groups. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

B. The reconciliation will limit the AdSS profits and losses to the percent of net capitation according to the following schedule:

<table>
<thead>
<tr>
<th>PROFIT</th>
<th>AdSS SHARE</th>
<th>STATE SHARE</th>
<th>MAX AdSS PROFIT</th>
<th>CUMULATIVE AdSS PROFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 1%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>&gt;1%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOSS</th>
<th>AdSS SHARE</th>
<th>STATE SHARE</th>
<th>MAX AdSS LOSS</th>
<th>CUMULATIVE AdSS LOSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 1%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>&gt;1%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*Note: Profits in excess of the percentages set forth above will be recouped by the Division. Losses in excess of the percentages set forth above will be paid to the AdSS.*

**Division Responsibilities**

A. No sooner than six months after the end of the period to be reconciled, the Division shall perform an initial reconciliation of actual medical cost experience to net capitation and reinsurance, as follows:

\[
\text{Profit/Loss to be reconciled} = \text{Net Capitation} - \text{Total Medical Expenses} - \text{Subcapitated/block purchase Expense} + \text{Reinsurance payments.}
\]

\[
\text{Profit/Loss \%} = \frac{\text{Profit/Loss to be reconciled}}{\text{Net Capitation}}
\]
Note: ACOM 311, Attachment A provides an example of the tiered reconciliation calculation.

B. The Division will utilize only total medical expense supported by fully adjudicated encounters and subcapitated expense reported by the AdSS to determine the expenses subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to AHCCCS cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

C. The Division will utilize amounts paid to the AdSS for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

D. The Division will compare fully adjudicated encounters and self-reported subcapitated/block purchase expense information to financial statements and other AdSS submitted files for reasonableness. The Division may perform an audit of self-reported subcapitated/block purchase expense included in the reconciliation.

E. The Division will provide the AdSS the data used for the initial reconciliation and provide written notice of the deadlines for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through future monthly capitation payments.

F. A final reconciliation will be performed no sooner than 15 months after the end of the period to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. The Division will provide the AdSS the data used for the final reconciliation and written notice of the deadline for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

G. Any amount due to or due from the AdSS as a result of the final reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

H. The Division may include adjustments to the reconciliations to account for completion factors.

AdSS Responsibilities

A. The AdSS must submit encounters for prospective and PPC medical expenses and those encounters must reach fully adjudicated status by the required due dates. The Division will only utilize fully adjudicated encounters reported by the AdSS to determine the medical expenses used in the reconciliation.

B. The AdSS must maintain financial statements that separately identify all group transactions, and shall submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide.

C. The AdSS must monitor the estimated program tiered reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide and as specified in Contract, Contractor Chart of Deliverables.
D. It is the AdSS responsibility to identify to the Division any encounter data issues, or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data for reconciliations submitted by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

E. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file, reinsurance payments, etc.).

F. The AdSS must report all subcapitated/block purchase expense in a format requested by the Division.

G. If the AdSS performs recoupments/refunds/recoveries on prospective claims, the related encounters must be adjusted (voided or void/replaced) pursuant to AdSS Operations Manual, Policy 412. The Division reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation.
312 CHILDREN’S REHABILITATIVE SERVICES PROGRAM RECONCILIATION

EFFECTIVE DATE: 10/1/2018

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

The Children’s Rehabilitative Services (CRS) Program Reconciliation is based on adjudicated medical expense and net capitation as described in this Policy. The Division will recoup/reimburse a percentage of the AdSS’s profit or loss for the CRS program as described below. All profit/loss sharing is based on adjudicated encounter data and subcapitated/block purchase expense reports. This reconciliation is performed annually on a contract year basis.

Definitions

A. Administrative Component – an amount equal to the administrative. Per member Per Month (PMPM) awarded to the AdSS, including any administrative adjustments deemed necessary by the Division during the capitation rate setting process, multiplied by the actual member months for the contract year being reconciled.

B. Access to Professional Services Initiative (APSI) - effective October 1, 2017 and forward, is an initiative where AHCCCS seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to Medicaid recipients in Arizona and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the Division’s rates for professional services provided by qualified physicians and non-physician professional affiliated with designated hospitals who meet the definition outlines in ACOM Policy 325.

C. Health Insurer Fee Capitation Adjustment - an amount equal to the capitation adjustment for the year being reconciled that accounts for the AdSS’s liability for the excise tax imposed by section 9010 of the Patient Protection and Affordable Care Act and the premium tax and any other state or federal taxes associated with that portion of the capitation rate.

D. Medical Expense - expenses reported through fully adjudicated encounters and subcapitated/block purchase expenses incurred by the AdSS for covered services with dates of service during the contract year. This will exclude APSI expenses.

E. Net Capitation - capitation less the administrative component, the health insurer fee capitation adjustment, APSI capitation, and the premium tax component.

F. Premium Tax Component - is equal to the tax imposed pursuant to A.R.S. §36-2905 for all payments made to the AdSS for the contract year.

G. Prior Period Coverage (PPC) - period of time prior to the member’s enrollment, during which a member is eligible for covered services. The timeframe is from the
effective date of eligibility (usually the first day of the month of application) until the date the member is enrolled with the AdSS. Refer to 9 A.A.C. 22 Article 1. If a member made eligible via the Hospital Presumptive Eligibility (HPE) program is subsequently determined eligible for AHCCCS via the full application process, prior period coverage for the member will be covered by AHCCCS fee for service and the member will be enrolled with the AdSS only on a prospective basis.

H. **Reinsurance** - for purposes of this reconciliation, the actual reinsurance payments received by the AdSS as the result of medical expense incurred by the AdSS for covered services with dates of service during the contract year being reconciled.

I. **Subcapitated/Block Purchase Expenses** - expenses incurred by the AdSS as payments to a provider under a subcapitated or block purchase arrangement. The subcapitated/block purchase expenses used in this reconciliation are reported by the AdSS through quarterly financial reports in the format required by the Division.

J. **Reconciliation Population** - all CRS members, except State Only Transplant members, subject to this reconciliation.

**General**

The CRS reconciliation must be based on net capitation less medical expense plus reinsurance payments. The amount due from, or due to, the AdSS as the result of this reconciliation will be based on aggregated profits and losses across the reconciliation population. The enhanced portion of a payment for Primary Care Enhanced Payment (PCP Parity) that is subject to Division cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation. The enhanced portion of a payment for APSI that is subject to a unique reconciliation as outlined in ACOM 325 will also be excluded from this reconciliation.

The reconciliation will limit the AdSS’s profits and losses to the percent of net capitation according to the following schedule, per contract year as noted:

<table>
<thead>
<tr>
<th>Profit</th>
<th>AdSS Share</th>
<th>State Share</th>
<th>Max AdSS</th>
<th>Cumulative AdSS Profit</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 1%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>&gt; 1%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loss</th>
<th>AdSS Share</th>
<th>State Share</th>
<th>Max AdSS</th>
<th>Cumulative AdSS Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;= 1%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>&gt; 1%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Profits in excess of the percentages set forth above will be recouped by the Division. Losses in excess of the percentages set forth above will be paid to the AdSS.
Division Responsibilities

A. No sooner than six months after the end of the period to be reconciled, the Division will perform an initial reconciliation of actual medical cost experience to net capitation and reinsurance, as follows:

\[
\text{Profit/Loss to be reconciled} = \text{Net Capitation} - \text{Medical Expense} - \text{Subcapitated Expense/Block Purchase Expenses} + \text{Reinsurance payments.}
\]

\[
\text{Profit/Loss \%} = \frac{\text{Profit/Loss to be reconciled}}{\text{Net Capitation}}.
\]

B. The Division will use only medical expense supported by fully adjudicated encounters and subcapitated/block purchase expenses reported by the AdSS to determine the expense subject to reconciliation. The enhanced portion of a payment for PCP Parity that is subject to Division cost settlement will not be included in the reconciliation; the non-enhanced portion of the payment will be included in the reconciliation.

C. The Division will use amounts paid to the AdSS for reinsurance as of the date the reconciliation is processed to determine profit/loss to be reconciled.

D. The Division will compare fully adjudicated encounters and self-reported subcapitated/block purchase expense information to financial statements and other AdSS submitted files for reasonableness. The Division may perform an audit of self-reported subcapitated or block purchase expenses included in the reconciliation.

E. The Division will provide the AdSS the data used for the initial reconciliation and provide written notice of the deadlines for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through future monthly capitation payments.

F. A final reconciliation will be performed no sooner than 15 months after the end of the period to be reconciled. This will allow for completion of the claims lag, encounter reporting and reinsurance payments. The Division will provide the AdSS the data used for the final reconciliation and written notice of the deadline for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. Any amount due to or due from the AdSS as a result of the final reconciliation that was not distributed or recouped as part of the initial reconciliation will be paid or recouped through a future monthly capitation payment.

G. The Division may include adjustments to the reconciliations to account for completion factors.
**AdSS Responsibilities**

A. The AdSS must submit encounters for prospective medical expense and those encounters must reach fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the medical expense used in the reconciliation.

B. The AdSS must maintain financial statements that separately identify all CRS transactions, and must submit such statements as required by contract and in the format specified in the AHCCCS Financial Reporting Guide for the Children’s Rehabilitative Services (CRS) Contractor.

C. The AdSS must monitor the estimated CRS program reconciliation receivable/payable and record appropriate accruals on all financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide for the Children’s Rehabilitative Services (CRS) Contractor.

D. It is the AdSS’s responsibility to identify to the Division any encounter data issues or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data submitted for reconciliations by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

E. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g. encounter detail file, reinsurance payments).

F. The AdSS must report all subcapitated/block purchase expenses in a format requested by the Division. Subcapitated and block purchase encounters should have a CN 1 code of 05 and a paid amount of $0 for all non-PCP rate parity encounters. All subcapitated encounters that have a health plan paid amount greater than $0 will be excluded from the reconciliation expenditures. This includes all subcapitated amounts greater than $0 for PCP Rate Parity that are subject to Division cost settlement.

G. If the AdSS performs recoupments/refunds/recoveries on the related claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued reconciliation results for the impact of the revised encounters and recoup any amounts due to the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.
314 AUTO-ASSIGNMENT ALGORITHM

EFFECTIVE DATE: October 1, 2019
REFERENCES: Administrative Services Contract

This policy describes the method used to auto-assign members to an AdSS.

A. Upon award of a new contract, the Division will auto-assign members as follows:
   1. Prior to the start of the contract (choice period), current members will be given a choice to select from the newly awarded AdSS contractors.
   2. If a member does not select an AdSS during the choice period and the member’s current AdSS is awarded a contract, the member will be reassigned to the same AdSS.
   3. If a member does not select an AdSS during the choice period and the member’s current AdSS is NOT awarded a contract, the member will be auto-reassigned to one of the newly contracted AdSS.
   4. Auto-assignment to a newly contracted AdSS will continue until the number of members assigned to the newly contracted AdSS reaches 50% of the number of members assigned to the AdSS that continued to contract.
   5. If all AdSS are new, the members will be given a choice to select an AdSS prior to the start of the contract.

B. Ongoing, the Division will auto assign to the available AdSS in a revolving sequence. The Division may change the auto assignment process at any time during the term of the contract in response to AdSS-specific issues (e.g., imposition of an enrollment cap), when in the best interest of the ALTCS Program and/or the state, or to recognize and reward AdSS performance across a variety of factors of importance to the Division.
317 CHANGE IN ORGANIZATIONAL STRUCTURE

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 101-106; ACOM Policy 438, 103; Section F3, Contractor Chart of Deliverables
DELIVERABLES: Change in Contractor Organizational Structure: Notification; Change in Contractor Organizational Structure: Transition Plan Final Documents; Change in Contractor Organizational Structure: Transition Plan Initial Documents; Completed Change in Contractor Organizational Structure: Documents required after AHCCCS Approval

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes the procedure for approval of AdSS changes in Organizational Structure as defined below, including changes in a Management Service Agreement (MSA) subcontractor.

Definitions

A. Acquisition – an acquiring, by one company, of all of a target company’s assets, capital, or stock.

B. Administrative Services Subcontract - agreement that delegates any of the requirements of the contract with the Division, including, but not limited to the following:
   1. Claims processing, including pharmacy claims
   2. Credentialing, including those requirements for only primary source verification
   3. Management Service Agreements (MSAs)
   4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

Providers are not AdSSs.

C. Articles of Incorporation - basic legal instrument required to be filed with the state upon incorporation of a business (sometimes also referred to as the Certificate of Incorporation or the Corporate Charter).

D. Change In Organizational Structure - any of the following:
   1. Acquisition
   2. Change in Articles of Incorporation
   3. Change in ownership
   4. Change of MSA subcontractor (to the extent management of all or substantially all plan functions has been delegated to meet Division contractual requirements)
5. Joint venture
6. Merger
7. Reorganization
8. State agency reorganization resulting from an act of the Governor of the State of Arizona or the Arizona State Legislature
9. Other applicable changes that may cause a change in any of the following:
   a. Employer Identification Number/Tax Identification Number (EIN/TIN)
   b. Critical member information, including the website, member or provider handbook and member ID card
   c. Legal entity name.

E. Change in Ownership - any change in the possession of equity in the capital, stock, profits, or voting rights, with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non-stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.

F. Joint Venture - business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture, each of the participants is responsible for profits, losses and costs associated with it. However, the venture is its own entity, separate and apart from the participants’ other business.

G. Management Service Agreement (MSA) - type of subcontract with an entity in which the owner of an AdSS delegates all or substantially all management and administrative services necessary for the operation of the AdSS.

H. Merger - Two companies join together to form a single entity, using both companies’ assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors or their voting rights. Both companies cease to exist separately and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined or their voting rights are transferred to the new corporation.

I. Performance Bond - A cash deposit with the State Treasurer or a financial instrument secured by the AdSS in an amount designated by the Division to guarantee payment of AdSS claims.

J. Reorganization - An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work
with its creditors to restate its assets and liabilities which may be an attempt to avoid a bankruptcy.

**Change in AdSS’s Organizational Structure**

A change in AdSS organizational structure requires notification and prior approval of the Division. When submitting for prior approval, the Division will review documentation to ensure the following:

A. Uninterrupted services and ongoing adequate access to care and choice for members

B. The new entity’s ability to maintain and support the contract requirements including the commitments in the proposal submitted to the Division during the procurement process

C. Major functions of the AdSS’s organization, as well as Division-funded services, are not adversely affected

D. The integrity of a fair, competitive, procurement process for AdSS contracts.

The Division reserves the right to obtain stakeholder input on the proposed ownership change through a public notice and feedback process, and to temporarily suspend an AdSS’s new-member enrollment pending the Division’s review and final determination regarding an AdSS’s change in organizational structure. The AdSS must submit a written notification to the Division of any proposed merger, acquisition, reorganization, or change in ownership, 180 days before the effective date. This notification must include:

A. A detailed description of the type of change or new corporate structure and the purpose thereof

B. A detailed transition plan as outlined below.

**Transition Plan**

The AdSS must submit the transition plan 180 days before the effective date. Items for which information is not yet available for submission, or is still considered draft, must be noted and must be submitted or resubmitted no later than 90 days before the effective date.

All transition plan documents must be submitted electronically to the Division via the secured File Transfer Protocol (FTP) server.

A. The AdSS must submit the following as part of the transition plan, as applicable:

1. A letter of explanation that includes the following information:
   a. The type of entity if a new entity will be formed and/or any changes to existing entity
   b. Any material change to operations as specified in Policy 439 of this Manual and contract
2. Documents including the following:
   a. The formal name and any proposed logo used by the resulting organization
   b. The organizational chart of the new resulting organization or proposed changes to the existing organizational chart if a new entity is not being formed
   c. Current audited financial statements of current AdSS and merging entity
   d. Pro forma financial statements of entity resulting from the change in organizational structure that include, at a minimum: a balance sheet, statement of revenues and expenses, and statement of cash flows for the subsequent three years, and enrollment projections and footnotes detailing assumptions. The format can be the same as the audit format; however the Division lines of business should be detailed separately just as is required in the annual audit report.

3. A description of the following:
   a. An assessment of any potential interruption of services to members, and steps the AdSS is taking to ensure there are no interruptions
   b. Any changes to the management and staffing of the organization currently overseeing services provided under the contract
   c. Any changes to existing Administrative Services Subcontracts
   d. Any changes to the administration of critical components of the organizations, including but not limited to information systems, prior authorization, claims processing or grievances
   e. The AdSS’s plan for communicating the change to members, including a draft notification to be distributed to affected members and providers
   f. The AdSS’s plan for changes to critical member information, including the website, member and provider handbook and member ID card
   g. Any anticipated changes to the network.

B. Upon Division approval of the transition plan, the following documents must be submitted within 120 days of the change:
   1. The Articles of Incorporation, if applicable, including copies of all affiliation agreements

   An affiliate is an entity that directly or indirectly controls, is controlled by, or is under common control with another entity; also, a party with which
the entity may deal if one party has the ability to exercise significant influence over the other's operating and financial policies. The affiliation agreement (also referred to as a member agreement) defines and governs the affiliate relationship.

2. Any proposed change to the Employer Identification Number/Tax Identification Number (EIN/TIN)

3. Any additional information requested by the Division.

**Additional Submission Requirements**

The AdSS must submit the following to the Division no later than 45 days before the effective date of the change in organizational structure and commencement of operations under the new structure:

A. Automatic Clearing House (ACH) Vendor Authorization Form

   The ACH form is to be submitted as directed on the form in order for the AdSS to begin receiving reimbursement.

B. Information regarding Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of a Crime in accordance with the 42 CFR 101 through 106, the Corporate Compliance Contractual Provisions, and Division Policy Manuals

   The information is to be submitted via secured FTP server to the Division.

   For a change of MSA Subcontractor, the AdSS must also follow the process for the review and approval of the new subcontract as outlined in Division Operations Manual Policy 438.

The Division reserves the right to request additional items deemed necessary to complete the evaluation.

**Division Disposition of Request**

The Division will review and respond to the AdSS within 30 days of the Notification and submission of the Transition Plan. Incomplete submissions may require additional information before approval. Upon completion of the review, the Division may:

A. Approve the proposal without conditions.

B. Approve the proposal with conditions that may include, but are not limited to:
   1. Allowing an open enrollment for plan membership
   2. More rigorous oversight for a specified period of time
   3. A cap on enrollment.
C. Deny the proposal.

If the Division denies the proposal, and if the AdSS moves forward, the Division may terminate some or all of the Geographic Service Areas that are part of the contract.
320 HEALTH INSURER FEE (Health Insurance Provider Fee)

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2905, Section 9010 of the Patient Protection and Affordable Care Act; IRS Form 8963; ACOM Policy 320 Attachment A and Attachment B; Section F3, Contractor Chart of Deliverables


This policy applies to Division’s Administrative Services Subcontractors (AdSS). AHCCCS provides funding to the Division for the Health Insurance Provider Fee (HIPF) and associated taxes. The purpose of this policy is to define what the AdSS submits to AHCCCS and the process by which the Division reimburses the AdSS for the HIPF.

Definitions

A. Affordable Care Act (ACA) - Federal statute signed into law in March, 2010 as part of comprehensive health insurance reforms that will, in part, expand health coverage, expand Medicaid eligibility, establish health insurance exchanges, and prohibit health insurers from denying coverage due to pre-existing conditions. The Affordable Care Act is also referred to as the Patient Protection and Affordable Care Act (ACA).

B. Fee Year - The calendar year in which the fee must be paid.

C. Premium Tax - The premium tax is equal to the tax imposed pursuant to A.R.S. § 36-2905 for all payments made to contractors for the contract year.

HIPF Requirements and Exclusions

Section 9010 of the ACA requires that the AdSS, if applicable, pay an HIPF annually, beginning in calendar year 2014, based on its respective market share of premium revenues from the preceding calendar year. Insurer market share excludes premiums related to accident and disability insurance, coverage for a specified disease or illness, hospital indemnity or other fixed indemnity insurance, long-term care insurance, and Medicare supplement insurance. Certain entities will be excluded. Excluded entities include, but are not limited to:

A. Government entities, including independent nonprofit county-organized system entities that contract with state Medicaid agencies

B. Nonprofit entities that receive more than 80% of gross revenue from government programs that target low-income, elderly, or disabled populations, including Medicare, Medicaid, State Children’s Health Insurance Plan (SCHIP), and dual eligible plans.

Additionally, certain entities can exclude 50% of their net premium for the HIPF calculation because of their status as a public charity, social welfare organization, high-risk health insurance pool, or Consumer Operated and Oriented Plan (CO-OP).

Every health insurer must report its national net premiums written to the IRS annually by

320 Health Insurer Fee (Health Insurer Provider Fee)
April 15 of the fee year on IRS Form 8963, Report of Health Insurance Provider Information. The health insurer is responsible for allocating its national net premiums written to the entities recorded on its Form 8963. The allocation for each fee year is based on the prior calendar year’s revenue. The IRS will then send each health insurer a notice of preliminary fee calculation each fee year. The regulations provide that the IRS will send each health insurer its final fee calculation for a fee year no later than August 31 of that fee year, and that the health insurer must pay the fee to the IRS by electronic funds transfer by September 30.

**AHCCCS Responsibilities**

A. Subject to receipt and review of documentation from the AdSS as described below, AHCCCS will make a retroactive capitation rate adjustment to the Division consistent with the methodology approved by the Centers for Medicare and Medicaid Services (CMS).

For CMS-approved methodology to approximate the cost associated with the HIPF Premium tax, see AHCCCS Contractor Operations Manual (ACOM) Policy 320 Attachment A, CMS Approved Retroactive Capitation Rate Adjustment Methodology – One Month Method of Payment of Health Insurer Fee (HIPF).

B. For Fee Year 20 and forward, the retroactive capitation rate adjustment for the AdSS in “A” above will include the provision to approximate the federal income tax liability and Arizona state income tax liability incurred related to the HIPF, if applicable.

**AdSS Responsibilities**

A. The AdSS must submit to the AHCCCS Division of Health Care Management (DHCM) Finance Manager with a copy to the Division’s Business Administrator, a copy of its entity’s IRS Form 8963, Report of Health Insurance Provider Information filed with the IRS to report net premium along with its final fee estimate by September 30 of each fee year.

B. The AdSS must complete ACOM Policy 320 Attachment B, Health Insurer Fee Liability Reporting Template and submit both an executed copy and an electronic copy in an Excel format to the DHCM Finance Manager and the Division’s Business Administrator by September 30 of each fee year. Since the template includes all lines of business, an AdSS with multiple lines of business only needs to make one submission. The AdSS must include Title XIX only. The AHCCCS fee liability must be allocated to line of business based on the allocation of revenue reported in Attachment B. AHCCCS will verify the reasonableness of the data. In the case of differences between the executed copy and electronic template submissions, the executed copies will prevail.

C. If no fee is due, the AdSS must submit to the DHCM Finance Manager and the Division’s Business Administrator a written statement indicating no fee is due and the reason for the exemption.

D. The AdSS must submit to the DHCM Finance Manager and the Division’s Business Administrator a copy of its entity’s federal and Arizona state income tax filings by
April 30 of the year following the fee year. The AdSS must notify the DHCM Finance Manager and the Division’s Business Administrator of the federal and Arizona state income tax rates that apply to the AdSS.

E. If the AdSS requested a tax filing extension, the AdSS must submit its anticipated federal and Arizona state income tax rates that apply to the AdSS to the DHCM Finance Manager and the Division’s Business Administrator by April 30 of the year following the fee year. Within 30 days after submitting tax filing, the AdSS must submit copies of the federal and Arizona state income tax filings.

F. AHCCCS may adjust a capitation rate that was previously adjusted for tax liability purposes if the resulting tax liability is materially different from the anticipated tax rates reported.

G. The AdSS deliverables due to AHCCCS, including IRS Form 8963, Attachment B, and Federal and State Income Tax filings will be waived, should the Federal Government place a suspension on the HIPF, for the fee year in which the HIPF would have been due. See Section F3, Contractor Chart of Deliverables.
321 PAYMENT REFORM - E-PRESCRIBING

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The purpose of this policy is to define parameters for the Payment Reform-E-Prescribing Initiative.

Definitions

A. Electronic Prescription or E-Prescription - Electronic Prescriptions or E-Prescriptions include those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3.

B. Origin Code - The field located in the National Council for Prescription Drug Programs (NCPDP) standardized code set known as the Prescription Origin Code and also referred to as the NCPDP Prescription Origin Code.

General

E-Prescribing is a recognized and proven effective tool to improve members’ health outcomes and reduce costs. Benefits afforded by the electronic transmission of prescription-related information include, but are not limited to, reduced medication errors, reductions of drug and allergy interactions and therapeutic duplication, patient adherence, and increased prescription accuracy.

The following parameters must apply for the Payment Reform - E-Prescribing Initiative:

A. Only those prescriptions that meet the definition of an E-Prescription (see definition above) must be included for the purpose of the initiative. The initiative must not include other electronic methods of transmitting prescriptions, e.g., computer-generated paper prescriptions or facsimiles or telephone-generated prescriptions. The initiative also must not include E-Prescriptions converted to computer-generated facsimile when the E-Prescription is sent via an intermediary that is unable to complete the transaction.

B. Refills retain the origin of the prescription. Each time a prescription that meets the definition of an E-Prescription is refilled, it counts as an E-Prescription. Consequently, refills must not be counted as electronic originations for this initiative, as they overstate the number of prescriptions generated in this manner.

C. Controlled substances can be E-Prescribed and therefore may be counted as an E-Prescription if the electronic origination meets the definition of an E-Prescription.

D. Prescriptions generated by nurse practitioners and physician assistants may be counted as electronic originations if they meet the definition of an E-Prescription.

The Division may sanction the AdSS for failure to meet the requirements in the AdSS Responsibilities section of this policy.
AdSS Responsibilities

For CYE 16: The AdSS must increase the percent of prescriptions originating through E-Prescribing by 20% of the difference between the CYE 15 baseline percentage of original prescriptions generated as E-Prescriptions by line of business and the goal percentage of original prescriptions generated as E-Prescriptions as defined below, using the CYE 16 peak quarter to determine compliance with the E-Prescribing Initiative.

Goal (Percentage of Original Prescriptions Generated as E-Prescriptions)

DDD, including AdSS: 65%

The required increase in the percent of prescriptions originating through E-Prescribing will be calculated as follows:

- \( G = \text{E-Prescribing percentage Goal} \)
- \( B = \text{CYE 15 Baseline E-Prescribing percentage} \)
- \( R = \text{Required E-Prescribing percentage increase from CYE 15 Baseline E-Prescribing percentage per AdSS} \)
- \( T = \text{Target E-Prescribing percentage per AdSS} \)
- \( P = \text{CYE 16 Peak Quarter E-Prescribing percentage} \)

Calculation

\[
(G - B) \times 20\% = R \\
B + R = T \\
P \geq T
\]

Example

\[
(60\% - 45\%) \times 20\% = 3\% \\
45\% + 3\% = 48\% \\
49\% > 48\%
\]

Prescription origination data must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide.

The Prescription Fill Number (Original or Refill Dispensing) must be submitted on all pharmacy encounter records, as outlined in the AHCCCS NCPDP Post Adjudicated History Transaction Companion Guide.
325 ACCESS TO PROFESSIONAL SERVICES INITIATIVE AND RECONCILIATION

EFFECTIVE DATE: October 1, 2019

Purpose: To establish guidelines for Administrative Services Subcontractors (AdSS) regarding the Access to Professional Services Initiative (APSI) and related reconciliation.

Policy: The Division of Developmental Disabilities (Division) seeks to provide enhanced support to certain professionals in order to (1) preserve and enhance access to these professionals who deliver essential services to members and (2) support professionals who are critical to professional training and education efforts. APSI is a program to preserve and promote access to medical services through a uniform percentage increase to the AdSS rates for professional services provided by qualified practitioners affiliated with designated hospitals.

Due to uncertainty regarding actual use of qualified practitioners, and because the state share of the capitation paid to the AdSS will be funded using Inter-Governmental Transfer funds for this specific purpose, the Division intends to eliminate the financial risk to its AdSS. The Division will isolate the APSI revenue and expenses, and reconcile AdSS prospective and Prior Period Coverage (PPC) profits and losses to 0%. A risk pool will be used to capture unexpended funds.

Definitions

APSI Expense: The PPC and Prospective Expenses incurred by the AdSS for the 40% rate increase to providers. APSI Expenses excludes Subcapitated/Block Purchase Expenses.

APSI Revenue: The amount of additional PPC and Prospective capitation provided for the 40% rate increase to providers.

Designated Hospitals: For purposes of this Policy, designated hospitals include:

- A hospital facility with an Accreditation Council for Graduate Medical Education (ACGME)-accredited teaching program and which is operated pursuant to the authority in A.R.S. Title 48, Chapter 31 (A.R.S. § 48-5501 et seq.); or

- A hospital facility with:
  - An ACGME-accredited teaching program with a state university, and
  - AHCCCS inpatient discharge utilization volume greater than or equal to 30 percent as calculated by the Arizona Department of Health Services for calendar year 2019; or
  - A freestanding children’s hospital or a pediatric unit of a general acute care hospital with greater than 100 licensed pediatric beds, excluding nursery beds.
**Qualified Practitioner:** For purposes of this policy, qualified practitioners are providers who bill for services under one of the Group National Provider Identifier numbers that are affiliated with one of the Designated Hospitals identified in Section A.1. of this policy, and includes the following practitioners:

- Physicians, including doctors of medicine and doctors of osteopathic medicine
- Certified Registered Nurse Anesthetists
- Certified Registered Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dentists
- Optometrists

**A. Designated Hospitals**

1. Designated Hospitals participating in APSI effective October 1, 2019, include the following:
   
a. Banner University Medical Center Phoenix
b. Banner University Medical Center Tucson
c. Banner University Medical Center South
d. Cardon Children’s Medical Center at Banner Desert Medical Center
e. Maricopa Medical Center
f. Phoenix Children’s Hospital
g. St. Joseph’s Hospital and Medical Center
h. Tucson Medical Center

**B. Reconciliation**

1. The reconciliation must relate solely to the APSI portion of encounters for fully adjudicated prospective and PPC medical expenses, excluding services provided under subcapitated/block purchase arrangements, for Qualified Practitioners. The amount due from or due to the AdSS as a result of this reconciliation will be based on aggregated profits and losses from APSI
Revenue and Expenses across both prospective and PPC risk groups.

2. The reconciliation will limit the AdSS's profits and losses from APSI Revenue and APSI Expenses to 0%. Any losses in excess of 0% will be reimbursed to the AdSS and, likewise, profits in excess of 0% will be recouped.

C. Administrative Services Subcontractors’ Responsibilities

1. Effective with dates of service on and after October 1, 2019, the AdSS will provide a 40% increase to the otherwise contracted rates to Qualified Practitioners for all claims for which the Division is the primary payer.

2. The AdSS must submit encounters for APSI medical expenses, and those encounters must reach fully adjudicated status by the required due dates. The Division will only use fully adjudicated encounters reported by the AdSS to determine the APSI medical expenses used in the reconciliation.

3. The AdSS must maintain financial records that separately identify all APSI-related prospective and PPC transactions, and submit such information through a footnote in the financial statements as required by Contract and as specified in the AHCCCS Financial Reporting Guide.

4. The AdSS must monitor the estimated APSI reconciliation receivable/payable and record appropriate accruals on financial statements submitted to the Division on a quarterly basis as specified in the AHCCCS Financial Reporting Guide.

5. It is the AdSS’s responsibility to identify to the Division any encounter data issues or necessary adjustments associated with the initial reconciliation by the deadlines for review and comment. It is also the responsibility of the AdSS to have any identified encounter data issues corrected and adjudicated no later than 15 months from the end of the period being reconciled. The Division will not consider any data for reconciliations submitted by the AdSS after these timeframes. Any encounter data issues identified that are the result of an error by the Division will be corrected prior to the final reconciliation.

6. The AdSS must submit any additional data as requested by the Division for reconciliation purposes (e.g., encounter detail file).

7. If the AdSS performs recoupments/refunds/recoveries on any APSI claims, the related encounters must be adjusted (voided or void/replaced) pursuant to ACOM Policy 412. The Division reserves the right to adjust any previously issued APSI reconciliation results for the impact of the revised encounters and recoup any amounts due the Division. If the AdSS does not submit the revised encounters within the required timeframe, the Division may recoup the estimated impact on the reconciliation and reserves the right to sanction the AdSS.
D. **Division Responsibilities**

1. No less than six months after the Contract Year to be reconciled, the Division will perform an initial reconciliation. The reconciliation will be calculated as follows: Profit/Loss to be reconciled = APSI Capitation.

2. The Division will use only expenses supported by fully adjudicated encounters reported by the AdSS to determine the expenses subject to reconciliation.

3. The Division will compare fully adjudicated encounters to AdSS financial statements and other AdSS submitted files for reasonableness.

4. The Division will provide to the AdSS the data used for the initial APSI reconciliation and provide a set time period for review and comment by the AdSS. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted. The Division may then process partial distributions/recoupments through a future monthly capitation payment.

5. A final APSI reconciliation will be performed no sooner than 15 months after the end of the contract year to be reconciled. This will allow for completion of the claims lag and encounter reporting. The Division will provide to the AdSS the data used for the final reconciliation and provide a set time period for review and comment by the AdSS.

6. Upon completion of the review period, the Division will evaluate AdSS comments and make any adjustments to the data or reconciliation as warranted.

7. Any amount due to or due from the AdSS as a result of the final APSI reconciliation, that was not distributed or recouped as part of the initial reconciliation, will be paid or recouped through a future monthly capitation payment.

8. The Division may include adjustments to the initial APSI reconciliation to account for completion factors.

9. The Division will create and use an APSI risk pool to capture recouped funds. The monies included in the risk pool will be used to reimburse AdSS with losses in excess of 0%.
401 CHANGE OF DDD HEALTH PLAN AND ADMINISTRATIVE SERVICES SUBCONTRACTORS

EFFECTIVE DATE: October 1, 2019
REFERENCES: ACOM Policy 401- Attachment A, AHCCCS Acute Care Change of Contractor Form

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes requirements and timeframes for how, when and by whom AdSS change requests will be processed for members eligible for the Division outside of the AdSS choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period. This policy describes the rights, obligations, and responsibilities of the following parties when such changes are made:

- The Member
- The Relinquishing AdSS
- The Receiving AdSS
- The Division of Developmental Disabilities (DDD or the Division).

Definitions

A. Annual Enrollment Choice (AEC) - The opportunity for a member to change the DDD Health Plan and AdSS every twelve months.

B. Auto Assignment - The process by which members who do not exercise their right to choose an AdSS and members who are not assigned an AdSS based on family continuity rules are assigned to an AdSS through an auto assignment algorithm. The algorithm is a mathematical formula used to assign members to the various AdSSs in a manner that is predictable and consistent with Division goals.

C. Business Day - A Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

D. Freedom of Choice - The opportunity given to each member who does not specify an AdSS preference at the time of enrollment to choose between the AdSSs available.

E. Receiving AdSS - The AdSS with which the member will become enrolled as a result of annual enrollment choice, open enrollment, an AdSS change or a change in eligibility.

F. Relinquishing AdSS - The AdSS in which the member will be leaving as a result of annual enrollment choice, open enrollment, an AdSS change or a change in eligibility.

Policy

A. Criteria for Change of AdSS Outside of Initial Enrollment or AEC Period
AdSS change requests outside of the initial enrollment period or the member’s AEC period will be granted for members if certain conditions are met. These conditions include:

1. Administrative Actions That May Merit an AdSS Change:
   a. A member was entitled to Freedom of Choice but was not sent a choice letter.
   b. A member was entitled to participate in an AEC but:
      i. Was not sent a choice letter, or
      ii. Was sent a choice letter but was unable to participate in the AEC due to circumstances beyond the member’s control.
   c. Family members were inadvertently enrolled with a different AdSSs. A member who is enrolled with an AdSS through the Auto Assignment process may inadvertently be enrolled with a different AdSS than other family members. Upon receipt of notification by the Division, the member who was inadvertently enrolled will be disenrolled from the AdSS of assignment and enrolled with the AdSS where the other family members are enrolled. Other family members will not be permitted to change to the AdSS to which the new member was auto-assigned. This process must not apply if a member was afforded an enrollment choice during their AEC period.
   d. A member loses eligibility and regains eligibility within 90 days. The member shall be reenrolled with the AdSS that the member was enrolled with prior to the loss of eligibility. If this does not occur, the Division, upon notification, will enroll the member with the previous AdSS.
   e. A Title XIX eligible member who is entitled to Freedom of Choice but becomes eligible and is auto assigned prior to having the full choice period of 90 days will be given an opportunity to request an AdSS change following Auto Assignment. The member will be given 90 days from the date of the choice letter to request an AdSS change. A member who does not make a selection within 90 days will remain with the auto assigned AdSS.

2. Medical Continuity of Care

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

A plan change for medical continuity is not an automatic process. The member’s Primary Care Provider (PCP), or other medical provider, must provide documentation to both the Receiving and Relinquishing AdSSs that supports the need for an AdSS change. The AdSSs must be reasonable in
the request for documentation. However, the burden of proof that an AdSS change is necessary rests with the member’s medical provider. The AdSS change must be approved by both AdSS’s Medical Directors.

A pregnant member who is enrolled with an AdSS Auto Assignment or Freedom of Choice and is currently receiving or has previously received prenatal care from a provider who is affiliated with another AdSS, may be granted a medical continuity AdSS change if agreed to by the Medical Directors of both AdSSs. The member must be transitions within the requirements and protocols in AdSS Operation Manual Policy 402 and in Division Medical Policy Manual chapter 500.

When the Medical Directors of both the receiving and relinquishing AdSS have discussed the request and have not been able to come to an agreement, the relinquishing AdSS must submit the request to the Division’s Chief Medical Officer (CMO) or designee. Within 14 calendar days from the date of the original request, the Relinquishing AdSS must submit Attachment A and the supporting documentation to the Division for review.

The results of the review will be shared with both Medical Directors. The relinquishing AdSS will be responsible for issuing a final decision to the member. If the member request is denied, the relinquishing AdSS will send the member in writing. The letter will also advise the member of the Division Grievance and Appeal System policy and include timeframes for filing a grievance.

 Upon approval of a change in AdSS for medical continuity, the member must be transitioned within the requirements and protocols in AdSS Operations Manual Policy 402 and the Division Medical Policy Manual Chapter 520.

B. AdSS Responsibilities When an AdSS Change is Not Warranted

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

1. Quality of care delivery
2. Case management responsiveness
3. Transportation convenience and service availability
4. Institutional care issues
5. Physician or provider preference
6. Physician or provider recommendation
7. Physician or provider office hours
8. Timing of appointments and services

9. Office waiting time

10. Network limitations and restrictions.

When quality of care and delivery of care and service issues raised by the member are identified, the AdSS shall refer the issue for review by the Division's Quality Management Department, who will follow the Division’s established Quality Management process for timely resolution.

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

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

The current AdSS must notify the member, in writing, that an AdSS change is not warranted. If the AdSS change request was the result of a member concern, as defined in this Policy, the letter must include the AdSS’s resolution of this concern. The letter must also advise the member of the Division and AdSS Grievance and Appeal System policy and include timeframes for filing a grievance.

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

C. Relinquishing AdSS, Receiving AdSS And Division Responsibilities When an AdSS Change is Warranted

1. Relinquishing AdSS Responsibilities

If a member contacts the current AdSS, verbally or in writing, and states that the reason for the plan change request is due to situations defined in this Policy, the relinquishing AdSS must advise the member to telephone the Division Customer Service at 1-844-770-9500 and follow the prompts for health plan changes and questions, in order for the Division to process the change.

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

a. The relinquishing AdSS will contact the receiving AdSS to discuss the request. If a plan change is indicated for medical continuity of care, ACOM Policy 401, Attachment A, AHCCCS Acute Care Change of Contractor Form must be completed. All members impacted by the
change request must be indicated on the form. The form must be signed by the Medical Directors of both AdSSs. The signed form must be submitted to the Division Chief Medical Officer,

b. To facilitate continuity of prenatal care for the member, the AdSS must sign off and submit the ACOM Policy 401, Attachment A, AHCCCS Acute Care Change of Contractor Form to the Division Chief Medical Officer within two business days of the member’s AdSS change request. The timeframe for other continuity of care changes is as expeditiously as the member’s health care condition requires, or no later than 10 business days, and

c. The Division Chief Medical Officer will review the AdSS change documentation and process accordingly.

2. Receiving AdSS Responsibilities

The member must be transitioned within the requirements and protocols in AdSS Manual Policy 402 and in the Division Medical Policy Manual Chapter 500.

3. Division Responsibilities

The Division must process change of AdSS requests that are listed in Section A (1) and must send notification of the change via the daily recipient roster to the relinquishing and receiving AdSSs. It is the AdSS’s responsibility to identify members from the daily recipient roster who are leaving the AdSS.

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

If the Division receives a letter or verbal request from a member requesting an AdSS change, for reasons defined in this Policy, that also references other concerns (e.g., transportation, accessibility or availability of services), that information will be sent to the current AdSS who must follow the Policy requirements as outlined above.
402 MEMBER TRANSITION FOR ANNUAL ENROLLMENT CHOICE AND ELIGIBILITY CHANGES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-22-101

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes guidelines, criteria, and timeframes for how members are to be transitioned between AdSSs and how AdSSs are notified for Annual Enrollment Choice (AEC) and eligibility changes. This policy explains the rights, obligations, and responsibilities of the member’s current (relinquishing) AdSS and the requested (receiving) AdSS. The AdSS and the Division work together to ensure the smooth transition of members as they change from one AdSS to another. Maintenance of continuity and the quality of care are the overriding considerations for member transitions (the process during which members change from one AdSS to another).

This policy does not include requirements for the following member transitions:

A. Transitions due to AdSS Award, AdSS Termination, or material change to the AdSS’s network

B. Transitions due to member request for AdSS change outside of AdSS choice offered upon initial enrollment and the Annual Enrollment Choice (AEC) period

C. Member transition between ALTCS/Elderly and Physically Disabled (EPD) and Division contractors. Members may be transitioned between an ALTCS/EPD contractor and Division. Transfers between an ALTCS/EPD contractor and the Division are the result of a change in Division eligibility, as determined by the Division.

Definitions

A. Annual Enrollment Choice (AEC) - the opportunity for a member to change the model and AdSS during the Division’s open enrollment period.

B. Enrollment Transition Information (ETI) - member-specific information the relinquishing AdSS must complete and transmit to the receiving AdSS for those members requiring coordination of services as a result of transitioning to another contractor (see Division Medical Manual Chapter 500).

C. Health Care Professional - physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife), licensed social worker, registered respiratory therapist, licensed marriage and family therapist and licensed professional counselor.

D. Geographic Service Area (GSA) - an area designated by the Division within which a contractor of record provides, directly or through subcontract, covered health care
service to a member enrolled with that contractor of record, as defined in A.A.C. R9-22-101.

E. **Potential Plan Listing (PPL)** - a file which provides the Division with the basic demographic information of all members who may be joining or leaving.

F. **Receiving AdSS** - contractor with which the member will become enrolled as a result of AEC, open enrollment, a contractor change or a change in eligibility.

G. **Relinquishing AdSS** - contractor from which the member will be leaving as a result of AEC, open enrollment, a contractor change or a change in eligibility.

**Policy**

A. **Transitions**

1. **AEC**

   a. Members residing in a county with choice of model and AdSS may change enrollment once a year.

      i. The Division provides notice to members regarding annual enrollment 60 days before the member's AEC date.

      ii. The member may choose a new model and AdSS by contacting the Division to complete the enrollment process.

      iii. Members who notify the Division of their choice of model and AdSS prior to AEC will transition to the requested model or AdSS (receiving AdSS) on the first day of the new enrollment period. Members will receive services from their requested AdSS (receiving AdSS) on the first day of the new enrollment period.

   b. If the member does not participate in the AEC, no change of model and AdSS will be made.

   c. Members must maintain eligibility as a condition of enrollment in the Division and ALTCS.

      i. If a member loses eligibility after making an AEC and regains eligibility within 90 days, the member’s AEC will be honored.

      ii. If the member regains eligibility after 90 days, members who make a choice of model and AdSS will be enrolled with the model and AdSS of choice, if a choice is not made, the member will be auto-assigned to an available AdSS.

      iii. The Division sends a choice notice to the member, after the member is auto-assigned, allowing the member 90 days to choose an available AdSS.
2. Eligibility Changes

Member transitions due to eligibility changes include, but are not limited to, Acute Care to the Division.

Members who become eligible for the Division will be transitioned as outlined in this policy, and Division Medical Manual Chapter 500.

B. Division Enrollment Notification to AdSS

1. Final notification data containing the member’s choice of AdSS is provided via the 834 file.

2. Enrollment notification data is provided daily and monthly as follows:
   i. Daily Enrollment Notification (834 File) is completed by the Division between 8:00 p.m. and 11:59 p.m. each night for that day’s activity.
   ii. Monthly Enrollment Notification (834 File) occurs three days before the first of the next month for each Division AdSS.

C. AdSS Transition Policy

The AdSS must develop and implement policies and procedures for the acceptance and transfer of members in accordance with contract and Division policy.

D. Transition Coordinator

The AdSS must identify a representative to serve as Transition Coordinator. The Transition Coordinator must be a health care professional or an individual who possesses the appropriate education and experience and is supported by a health care professional to effectively coordinate and oversee all transition issues, responsibilities, and activities.

The role of the Transition Coordinator includes:

1. Ensuring the transition activities are accomplished in accordance with Division and AdSS policies and procedures
2. Acting as an advocate for members leaving and joining the AdSS
3. Facilitating communication between AdSSs and the Division
4. Assisting Primary Care Providers (PCPs), internal AdSS departments, and other contracted providers with the coordination of care for transitioning members
5. Ensuring continuity of care is maintained during transitions
6. Participating in Division transition meetings.

E. Relinquishing AdSS Responsibilities
The relinquishing AdSS must complete and transmit ETI to the appropriate parties no later than 10 business days of receipt of the Division notification described above for each member who has special circumstances. The AdSS must comply with the notification requirements specified in Division policy for all member transitions.

Special circumstances include, but are not limited to, medical conditions or circumstances such as pregnancy, major organ or tissue transplantation services which are in process, Serious Mental Illness, chronic illness which has placed the member in a high-risk category, and other conditions, circumstances, and all members eligible for the Division.

The relinquishing AdSS must:

1. Coordinate care for members with special health care needs with the receiving AdSS to ensure that services are not interrupted.

2. Be responsible for timely notification to the receiving AdSS of pertinent information related to any special needs of transitioning members.

3. Notify the receiving AdSS.

Relinquishing AdSSs, who fail to notify receiving AdSSs about members that meet the Division transition notification requirements specified in Division Medical Policy Manual Chapter 500, will be responsible for the cost of medically necessary services received by the member for the first 30 days. The scope and responsibility for such cases will be reviewed and determined by the Division.

If the Division determines that the relinquishing AdSS is responsible for payment of services following the transition date, the Division will require the receiving AdSS to provide the Division with information about all costs incurred by the member during the period determined by the Division. Failure to timely provide the requested information to the Division will void the receiving AdSS’s claim to reimbursement in that case.

4. Notify the hospital before transitioning a member who is hospitalized on the date of transition and comply with the requirements of the Division Medical Policy Manual Chapter 500.

5. Be responsible for ensuring that a transitioning member’s medical records are copied and transmitted when requested by the member’s new PCP or designated office staff.

In cases where additional information is medically necessary but is exceptionally lengthy, the relinquishing AdSS is responsible for the cost of copying and postage.

The member is never required to pay fees or costs associated with the copying and/or transfer of medical records to the receiving AdSS.

6. Ensure coverage and provision of medically necessary services to their
assigned members through the date of transition.

An AdSS must never cancel, postpone, or deny a service based on the fact that a member will be transitioning to another AdSS.

7. Be responsible for ensuring that all staff involved with the coordination and/or authorization of services between members and providers are aware of the relinquishing AdSS’s duties and obligations to deliver medically necessary services to transitioning members through the date of transition.

8. Remain responsible for adjudicating all pending member grievances and appeals that are filed before the member’s transition.

F. Receiving AdSS Responsibilities

Receiving AdSSs which fail to timely act upon ETI or fail to timely coordinate or provide the necessary covered services to transitioning members after being properly notified will be subject to sanctions as outlined in contract and AdSS Operations Manual Policy 408.

The receiving AdSS must perform the following:

1. Coordinate care for members with special health care needs with the relinquishing AdSS so that services are not interrupted, and provide the new member with AdSS and service information, emergency numbers and instructions about how to obtain services.

2. Do not delay the timely process of a transition because of missing or incomplete information.

   If notification of a transition is received before a relinquishing AdSS’s ETI, the receiving AdSS must begin care coordination efforts immediately upon notification.

3. Extend previously approved prior authorizations for a minimum period of 30 days from the date of the member’s transition unless a different time period is mutually agreed to by the member or member’s representative.

4. Provide at a minimum a 90-day transition period, for children who have an established relationship with a PCP that does not participate in the AdSS’s provider network, during which the child may continue to seek care from their established PCP while the child and child’s parents and/or guardian, the AdSS, and/or Support Coordinator finds an alternative PCP within the AdSS’s provider network.

5. Allow members who are in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider to continue receiving treatment from the non-participating/non-contracted provider through the duration of their prescribed treatment.

7. Ensure that transitioning members are assigned to a PCP and can obtain routine, urgent, and emergent medical care in accordance with Division standards.

8. Be responsible for the payment of obstetrical and delivery services when a pregnant woman who is considered high-risk, is in her third trimester, or is anticipated to deliver within 30 days of transition, elects to remain with her current physician through delivery. If the member’s current physician and/or facility selected as her delivery site are not within the receiving AdSS’s provider network, the receiving AdSS must negotiate for continued care with the member’s provider of choice for payment of obstetrical services even if delivery is scheduled to occur outside of the receiving AdSS’s contracted network.
404 CONTRACTOR WEBSITE AND MEMBER INFORMATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C R9-22-504; 42 CFR 438.10; 42 CFR 438.310(d)(3); ACOM Chapter 404; ACOM 404, Attachment A – Organizations Recognized by AHCCCS, ACOM 404, Attachment B - Contractor Website Certification Checklist, and ACOM 404, Attachment C - Member Information Attestation Statement; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Member Information Attestation Statement; Member Newsletter

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes requirements for AdSSs regarding Member Information and the approval process for Member Information Materials developed by or used by the AdSS. This policy pertains to oral and written communication disseminated to an AdSS’s enrolled Members and to the content of an AdSS’s website.

The AdSS must obtain approval from the Division and AHCCCS for all member informational materials (messages) including, but not limited to, print, e-mail, and voice-recorded information messages.

This policy includes references to exhibits and attachments in the AHCCCS Contractor’s Operations Manual (ACOM) that have been adopted by the Division for use by the AdSS.

Definitions

A. **File and Use** - A process whereby the AdSS submits qualifying member information materials to the Division prior to use and can proceed with distributing the materials without any expressed approval from the Division.

B. **Incentive Item** – Items that are used to encourage behavior changes in the AdSS’s enrolled members or Health promotion incentives to motivate members to adopt a healthy lifestyle and/or obtain health care services.

C. **Member Information Materials** - Any materials given to the AdSS’s membership. This includes, but is not limited to; member handbooks, member newsletters, provider directories, surveys, on hold messages and health related brochures/reminders and videos, form letter templates, mobile applications and website content. It also includes the use of other mass communication technology such as e-mail and voice recorded information messages delivered to a member’s phone.

D. **Retention Materials** – Member information materials sent to members prior to and during Annual Enrollment Choice (AEC) for the purposes of retaining members as an enrollee with the AdSS.

E. **Vital Materials** – Written materials that are critical to obtaining services which include, at a minimum, the following:

1. Member Handbooks,
2. Provider Directories,
3. Consent Forms,
4. Appeal and Grievance Notices,
5. Denial and Termination Notices

Policy

A. Member Information Materials

1. The AdSS must comply with the requirements in this Policy for all member information materials. In addition, refer to the requirements outlined in:
   a. AdSS Operations Policy 405 for requirements regarding Cultural Competency, Language Access Plan and Family/Patient Centered Care,
   b. AdSS Operations Policy 406 for requirements regarding the Member Handbook and Provider Directory,
   c. AdSS Operations Policy 425 for requirements regarding Social Networking activities,
   d. AdSS Operations Policy 433 for requirements regarding Member ID Cards,
   e. AdSS Operations Policy 414 for sample Notice of Adverse Benefit Determination and Notice of Extension notice, and
   f. The Division Grievance and Appeal System standards
   g. ACOM Policy 406, Attachment B CMS Required Definitions regarding definitions for AHCCCS members pursuant to 42 CFR 438.10

2. The AdSS must attest it is in compliance with Member Information requirements by signing and submitting ACOM 404 Attachment C, Member Information Attestation Statement, as specified in the Contract.

3. The AdSS must provide all Member Information Materials to Members and Potential Members in a manner and format that may be easily understood and is readily accessible by Members and Potential Members.

4. The AdSS must inform Members that Member Information is available in paper form, without charge and upon request, and must provide it upon request within five business days.

5. The AdSS must use state developed Member notices as indicated in Contract and Policy [42 CFR 438.10(c)(4)(ii)].

B. Language, Readability, and Oral Interpretation Requirements
All member information materials must include taglines in the prevalent non-English languages in Arizona and include large print (font size of at least 18 point) explaining the availability of written translation or oral interpretation services with the AdSS’s toll free and TTY/TDY telephone numbers for customer service which must be available during normal business hours. In addition, the AdSS must provide members the AdSS toll free and TTY/TDY nurse triage line telephone number which must be available 24hr/7days a week.

1. Vital materials must be made available in the prevalent non-English language spoken for each LEP population [42 CFR 438.310(d)(3)]. Oral interpretation services must not substitute for written translation of vital materials. The AdSS is not required to submit to the Division the translated member materials to AHCCCS translated into a language other than English14. It is the Contractor's obligation to ensure that the translation is accurate and culturally appropriate.

2. All written materials for members must be translated into Spanish regardless of whether or not the materials are vital.

3. Readability - The AdSS must make every effort to ensure that all information prepared for distribution is written in an easily understood language and format. The AdSS should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale. The AdSS must use a font size no smaller than 12 point. Member Information Materials must also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, have other disabilities, or who have limited reading proficiency. Large print materials must be made available using a font size no smaller than 18 point.

4. Oral Interpretation - The AdSS must make oral interpretation services available to its Members at no cost. This applies to American Sign Language and all non-English languages, not just those identified as prevalent. The AdSS must ensure interpretative services including the use of auxiliary aids such as TTY/TDY are made available.[42 CFR 438.10(d)(4)].

C. Incentives

The AdSS may offer Incentive Items (e.g. gift cards, discounts for merchandise or services, manufacturer or store coupons for savings on products) to Members to participate in health-related promotions, but total value of the items may not exceed $75.00 per Member annually. Incentives may not be given to Members to influence continued enrollment with the AdSS, as specified in A.A.C R9-22-504.

D. Materials not Requiring Submission to the Division

1. Customized letters for individual Members need not be submitted to the Division as described in this Policy. Information sent by the AdSS to Members enrolled in an AdSS’s Medicare Dual Special Needs Plan (D-SNP) that clearly
and exclusively relate to their Medicare benefits and services do not require submission to the Division.

2. Health related brochures developed by a nationally recognized organization included in ACOM Policy 404 Attachment A-Organizations Recognized by AHCCCS, do not require submission to the Division. However, in the event the informational material provided by an approved organization references services that are not medically necessary, or are not Division covered benefits, or do not align with Division policy, the AdSS may not distribute the organization's informational materials to Members. In these instances, the AdSS may use the organization's material only as a reference to develop its own Member Information Materials specific to Division recipients.

3. The AdSS must refer to this Policy for updates when considering using information from organizations listed in ACOM Policy 404 Attachment A-Organizations Recognized by AHCCCS. The AdSS will be held accountable for the content of materials developed by the organizations listed in Attachment A. The AdSS must review the materials to ensure that:

a. The services are covered by the Division.
b. The information is accurate.
c. The information is culturally sensitive.

It is important to note that in all instances where the AdSS is required by its Contract with the Division to educate its Members, brochures developed by outside entities must be supplemented or replaced with informational materials developed by the AdSS which are customized for the Medicaid population.

E. Member Newsletter Content and Requirements

1. The AdSS must develop and distribute, at a minimum, two Member newsletters during each contract year. Newsletters must be submitted in the form of an initial mock-up version of what the Member will be receiving in addition to the individual articles referencing readability levels and must be submitted as specified in the Contract. Member newsletters will be reviewed in accordance with this Policy. The Member Newsletter does not fall under the 15-day File and Use review process.

2. At a minimum, the Member newsletter must include the following at least annually (except as otherwise indicated):

a. Educational information on chronic illnesses and ways to self-manage care,
b. Reminders of flu shots and other preventative measures at appropriate times,
c. Medicare Part D issues,
d. Cultural Competency, other than translation services,
e. Contractor specific issues (in each newsletter),
f. Tobacco cessation information,
g. HIV/AIDS testing for pregnant women,
h. Suicide Prevention information,
i. Opioid/Substance Use information,
j. AdSS contact information and Crisis Hotline information (in each newsletter),
k. Resources to assist with Social Determinants of Health,
l. Information on the AdSS’s integration efforts to improve overall Member outcomes, as applicable (e.g. behavioral health and physical health services), and
m. Other information required by the Division or AHCCCS.

F. Website

The AdSS’s website must contain all the information required in ACOM Policy 404-Attachment B, Contractor Website Certification Checklist and Attestation. The AdSS must submit Attachment B as specified in Contract. All of the information must be located on the AdSS’s website in a manner that Members can easily find and navigate (e.g. “Consumer, Enrollee, Member or Recipient Page”) from the AdSS’s home page. Information should be in a format that can be retained and printed by the Member.

Websites must be specific to the AdSS’s Medicaid program and must not include links or references to private insurance. The website may contain links and references to the AdSS’s Medicare programs and services exclusively to promote coordination of care for Members enrolled in both Medicaid and Medicare. For the approval process for additional information added to the AdSS’s website that is directly related to Members or Potential Members, see refer to requirements outlined in this Policy.

The Division will review the content of the AdSS’s website to ensure the AdSS is in compliance with this Policy and the Division Contract.

G. Submission, Requirements and Restrictions for All Other Materials

1. The AdSS must inform all members of any changes considered to be significant by the Division 30 calendar days prior to the implementation date of the change. These changes include, but are not limited to:
   a. Cost Sharing
b. Prior Authorization

c. Service Delivery

d. Covered Services.

In addition, the AdSS must make a good faith effort to give written notice to Members within 15 calendar days after receipt or issuance of a provider termination notice to each Member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(1)].

The Division has adopted a File and Use review process for all other Member Information Materials developed by the AdSS. All other Member Information Materials disseminated by the AdSS to its Members must be submitted, as specified in Contract 15 calendar days before it is to be released. If a 15-day notice is not possible, the AdSS may request an expedited review, but the request must be clearly marked as expedited and also indicate the reason for the shortened timeframe. The Division reserves the right to determine if the request for an expedited review is warranted.

2. The AdSS must submit the following information to the Division prior to releasing Member Information Materials:

b. A copy, transcript, screenshot or other documentation of the material as intended for distribution to its Members or Potential Members. Translations of the material into other languages as required by this policy are not required to be submitted. A cover letter containing a description of the purpose, the process the AdSS will use to disseminating the material.

c. The reading level of the material as measured on the Flesch-Kincaid scale.

The AdSS may disseminate the member information as indicated in their request upon the expiration of the 15-day time period, unless the Division notifies the AdSS otherwise. Member materials submitted outside of standard business hours will be considered received the following Business Day. State Holidays that fall on business days are not counted as part of the 15-day review period.

Member Information Materials that are a component of new initiatives, special projects, (e.g. new Member portal, health education initiatives), or are comprised of a bulk submission (e.g. booklet, magazine, multiple submissions in a short time frame) may require additional review time.

The Division reserves the right to require any necessary changes to the material. The Division may also conduct audits and/or operational reviews to ensure compliance.

Member Information Materials can also be used for marketing purposes as defined in Division Operations Manual, Policy 101. In these cases, the materials must receive prior approval from the Division as outlined in Policy 101. In addition, for social
networking applications and content requirement, refer to Division Operations Manual, Policy 425.

3. The AdSS must ensure:
   a. All materials must be labeled with the AdSS’s name and/or logo; this includes Member material that is located on the AdSS’s website, e-mail messages, and voice or text-recorded phone messages delivered to the Member’s phone.
   b. Information contained within the material is accurate, updated regularly, and appropriately based on changes in benefits, Contract, policy, or other relevant updates.
   c. Updated Member information is re-submitted for approval, including the date the material was previously approved, the reason for the update and clearly identify all content revisions,
   d. A log is kept for all Member material distributed each year; the log must identify the date the materials was originally submitted to the Division as described in this policy, as well as resubmission dates,
   e. The log is made available to the Division upon request,
   f. Member Information Materials do not directly or indirectly refer to the offering of private insurance, do not include inaccurate, misleading, confusing or negative information about AHCCCS, the Division or the AdSS, or any information that might defraud Members,
   g. Member Information Materials do not use the word “free” in reference to covered services,
   h. Member Information Materials directly relate to the administration of the Medicaid program, or relate to health and welfare of the Member,
   i. Member Information Materials do not have political implications, and
   j. Retention materials do not refer to competing plans.

Member Information Materials developed for services under contract with the Division are not considered proprietary to the AdSS.
405  CULTURAL COMPETENCY, LANGUAGE ACCESS PLAN AND FAMILY/MEMBER-CENTERED CARE

EFFECTIVE DATE: October 1, 2019

REFERENCES: ACOM Policy 405, Attachment A, Cultural Competency Plan, Assessment, Language Access Plan, and Family-Member Centered Care Reporting Checklist; 42 CFR 438.206(c)(2); Section F3, Contractor Chart of Deliverables

DELIVERABLES: Cultural Competency Plan Assessment

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The purpose of this policy is to outline the requirement that AdSS offer accessible and high-quality services in a culturally competent manner and provide family/patient-centered care, as applicable.

Definitions

A. Competent - Properly or well qualified and capable.

B. Cultural Competency - A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables that system, agency, or those professionals to work effectively in cross-cultural situations. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. Competence implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

C. Culture - 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.

D. Family-Centered - Care that:

- Recognizes and respects the pivotal role of the family in ensuring the health and well-being of children and family members of all ages
- Supports families in their natural caregiving roles, and acknowledges that emotional, social, and developmental supports are integral components of health care
- Seeks mutually beneficial partnerships among health care providers, patients, and families
- Ensures family collaboration in the development of policies and programs, and promotes choice in the provision of services to the member.

E. Interpretation - The conversion of oral communication from English into the member’s preferred language while maintaining the original intent.
F. Limited English Proficiency (LEP) - Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or “LEP.” These individuals may be entitled language assistance with respect to a particular type or service, benefit or encounter.

G. Linguistic Need - For the purposes of this policy, linguistic need is defined as the necessity of providing services in the member’s primary or preferred language, including sign language, and the provision of interpretive and translation services.

H. Translation - The conversion of written communication from English into the member’s preferred language while maintaining the original intent.

I. Vital Materials – Information, provided to the member, which assists the member to receive covered services through the Arizona Long Term Care System (ALTCS) program. These materials include but are not limited to:

1. Member handbooks
2. Notices of Adverse Benefit Determinations
3. Notices of Appeal Resolution
4. Consent forms
5. Member notices
6. Communications requiring a response from the member
7. Grievance, appeal, and request for state fair hearing information
8. Written notices informing members of their right to interpretation and translation services.

**Cultural Competency Plan**

The AdSS must have a comprehensive cultural competency program that includes those with limited English proficiency and diverse cultural backgrounds, and the AdSS must develop a written Cultural Competency Plan (CCP).

The CCP must describe how care and services will be delivered in a culturally competent manner [42 CFR 438.206(C)(2)] and must include all information provided in ACOM Policy 405, Attachment A, Cultural Competency Plan, Assessment, Language Access Plan, and Family-Member Centered Care Reporting Checklist, which is located in the AHCCCS Operations Manual.

The AdSS must identify a staff member responsible for implementation and oversight of all requirements for the cultural competency program and plan. The AdSS must employ a Cultural Competency Administrator as a key staff position. If there is a change in the staff member responsible for the cultural competency program and plan, the AdSS must notify the Division. The CCP must address the following:
A. Education and Training

1. The education program consists of the methods the AdSS will use to train its staff to ensure that services are provided in a culturally competent manner to members of all cultures. Training must be customized to fit the needs of staff based on the nature of the contacts they have with providers and/or members.

2. The education program consists of methods the AdSS will use for providers and other subcontractors with direct member contact. The education program must be designed to make providers and subcontractors aware of the importance of providing services in a culturally competent manner and understanding of health literacy. The AdSS must also make additional efforts to train or assist providers and subcontractors with how to provide culturally competent services.

   The AdSS must ensure all staff receives Cultural Competency training during new employee orientation and annually thereafter.

3. Culturally Competent Services and Translation/Interpretation Services

   The AdSS must describe the method for evaluating the cultural diversity of its membership to assess needs and priorities in order to provide culturally competent care to its membership. Culturally competent care requires that the AdSS evaluate its network, outreach services and other programs to improve accessibility and quality of care for its membership. It should also describe the provision and coordination needed for linguistic and disability-related services.

   The availability and accessibility of translation/interpretation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they should not be encouraged to substitute a friend or relative for a translation/interpretation service. AdSSs, at any point of contact, must make members aware that translation/interpretation services are available and provide written notice informing members of the right to translation/interpretation services in their preferred language. Additionally, the AdSS must ensure access to oral interpretation, translation, sign language, disability-related services, and provide auxiliary aids and alternative formats upon request. The services offered must be provided by an individual who is proficient and skilled in translation/interpretation. Translation/interpretation services must be provided at no cost to members.
Translations must be provided in the following manner:

a. All member materials must be translated when the AdSS is aware that a language is spoken by 3,000 or 10% (whichever is less) of the AdSS’s members who also have Limited English Proficiency (LEP). However, those materials that are considered to be vital materials must be translated when the AdSS is aware that a language is spoken by 1,000 or 5% (whichever is less) of the AdSS’s members who also have LEP.

b. All written notices informing members of their right to interpretation and translation services in a language, must be translated when the AdSS is aware that 1,000 or 5% (whichever is less) of the AdSS’s members speak that language and have LEP.

c. The AdSS must make oral interpretation services available at no cost to the member. This applies to sign language and all non-English languages, not just those identified as prevalent. The AdSS must also provide information on which providers speak languages other than English. Refer to AdSS Operations Policy 404 for more information regarding language, readability, and oral interpretation requirements.

4. The AdSS must provide easy-to-understand print and member information materials as well as signage in the languages commonly used by the populations in the service area. This includes the production of materials with consideration of members with LEP or limited reading skills, those with diverse cultural and ethnic backgrounds, and those with visual or auditory limitations.

5. The AdSS and its subcontractors must:

a. Use licensed interpreters for the Deaf and the Hard of Hearing.

b. Provide auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request. Auxiliary aids include computer-aided transcriptions, written materials, assistive listening devices or systems, closed and open captioning, and other effective methods of making aurally delivered materials available to persons with hearing loss.

6. The Arizona Commission for the Deaf and the Hard of Hearing provides a listing of licensed interpreters, information on auxiliary aids and the complete rules and regulations regarding the profession of interpreters in the State of Arizona.

B. CCP Assessment Reporting

The AdSS must assess its CCP for effectiveness, at a minimum on an annual basis, including modifications based on the assessment. The assessment should consider:
linguistic need, comparative member satisfaction surveys, outcomes for certain
ultural groups, translator/interpretive services and use, member complaints,
grievances, provider feedback and/or employee surveys. Identified issues must be
tracked and trended, and actions taken to resolve the issue(s). The CCP should also
address how the AdSS communicates its progress in implementing and sustaining
the CCP goals to all stakeholders, members and the general public.

The CCP Assessment must be submitted with Attachment A, as specified in Section
F3, Contractor Chart of Deliverables.

**Language Access Plan**

The AdSS must submit a Language Access Plan annually that indicates how the needs of
members with Limited English Proficiency are met. The plan must be submitted with
ACOM 405 Attachment A, as specified in the Contract. The plan must address each of
the following elements:

A. **Assessment: Needs and Capacity**

   Processes to regularly identify and assess the language assistance needs of its
   members, as well as the processes to assess the AdSS’s capacity to meet these
   needs according to the elements of this plan

B. **Oral Language Assistance Services**

   Processes for providing oral language help (such as qualified interpreters or staff
   whose proficiency in non-English languages has been documented), in both face-
   to-face and telephone encounters, that addresses the needs as specified in
   assessment above. The AdSS must provide the established point of contact for
   members with LEP, such as an office, official, or phone number. The AdSS must
   include the process used to ensure that the interpreters used are qualified to
   provide the service and understand interpreter ethics and client confidentiality
   needs,

C. **Written Translations**

   Processes to identify, translate, and make accessible in various formats, vital
   materials in accordance with assessments of need and capacity conducted as
   specified in assessment, AdSS Operations Manual, Policy 404, and ACOM Policy
   406,

D. **Policies and Procedures**

   Written policies and procedures that ensure members with LEP have meaningful
   access to programs and activities

E. **Notification of the Availability of Language Assistance at No Cost**

   Processes to inform members with LEP that language help is available at no cost.
The AdSS must take steps to ensure meaningful access to its programs, including
notifying current and potential members with LEP about the availability of free
language help. Notification methods may include multilingual taglines in member materials, and statements on forms including electronic forms such as agency websites. The results as specified in the Needs and Capacity assessment above, should be used to determine the languages in which the notifications should be translated.

F. Staff Training

Description of employee training to ensure management and staff understand and can implement the policies and procedures of this plan.

G. Assessment: Access and Quality

Processes to:

- Regularly assess the accessibility and quality of language assistance activities for members with LEP
- Maintain an accurate record of language assistance services
- Implement or improve LEP outreach programs and activities in accordance with customer need

H. Stakeholder Consultation

Process for engaging stakeholder communities to:

- Identify language assistance needs of members with LEP,
- Implement appropriate language access strategies to ensure members with LEP have meaningful access in accordance with assessments of customer need
- Evaluate progress on an ongoing basis

I. Subcontractor Assurance and Compliance

Processes for ensuring subcontractors understand and comply with their obligations under civil rights statutes and regulations, enforced by AHCCCS, related to language access.

**Children’s Rehabilitative Services (CRS) Family-Centered and Culturally Competent Care**

The CRS AdSS provides family-centered care in all aspects of the service delivery system (as specified in Division Medical Manual Policy 330). The additional responsibilities of the CRS AdSS for support of family-centered care include, but are not limited to:

A. Recognizing the family as the primary source of support for the member’s health care decision-making process; service systems and personnel should be made available to support the family’s role as decision makers
B. Facilitating collaboration among recipients, families, health care providers, and policymakers at all levels for the:

1. Care of the member
2. Development, implementation, evaluation of programs
3. Policy development

C. Promoting a complete exchange of unbiased information between recipients, families, and health care professionals in a supportive manner at all times

D. Recognizing cultural, racial, ethnic, geographic, social, spiritual, and economic diversity and individuality within and across all families

E. Implementing practices and policies that support the needs of recipients and families, including medical, developmental, educational, emotional, cultural, environmental, and financial needs

F. Participating in Family-Centered Cultural Competence Trainings

G. Facilitating family-to-family support and networking

H. Promoting available, accessible, and comprehensive community, home, and hospital support systems to meet diverse, unique needs of the family

I. Acknowledging that families are essential to the members’ health and well-being and are crucial allies for quality within the service delivery system

J. Appreciating and recognizing the unique nature of each recipient and their family.
406 MEMBER HANDBOOK AND PROVIDER DIRECTORY

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.10, 42 CFR 438.102(a)(2); ACOM Policy 404, Attachment C, ACOM 406 Attachment A; ACOM 406 Attachment B; Section F3, Contractor Chart of Deliverables
DELIVERABLES: Member Handbook; Member Handbook Request for Approval to Forgo Issuing Hard Copy; Website Certification

Purpose

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes guidelines regarding member handbooks and provider directories.

Definitions

A. Business Day - A Monday, Tuesday, Wednesday, Thursday, or Friday unless a legal holiday falls on Monday, Tuesday, Wednesday, Thursday, or Friday.

B. Multi-Specialty Interdisciplinary Clinic (MSIC) - A facility where specialists from more than one specialty meet with members and their families in order to provide interdisciplinary services to treat members.

General Requirements

A. The AdSS must provide annually a Member Handbook to members.

B. The AdSS must provide annually a Provider Directory to members.

C. The member handbook must contain all information required, as identified in AHCCCS ACOM 406 Attachment A, Model Member Handbook Checklist, including definitions as required by Centers for Medicare and Medicaid Services specified in AHCCCS ACOM 406 Attachment B, Definitions for AHCCCS Members. The required information must be incorporated into the AdSS’s Member Handbook in the order identified on the Checklist.

D. The Member Handbook must be submitted as described in the section “Member Handbook Review Process” below.

E. The Division may require the AdSS to publish information modifying or expanding the contents of the AdSS’s Member Handbook, and to distribute this information in the form of inserts and supply these inserts with subsequently distributed Member Handbooks.

F. The AdSS must update paper provider directories at least monthly [42 CFR 438.10(h)(3)],

G. The AdSS must ensure the electronic versions of the Member Handbook and Provider Directory meet the following requirements [42 CFR 438.10]:

406 Member Handbook and Provider Directory
1. The format is readily accessible.
2. The information is located in a place on the AdSS’s website that is prominent and readily accessible.
3. The information is provided in an electronic form which can be electronically retained and printed.
4. The information is consistent with federal content and language requirements.
5. The member is informed that the information is available in paper form upon request at no cost and it is provided within five business days.
6. Adhere to the requirements identified in Policy 416 in this Policy Manual. [42 CFR 438.10(h)(3)].

H. Language and format requirements are as outlined in Policy 404 in this Policy Manual.

**Member Handbooks**

A. Member Handbook Review Process

The AdSS’s Member Handbook, along with a redlined version, must be submitted annually as specified in Section F3, Chart of Deliverables, or as directed by the Division. A copy of the Member Handbook must be submitted to the Division after the Division has given final approval, as specified in Section F3, Contractor Chart of Deliverables. The Division is responsible for the Member Handbooks and Provider Directories issued by its AdSS.

B. Distribution Requirements

1. **Electronic-Only Member Handbooks**

   If a hard copy member handbook will not be provided:
   a. Submit a request for approval to forego providing the hard copy of the handbook and include a statement of intent to notify members as specified in Section F3, Contractor Chart of Deliverables.

   Ensure the written notification gives the member the option to obtain a printed version of the member handbook.
   b. Acquire approval of the member notification in accordance with Administrative Services Subcontractors Operations Manual, Policy 404.
   c. Send the written notification to members within the member handbook timeframes as outlined above [42 CFR 438.102(a)(2)].
2. Providing Member Handbooks to Members
   a. Provide to the member either a hard copy of the member handbook or an electronic version of the member handbook (or both versions) as follows:
      i. Hard Copy
         Provide the member handbook in hard copy format with the new member packet or inform the member that the information is available in paper form upon request at no cost and provide it within five business days.
      ii. Electronic
         Via electronic mail or postal mailing, provide notification of how to access the information in the member handbook on the AdSS website, to each member/representative or household within 10 business days of receipt of:
         - Notification of the enrollment date [42 CFR 438.102(a)(2)]
         - When member is determined medically eligible for CRS covered services [42 CFR 438.102(a)(2)]
   b. Annually, provide the member handbook, or notification of how to access the information in the member handbook, to each member/representative or household.

C. Other Requirements
   1. The Division may, at its discretion, require the AdSS to provide written notification that the AdSS’s member handbook is available on the subcontractor’s website, or upon request via electronic mail or by postal mailing.
   2. The AdSS must, when providing behavioral health services, make available copies of the member handbook to known consumer and family advocacy organizations and other human service organizations.
   3. Member Handbook Inserts – the Division may require the AdSS to update its Member Handbooks throughout the contract year to address program changes for inclusion in the member handbook.
      a. These changes must be incorporated in subsequently distributed handbooks through inserts until the handbooks are updated with the new information.
      b. The AdSS must also post the content of the insert on its website.
Provider Directory

A. Creating, Revising, and Maintaining Provider Directories

The AdSS must:

1. Update paper provider directory at least monthly [42 CFR 438.10(h)(3)].

2. Ensure the electronic version of the provider directory is searchable (including specialists for referrals) and meets the following requirements [42 CFR 438.10] (see ACOM Policy 404, Attachment C).
   a. Format is readily accessible and user friendly.
   b. Information is placed in a location on the AdSS’s website that is prominent and readily accessible.
   c. Information is provided in an electronic form which can be electronically retained and printed.
   d. Information is consistent with federal content and language requirements.
   e. Language and formatting comply with Division Administrative Services Subcontractors Operations Manual Policy 404. [42 CFR 438.10]


4. Ensure the provider directory (hard copy and electronic) includes:

   Note: See 42 CFR 438.10.

   a. Provider name as well as any group affiliation
   b. Provider address
   c. Provider telephone number
   d. Web site URL, as appropriate
   e. Specialty, as appropriate
   f. Non-English languages spoken
   g. Whether or not the provider is accepting new patients
   h. Information for the following provider types:
      i. Physicians, including specialists
      ii. Hospitals
iii. Pharmacies

iv. Behavioral Health Providers

v. Skilled Nursing Facilities

vi. Emergency Alert System

vii. Physical Therapy for members age 21 and over

viii. Community-based, peer and family support providers throughout the State, and

ix. MSICs

i. Provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office, and whether the provider has completed cultural competence training

j. Locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post stabilization services covered under the contract

k. A designation for identifying provider locations that meet the AdSS’s criteria for accommodating members with physical or cognitive disabilities and a description of how the members can obtain details of the accessibility features for specific providers with this designation.

l. Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide Multi-Specialty, Interdisciplinary Care when needed in other areas of the State.

m. The following provider and MSIC-specific information:

i. Specialty Provider and MSIC names

ii. Specialty Provider and MSIC address

iii. Specialty Provider and MSIC telephone number

iv. Non-English languages spoken by providers

v. Whether or not the specialty provider is accepting new patients

n. Any restrictions on the member’s freedom of choice among network providers and MSICs (this information must be current and can be in the same form as typical correspondence to members).
o. For CRS provider directory, the additional following information:

i. Physicians (including adult and child psychiatrists), laboratory, x-ray and therapy services available onsite at the MSIC and through a network of community-based providers closer to members’ homes

ii. Innovative service delivery mechanisms such as field clinics and virtual clinics that incorporate the use of telemedicine, teleconferencing among providers, and an Integrated Medical Record to provide multi-specialty, interdisciplinary care when needed in other areas of the State

iii. Community-based, family support providers throughout the state.

B. Providing Provider Directories to Members

The AdSS must:

1. Inform the member that information is available in paper form upon request at no cost, and if the information is requested in paper form, provide it within five business days.

2. Provide to the member either a hard copy of the provider directory or an explanation of how to use the electronic version of the provider directory (or both versions) as follows:

a. Hard Copy

Provide the provider directory in hard copy format with the new member packet.

b. Electronic

Within 10 business days of receipt of notification of the enrollment date [42 CFR 438.102(a)(2)], inform each member/representative or household how to access the provider directory.

Via electronic mail, postal mailing, or inclusion in the member handbook, provide written notification of how the provider directory information is available to the member on the AdSS’s website. This member notification must:

i. Be approved in accordance with this policy and with Division Administrative Services Subcontractors Operations Manual Policy 404

ii. Give the member the option to obtain a hard copy version of the provider directory.
D. Other Requirements

The Division may, at its discretion, require the AdSS to provide written notification that the AdSS’s provider directory is available on the subcontractor’s website, or upon request via electronic mail or by postal mailing.
407 WORKFORCE DEVELOPMENT

EFFECTIVE DATE: October 1, 2019
DELIVERABLES: Workforce Development Plan; Workforce Development Plan Implementation Progress Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). Overseeing the development of the provider workforce is a function of the AdSS’s network management responsibilities. The purpose of this policy is to describe the AdSS requirements to monitor and collect information about the workforce, collaboratively plan workforce development initiatives including the recruitment and employment of members eligible for the Division into healthcare roles, and when necessary, provide direct assistance to providers in order to develop the workforce.

Definitions

Competency Requirement - A requirement mandating personnel to behaviorally demonstrate to a qualified staff member that they have acquired specific information or skill and or that they are capable of routinely using the information or skill in the performance of their duties.

Training Requirement - A requirement mandating personnel to participate in a specific training course or program.

A. General

The Division, AHCCCS, providers and the AdSS work together to ensure members receive services from a workforce that is qualified, capable and sufficiently staffed,

1. Providers are responsible for acquiring, developing and deploying a sufficiently staffed and qualified workforce that capably delivers services to members.

2. AHCCCS and the Division are responsible for generating policies that shape worker, workplace and workforce development practices. AHCCCS’s Office of Workforce Policy analyzes current and future healthcare trends; forecasts the workforce capacities and capabilities needed to address these trends, and assists Contractors and providers by mobilizing governmental and community resources as necessary to strengthen Arizona’s healthcare workforce.

3. AdSS are responsible for ensuring that provider workforce management and development processes are aligned with the Division’s workplace and workforce development policies. The AdSS monitors the performance of the network, collects information about the workforce, develops plans to strengthen the workforce, and when necessary, directly assist providers to develop and maintain a qualified, capable and sufficiently capacitated workforce.
The AdSS must ensure that subcontracted provider organizations are deploying a qualified, sufficiently staffed workforce that capably provides services to members eligible for the Division in an interpersonally, clinically, culturally and technically effective manner.

B. Maintain A Workforce Policy Management Function

The AdSS must perform specific workforce monitoring, data collection, planning and technical assistance as follows:

1. Maintain a workforce policy management function to implement the requirements of this policy.

2. Designate a staff member with experience and expertise in workforce development to oversee the AdSS’s workforce development responsibilities.

3. Ensure that resources are available to monitor provider workforce development activities, collect workforce data, produce a workforce development plan, ensure subcontracted personnel are receiving the training required by Division policy, and provide technical assistance to provider organizations to improve their workforce development programs if determined necessary.

C. Workforce Development Plan And Progress Report

The AdSS must produce a Workforce Development Plan (WFD) in collaboration with providers, members eligible for the Division and their families and other stakeholders including but limited to Division staff, other Division Administrative Services Subcontractors, and industry, education and community groups. The WFD Plan must describe the goals, objectives, tasks and timelines to develop the workforce. The WFD Plan must be submitted as specified in Contract.

The WFD Plan must include the following:

1. Short and long term strategic WFD capacity and capability requirements (e.g. addressing health professional shortage areas, and integrated care)

2. Forecast of anticipated workforce capacity (size, job types etc.) and capability (skills and workplace support) needs

3. Specific WFD goals

4. Description of the actions to be taken to implement WFD initiatives, such as programs to recruit members eligible for the Division to seek employment in various roles within the AHCCCS healthcare system, and

5. How stakeholders, members, families and the general public will be involved in the development and implementation of the WFD Plan.
The AdSS must maintain a general assessment of the progress of the WFD Plan and must formally assess and submit a written WFD Progress Report of overall progress as specified in Contract. The WFD Progress Report(s) must include:

1. Progress being made toward the achievement of statewide WFD goals as well as AdSS specific – provider network identified WFD goals, and

2. A summary of technical assistance activities provided to provider organizations.

D. Monitor Provider Workforce Development Activities

Division and AHCCCS policies, guidance documents, manuals and plans may include training and or competency requirements. As part of the routine audit and compliance monitoring process the Contractor must ensure the following:

1. All required training content or competency descriptions are incorporated into the appropriate orientation, education or training program and evaluation processes and are being made available to provider personnel.

2. Providers have processes for documenting training, verifying the qualifications, skills and knowledge of personnel, and retaining required training and competency transcripts and records

3. All initiatives specified in the WFD Plan are routinely monitored and evaluated.

E. Workforce Data

The AdSS must collect and analyze required and ad hoc workforce data. This process must include, but is not limited to, the following:

1. Proactively identifying potential challenges and threats to the viability of the workforce

2. Conducting analysis of the potential impact of the challenges and threats to access to care for members

3. Developing and implementing interventions to prevent or mitigate threats to workforce viability

4. Developing indicators to measure and monitor workforce sustainability.

The AdSS must also assist the Division to develop forecasts and plans concerning the WFD needs of Arizona’s healthcare system.
F. Provider Technical Assistance

On an as needed basis, the AdSS must provide technical assistance to providers to develop, implement and improve workforce recruitment, selection, evaluation, education, training and retention programs. The Contractor must determine the need, scope (all, segments or individual providers), and the most effective and efficient methods for providing technical assistance to providers. Potential examples of technical assistance include, but are not limited to, the following:

1. Workforce development planning
2. Talent identification and acquisition
3. Competency based training and development programs and systems
4. Workforce retention and promotion strategies
5. Workplace culture development.

The AdSS’s technical assistance activities must be reported on the WFD Progress Report(s).
408 SANCTIONS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §36-2903.01(B)(4); 42 CFR 438.700 et sq.

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy specifies the sanctions that may be imposed by the Division in accordance with federal and state laws, regulations and the contract with the Division. This policy does not limit the authority of the Division or AHCCCS Office of the Inspector General to investigate fraud, waste and abuse, conduct audits, and pursue any legal remedies arising from the findings of those investigations and audits.

Definitions

A. Corrective Action Plan (CAP) - A written work plan that identifies the root cause(s) of a deficiency, includes goals and objectives, actions/tasks to facilitate an expedient return to compliance, methodologies to be used to accomplish CAP goals and objectives, and staff responsible to carry out the CAP within established timelines. CAPs are generally used to improve performance of the AdSS and/or its providers, to enhance Quality Management/Process Improvement activities and the outcomes of the activities, or to resolve a deficiency.

B. Notice to Cure (NTC) - A formal written notice to an AdSS regarding specific non-compliance. The NTC contains specific timelines for meeting performance standards and possible penalties for continued non-compliance. An NTC may contain specific activities or reporting requirements that must be adhered to as the AdSS works toward compliance. Failure to achieve compliance as the result of a Notice to Cure may result in the imposition of a Sanction.

C. Sanction - A monetary and/or non-monetary penalty assessed or applied for failure to demonstrate compliance in one or more areas of contractual responsibility. Non-monetary penalties may include, but are not limited to any or all the following:

1. Appointment of temporary management for the AdSS, granting the AdSS enrollees the right to terminate enrollment with the AdSS
2. Suspension of auto-assignment and/or new enrollment
3. Suspension of payment to the AdSS until CMS or the state is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

General

The Division expects the AdSS to align its performance of the Contract with the AHCCCS and Division mission and vision and implement program innovation and best practices on a continual basis while adding value to the ALTCS program.

If the AdSS fails to demonstrate compliance with contractual requirements, the Division may elect to impose an administrative action. The Division reserves the right to issue an administrative action for any occurrence of non-compliance. Each occurrence of non-compliance will be evaluated for determination and issuance of potential administrative...
action. Administrative actions may include issuance of any or all the following: Notice of Concern, Notice to Cure, a mandate for a Corrective Action Plan, and Sanctions. The administrative actions described in this policy are non-exclusive; that is, the issuance of an administrative action or the imposition of any sanction by the Division does not preclude the Division from pursuing any other remedy available in law or contract arising from the same conduct.

To promote transparency, administrative actions and related documentation may be published on the Division website.

**Division Compliance Committee**

A. Except for encounter-related sanctions for aged, pended encounters as outlined in the Division Encounter Manual, the Division Compliance Committee will evaluate recommendations for proposed sanctions and will determine the appropriate sanction to be imposed after consideration of relevant factors. The Compliance Committee, however, will regularly review encounter-related sanctions to ensure just and consistent application of such sanctions. The Compliance Committee may, but is not required to, review administrative actions that do not include a sanction such as issuing a Notice of Concern, a Notice to Cure, or requiring a Corrective Action Plan.

B. The Division’s Health Plan Compliance Committee is comprised of the following individuals, or their designees:

- Medical Director
- Compliance Officer
- Quality Management Manager
- Performance/Quality Improvement Coordinator
- Maternal Child Health/EPSDT Coordinator
- Medical Management Manager
- Network Manager
- Behavioral Health Coordinator
- Policy Manager

C. All Compliance Committee members listed above, or their designee, must be present at each Committee meeting. Sanctions will be approved based on a majority vote.

D. The Division’s Health Plan Compliance Committee may consult with subject matter experts as appropriate and will consider the following in its decision making:

1. Applicable statutes and rules and contractual requirements
2. Application of consistent standards for determination of sanction type
3. Administrative actions
4. The goals and objectives of the agency
5. Aggravating or mitigating factors such as:
a. Quality of care or safety concerns for members
b. Repeated/continual deficiencies
c. Previous administrative actions
d. Intentional non-compliance
e. Self-identification of deficiencies and remediation
f. Risk to the financial viability of the AdSS
g. Non-compliance with key staffing requirements
h. Financial implications for providers,
i. Financial harm to the state.

E. Upon the Committee’s decision regarding the sanction, the Division will provide written notification to the AdSS which explains the basis and nature of the sanction, and any applicable appeal rights [42 CFR 438.710(a)(1)].

**Basis for Imposition of Sanctions**

The Division may impose sanctions for any breach of the Contract, or any failure to comply with applicable state or federal laws or regulations including but not limited to any conduct described in 42 CFR 438.700 et seq.

**Types of Sanctions**

The Division may impose the following types of sanctions:

A. Member Enrollment Related Sanctions

the Division may sanction an AdSS by:

1. Granting members, the right to terminate enrollment without cause and notifying the affected members of their right to disenroll (if another AdSS is available)

2. Suspending all new enrollment, including auto-assignments, after the effective date of the sanction (if another AdSS is available)

3. Suspending payment for members enrolled after the effective date of the sanction until CMS or the Division is satisfied that the reason for the sanction no longer exists and is not likely to recur.

**Right to Appeal**

The AdSS may file a grievance to dispute the decision to impose a sanction in accordance with A.R.S. §36-2903.01(B)(4).
Sanctions Imposed to AdSS

A. Sanctions imposed against the Division by AHCCCS for noncompliance with requirements for encounter data or reporting that would not have been imposed but for the AdSS action or lack thereof will be assessed to the AdSS as actual damages.

B. Any other sanctions imposed against the Division by AHCCCS in accordance with applicable AHCCCS rules, policies, and procedures that would not have been imposed but for the AdSS action or lack thereof will be assessed dollar for dollar to the Contractor as actual damages.

C. Sanctions imposed against the Division by AHCCCS for failure of AdSS to submit requested disclosure statements will be assessed dollar for dollar to the AdSS as actual damages.
412 CLAIMS RECOUPMENT

EFFECTIVE DATE: October 1, 2019


DELIVERABLES: Claim Recoupments >12 Months from Original Payment; Data Processes for Recoupmements; Single Claim Recoupments >$50,000

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). It outlines the guidelines for claims recoupment and refund activities.

AdSS are responsible for reimbursing their providers and coordinating care for services provided to a member pursuant to state and federal regulations.

Definitions

A. Day - Calendar day unless otherwise specified.

B. Provider - Any person or entity that contracts with the AdSS for the provision of covered services to members according to the provisions A.R.S. §36-2901 et seq. or any subcontractor of a provider delivering such services.

C. Recoupment - An action initiated by the AdSS to recover all or part of a previously paid claim(s). Recoupments include AdSS initiated/requested repayments, as well as overpayments identified by the provider where the AdSS seeks to actively withhold or withdraw funds to correct the overpayment from the provider. For purposes of this policy, a recoupment is a recovery and subsequent repayment of a claim(s) with a differential greater than $50,000 that is not completed within 30 days. An adjustment that is greater than $50,000 and is completed within 30 days is not considered a recoupment but must be tracked and made available to the Division upon request. The information tracked should include, at a minimum, the AHCCCS Member ID number, date(s) of service, original claim number, date of payment, amount paid, amounts recovered and subsequently repaid, and dates of recovery and repayment.

D. Refunds - An action initiated by a provider to return an overpayment to the AdSS. In these instances, the provider writes a check or transfers money to the AdSS directly.

Recoupments Over $50,000 Or One Year

A. Single Recoupment in Excess of $50,000

Prior to initiating any single recoupment in excess of $50,000 per provider Tax Identification Number (TIN), the AdSS must submit a written request for approval to the Division Compliance Officer at least 30 calendar days prior to initiating the recoupment, or earlier if the information is available, in the format detailed below:

1. A detailed letter of explanation that describes:
   a. How the need for recoupment was identified
b. The systemic causes resulting in the need for a recoupment

c. The process that will be used to recover the funds

d. Methods to notify the affected provider(s) prior to recoupment

e. The anticipated timeline for the project

f. The corrective actions that will be implemented to avoid future occurrences

g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted

h. Other recoupment action specific to this provider within the contract year.

2. An electronic file containing:

a. AHCCCS member ID

b. Date of service

c. AHCCCS original claim number

d. Date of payment

e. Amount paid

f. Amount to be recouped.

3. A copy of the written communication that will serve as prior notification to the affected provider(s). The communication must include, at a minimum:

a. How the need for the recoupment was identified

b. The process that will be used to recover the funds

c. The anticipated timeline for the recoupment

d. The provider’s right to file a claim dispute

e. Total recoupment amount, total number of claims and ranges of dates for the claims being recouped

f. Listing of impacted claim numbers.

The written communication must be approved by Division prior to being sent to the provider(s).

B. Recoupment of Payments Initiated More than 12 Months from the Date of Original Payment
The AdSS is prohibited from initiating recoupment of monies from a provider TIN more than 12 months from the date of original payment of a clean claim unless approval is obtained from the Division. Retroactive third party recoveries for Third Party Liability (TPL) are not included in this discussion.

To request approval from the Division, the AdSS must submit a request in writing to the designated Division Compliance Officer with all the following information:

1. A detailed letter of explanation that describes:
   a. How the need for the recoupment was identified
   b. The systemic causes resulting in the need for recoupment
   c. The process that will be used to recover the funds
   d. Methods to notify the affected provider(s) prior to recoupment
   e. The anticipated timeline for the project
   f. The corrective actions that will be implemented to avoid future occurrences
   g. Total recoupment amount, total number of claims, range of dates for the claims being recouped, and total number of providers impacted.

2. An Electronic file containing:
   a. AHCCCS member ID
   b. Date of service
   c. AHCCCS original claim number
   d. Date of payment
   e. Amount paid
   f. Amount to be recouped.

3. A copy of the written communication that will serve as prior notification to the affected provider(s). The communication must include at a minimum:
   a. How the need for the recoupment was identified
   b. The process that will be used to recover the funds
   c. The anticipated timeline for the recoupment
   d. Total recoupment amount, total number of claims, and ranges of dates for the claims being recouped
   e. Listing of impacted claim numbers.
The written communication must be approved by the Division prior to being sent to the provider(s).

C. Cumulative Recoupment in Excess of $50,000 per Contract Year

The AdSS must continuously track recoupment efforts per provider TIN. When recoupment amounts for a provider TIN cumulatively exceed $50,000 during a contract year (based on recoupment date), the AdSS must report the cumulative recoupment monthly to the designated Division Compliance Officer as outlined in the Division Claims Dashboard Reporting Guide.
414 REQUIREMENTS FOR SERVICE AUTHORIZATION DECISIONS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

EFFECTIVE DATE: October 1, 2019

REFERENCES: Section F3, Contractor Chart of Deliverables; 42 CFR 438; 42 CFR 431.211; 42 U.S.C. 1396d(r)(5); A.A.C. R9-34-202, A.A.C. R9-22-213; ACOM Policy 414-Attachments A, B, and C

DELIVERABLE: Notice of Adverse Benefit Determination Audit

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This Policy provides clarification regarding required content of a Notice of Adverse Benefit Determination (NOA) relating to Title XIX/XXI coverage and authorization of services. The AdSS must follow all other requirements regarding Notice of Adverse Benefit Determination set forth in Contract and refer to as NOA throughout.

Definitions

A. Adverse Benefit Determination - The denial or limited authorization of a service request, or the reduction, suspension, or termination of a previously approved service.

B. Appeal - A request for review of an Adverse Benefit Determination.

C. Calendar days - Every day of the week including weekends and holidays.

D. Computation of time in calendar days - Computation of time in calendar days that begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing member appeal dates only, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend (Saturday or Sunday) or a legal holiday. The first day of the “count” always begins on the day after the event.

E. Expedited service authorization request - A request for services in which either the requesting provider indicates, or the AdSS determines that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function and requires the authorization decision within 72 hours from the receipt of the service request.

F. Legal holidays - Legal holidays as defined by the State of Arizona are:

• New Year’s Day – January 1
• Martin Luther King Jr./Civil Rights Day – 3rd Monday in January
• Lincoln/Washington Presidents’ Day – 3rd Monday in February
• Memorial Day – Last Monday in May
• Independence Day – July 4
• Labor Day – 1st Monday in September
• Columbus Day – 2nd Monday in October
• Veterans Day – November 11
• Thanksgiving Day – 4th Thursday in November
• Christmas Day – December 25

When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday.

G. Notice of Adverse Benefit Determination (NOA) – A written notice provided to the member that explains the reasons for the Adverse Benefit Determination made by the AdSS regarding the service authorization request and includes the information required by this Policy.

H. Notice of Extension (NOE) – A written notice to a member to extend the timeframe for making either an expedited or standard authorization decision by up to 14 days if criteria for a service authorization extension are met.

I. Service authorization request - A request by the member, the representative, or a provider for a physical or behavioral health service for the member that requires Prior Authorization (PA) by the AdSS.

J. Working Days - “Working Day” as defined in A.A.C. R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless:
• A legal holiday falls on one of these days; or
• A legal holiday falls on Saturday or Sunday and an AdSS is closed for business the prior Friday or following Monday.

Policy Overview

When the AdSS decides to deny or limit an authorization request or reduce, suspend, or terminate previously authorized services, the AdSS must provide a written NOA to the member as described in 42 CFR 438.404.

A. The AdSS must use the AHCCCS-developed member NOA templates specified in 42 CFR 438.10(c)(4)(ii). The templates must not be altered except for the areas designated in the template that permit alteration and the removal of the header. Refer to AHCCCS Contractors Operations Manual (ACOM) 414 Attachment A-1 (Notice of Adverse Benefit Determination not Involving Medications Template) for the NOA template for service authorization requests that do not pertain to medications and AHCCCS Contractors Operations Manual (ACOM) 414 Attachment A-2 (Notice of
Adverse Benefit Determination Involving Medications Template) for the NOA template for service authorization requests that pertain to medications.

B. The AdSS Member Handbook informs members:
   1. Of their right to make a complaint to the AdSS about an inadequate NOA.
   2. That if the AdSS does not resolve the complaint about the NOA to the member’s satisfaction, the member may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at MedicalManagement@azahcccs.gov; and
   3. That the AdSS and its providers are prohibited from taking punitive action against members exercising their right to appeal.

Right to be represented

The AdSS acknowledges the member’s right to be assisted by a third-party representative, including an attorney, during an appeal of an Adverse Benefit Determination. A list of legal aid services available to members is provided in ACOM Policy 414, Attachment B (Legal Services Program). The AdSS’s appeals process registers the existence of the third-party and the AdSS ensures that the required communications related to the appeals process occur between the AdSS and the representative. The member’s representatives, upon request, must be provided timely access to documentation relating to the decision under appeal. Consistent with federal privacy laws, the AdSS must make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the representative provide a written authorization signed by the member, however, if the AdSS questions the authority of the representative or the sufficiency of a written authorization, it must promptly communicate that to the representative.

Notice of Adverse Benefit Determination Content Requirements

A. The NOA must contain and clearly explain in easily understood language, at 6th grade or below reading level, the information necessary for the member to understand the Adverse Benefit Determination, the reason for the AdSS’s determination such that the member may make an informed decision regarding appealing the determination, and how to appeal the decision. If the reason for the denial of a service authorization request is due to the lack of necessary information, the member must be clearly informed of that reason in order to be given the opportunity to provide the necessary information.

B. The NOA must contain and clearly explain in easily understood language, at 6th grade or below reading level, the following information and must be consistent with 42 CFR 438.404:
   1. The requested service;
   2. The reason or purpose of the requested service;
   3. The reasons for the Adverse Benefit Determination the AdSS has made or
intends to make (i.e. denial, limited authorization, reduction, suspension or termination) with respect to the requested service consistent with 42 CFR 438.404(b)(1);  

4. The effective date of a service denial, limited authorization, reduction, suspension, or termination;  

5. The right of the member to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits as required in 42 CFR 438.404(b)(2);  

6. The legal basis for the Adverse Benefit Determination;  

7. Where members can find copies of the legal basis, (e.g. the local public library and the web page with links to legal authorities). When a legal authority or an internal reference to the AdSS’s policy manual is available online, the AdSS must provide the accurate URL site to enable the member to find the reference online;  

8. A listing of legal aid resources;  

9. The member’s right to request an appeal and procedures for filing an appeal of the AdSS Adverse Benefit Determination, including information on exhausting the AdSS’s appeals process described in 42 CFR 438.402(b) and the right to request a State fair hearing consistent with 42 CFR 438.402(c);  

10. The procedures for exercising the member’s rights as described in 42 CFR 438.404(b)(4);  

11. The circumstances under which an appeal process can be expedited and how to request it; and  

12. Explanation of the member’s right to have benefits continue pending the resolution of the appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services if the appeal is denied [42 CFR 438.420(d)].  

C. It is unacceptable to cite lack of medical necessity as a reason for denial, unless the NOA also provides a complete explanation of why the service is not medically necessary. Failure to provide the reasons and explanation supporting the lack of medical necessity in the Adverse Benefit Determination will result in regulatory action by AHCCCS. Refer to ACOM 414 Attachment C (Guide to Language in Notices of Adverse Benefit Determination) for examples where medical necessity is appropriately used in denying or limiting services.  

D. The NOA must state the reasons supporting the denial, reduction, limitation, suspension, or termination of a service. NOAs that do not provide explanation of
why the service has been denied, reduced, limited, suspended, or terminated and merely refer the member to a third party for more information are unacceptable. The AdSS may include a statement referring a member to a third party for more help when the third party can explain treatment alternatives in more detail.

**Early Periodic Screening, Diagnosis, and Treatment (EPSDT)**

The AdSS must cite Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Federal law 42 U.S.C. 1396d(r)(5) when denying, reducing, limiting, suspending, or terminating a service for a Title XIX member who is younger than 21 years of age when these provisions are applicable. The AdSS must explain in accordance with this Policy and the AdSS Medical Manual Policy 430 the denial, reduction, limitation, suspension, or termination of the requested EPSDT service.

In such circumstances, the AdSS must specify why the requested service does not meet the EPSDT criteria and is not covered and must also specify that EPSDT services include coverage of screening services, vision services, dental services, hearing services, and such other necessary health care, diagnostic services, treatment, and other measures described in Federal law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

**Member Complaints Regarding the Adequacy or Understandability of the Notice of Adverse Benefit Determination**

If a member complains about the adequacy of a NOA, the AdSS must review the initial NOA against the content requirements of this Policy. If the AdSS determines that the original NOA is inadequate or deficient, the AdSS must issue an amended NOA consistent with the requirements of this Policy. Should an amended NOA be required, the timeframe for the member to appeal and continuation of services must start from the date of the amended NOA.

**Timeframes for Service Authorization Decisions**

A. All references to “days” in this Policy mean “calendar days” unless otherwise specified.

B. When a service authorization request is submitted, the AdSS ensures completion and issuance of the service authorization decision within the following timeframes. Different timeframes apply depending upon whether or not the service authorization request is a standard request, an expedited request, and whether the service request relates to medications. The date/time the AdSS receives the request is considered the date/time of receipt, whichever is applicable. The date/time is used to determine the due date for completion of the authorization decision, depending on the timeframe applicable to the particular type of service request. The AdSS may use electronic date stamps or manual stamping for logging the receipt. If the AdSS subcontracts prior authorization to a delegated entity, the date or time the delegated entity receives the request is used for establishing receipt of the request.
C. Standard and expedited authorization requests pertain to service requests that do not involve medications. Service authorization decisions pertaining to requests for medication must be completed within the timeframe specified below and do not follow the standard or expedited timeframes used for other service authorization requests.

D. An expedited authorization request is a request for a service that is not medication in which either the requesting provider indicates, or the AdSS determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. For expedited requests that meet these requirements, the authorization decision is prioritized and must be completed in the 72-hour expedited timeframe as described in this Section.

E. A standard authorization request is a request for a service that is not medication and does not meet the definition of an expedited service authorization request. For standard service authorization requests, the date the AdSS receives the request is considered the date of receipt and is used to determine the due date for completion of the decision.

F. For expedited service authorization requests and medication requests, the time the request is received is used to determine the completion time for the decision.

G. Service Authorization Decision Timeframe for Medications
   1. The AdSS must issue a service authorization decision for medication no later than 24 hours from receipt of the submitted request for PA regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. If the prior authorization request lacks sufficient information for the AdSS to render a decision for the medication, the AdSS must send a request for additional information to the prescriber no later than 24 hours from receipt of the request. The AdSS must issue a final decision no later than seven working days from the initial date of request. Refer to 42 CFR 438.3(s).

H. Standard Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications
   1. The AdSS must issue service authorization decisions as expeditiously as the member’s condition requires but no later than 14 calendar days from receipt of the request for the service regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

   2. The AdSS may issue an NOE of up to 14 additional calendar days, utilizing ACOM 414 Attachment D, if the criteria for a service authorization extension are met as specified in this Policy.
I. Expedited Service Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications

1. The AdSS must issue an expedited service authorization decision as expeditiously as the member’s health condition requires but no later than 72 hours from receipt of the request for service consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6)] regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

2. The Division may issue an NOE of up to 14 additional calendar days, utilizing ACOM 414 Attachment D, if the criteria for a service authorization extension are met as specified in this Policy.

J. Expedited Service Authorization Request Treated as a Standard Request:

When the AdSS receives an expedited request for a service authorization and the service request fails to meet the requirements for expedited consideration, the AdSS may treat the expedited authorization request as a standard request. The AdSS must have a process included in the AdSS’s policy for Prior Authorization (PA) that describes how the member will be notified of the downgrade change to a standard authorization request and be given an opportunity to provide additional information (Refer to Division of Developmental Disabilities Provider Policy Manual, Chapter 17). The requesting provider must be permitted to send additional documentation supporting the need for an expedited authorization.

K. Service Authorization Decisions Not Reached Within the Timeframes:

A service authorization decision that is not reached within the required timeframes for a standard, medication, or expedited request constitutes a denial. The AdSS must issue an NOA denying the request on the date that the timeframe expires.

L. Service Authorization Decisions Not Reached Within the Extended Timeframes:

A service authorization decision that is not reached within the timeframe noted in the NOE constitutes a denial. The AdSS must issue an NOA denying the service request on the date that the timeframe expires [42 CFR 438.404(c)(5)].

**Timeframes for Completing Notices of Adverse Benefit Determinations**

The AdSS must mail the NOA within the following timeframes:

A. For termination, suspension, or reduction of a previously authorized service, the NOA must be mailed at least 10 calendar days before the date of the proposed
termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice [42 CFR 431.211, 42 CFR 438.404(c)(1)].

B. For Standard Service Authorization decisions that deny or limit services, the AdSS must provide an NOA:

1. No later than 24 hours from the receipt of the request for authorization of medication regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. When the prior authorization request for a medication lacks sufficient information from the prescriber no later than 24 hours from receipt of the request. A final decision and an NOA must be rendered no later than seven working days from the initial date of the request.

2. For a non-medication request for authorization, as expeditiously as the member’s health condition requires but no later than 14 calendar days from the receipt of the request, regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, unless there is an NOE. For extension timeframes, refer to NOE Requirements in this Policy [42 CFR 438.404(c)(3) and (4), 42 CFR 438.210(d)(1)];

3. As expeditiously as the member’s health condition requires but no later than 72 hours from receipt of an expedited service authorization request consistent with 42 CFR 438.210(d)(2)(i) and 42 CFR 438.404(c)(6), regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona unless there is an NOE. For extension timeframes, refer to NOE Requirements in this Policy.

**Notice of Extension Requirements**

**NOE Timeframes**

A. The AdSS may extend the timeframe to make a Service Authorization Decision for both standard and expedited service authorization requests when the member or provider (with written consent of the member) requests an extension, or when the AdSS justifies the need for additional information is in the member’s best interest. The NOE must not be sent until the AdSS has made sufficient attempts to obtain the necessary information from the requesting provider [42 CFR 438.404(c)(6), 42 CFR 438.210(d)(2)(ii)];

B. For Standard Service Authorization requests (requests that do not involve medications), the AdSS may extend the 14-calendar day timeframe to make a decision by up to an additional 14 calendar days, not to exceed 28 calendar days from the service request date, regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona;

C. For Service Authorization requests involving medication, refer to Timelines for Completing Notices of Adverse Benefit Determinations (B)(2) in this Policy when the prior authorization requests lack sufficient information from the prescriber;
D. For an expedited Service Authorization Request (requests that do not involve medication), the AdSS may extend the 72-hour timeframe to make a decision by up to an additional 14 calendar days, regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona;

E. Refer to Computation of Time in Calendar Days under “Definitions” for further information regarding when the end date falls on a weekend or legal holiday;

F. If the AdSS extends the timeframe in order to make a decision, in accordance with 42 CFR 438.210(d)(1) the AdSS must:

1. Give the member written notice of the reason for the decision to extend the timeframe in easily understood language, at 6th grade or below reading level;

2. Include what information is needed in order to make a determination.

3. Inform the member of the right to file a grievance (complaint) if the member disagrees with the decision to extend the timeframe as described in 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(i); and

4. Issue and carry out the decision as expeditiously as the member’s condition requires and no later than the date the extension expires consistent with 42 CFR 438.210(d)(1)(ii); 42 CFR 438.404(c)(4)(ii); and

G. For examples of easily understood NOA language, refer to ACOM Policy 414 Attachment C (Guide to Language in Notices of Adverse Benefit Determination).
415 PROVIDER NETWORK DEVELOPMENT AND MANAGEMENT PLAN; PERIODIC NETWORK REPORTING REQUIREMENTS

EFFECTIVE DATE: October 1, 2019


DELIVERABLES: Durable Medical Equipment (DME) Wheelchair Service Delivery Reporting; Provider Network Development and Management Plan; Provider/Network Changes Due to Rates Report Attachment D and E; Value-Based Providers/Centers of Excellence Attachment to Provider Network Development and Management Plan

Network Development and Management Plan

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The AdSS provider networks must be a foundation that supports an individual’s needs as well as the membership in general. This policy establishes guidelines for the submission of the Network Development and Management Plan to the Division.

The AdSS must develop and maintain a provider Network Development and Management Plan, which assures the Division that the provision of covered services will occur as stated in the contract [42 CFR 438.207(b)]. The Network Development and Management Plan must outline the AdSS’s process to develop, maintain, and monitor an adequate provider network that is supported by written agreements and is sufficient to provide access to all services covered under the contract and satisfy all service delivery requirements.

The Network Development and Management Plan must be evaluated, updated, and submitted along with the following, as specified in Section F3, Contractor Chart of Deliverables:

A. ACOM 415 Attachment A, Network Attestation Statement

B. ACOM 415 Attachment B, Network Development and Management Plan Checklist


The AdSS must notify the Division in writing when there has been a material change that would affect network capacity and services as outlined in contract and AdSS Operations Manual, Policy 439. The changes include, but are not limited to, changes in services, geographic service areas, and payments.

Provider/Network Changes Due to Rates Report

The AdSS must submit, as specified in Section F3, Contractor Chart Deliverables, a Provider/Network Changes Due to Rates Report, which consists of ACOM 415 Attachment D and E.

A. ACOM 415 Attachment D, Provider Terminations Due to Rates, documents providers who have terminated their contract due to rates. Submission of ACOM 415 Attachment D is required for each Geographical Service Area (GSA) even when the AdSS does not have any terminations to report.
B. ACOM 415 Attachment E, Providers That Diminished Their Scope of Services and/or Closed Their Panel Due to Rates, documents providers that have diminished their scope of service and/or closed their panel due to rates. Submission of ACOM 415 Attachment E is required for each GSA even when the AdSS does not have any providers to report.

**Value-Based Providers/Centers of Excellence Report**

The Centers of Excellence attachment shall outline the Contractor’s process to develop, maintain and monitor activities for Centers of Excellence. The Attachment shall be limited to no more than two pages and include at a minimum:

A. Description of the Contractor’s initiatives to encourage member utilization

B. Goals and outcome measures for the Contract Year

C. Description of monitoring activities to occur throughout the year

D. Evaluation of the effectiveness of the previous year’s initiatives

E. Summary of lessons learned and any implemented changes

F. Description of the most significant barriers

G. Plan for next Contract Year.
416 PROVIDER NETWORK INFORMATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12, 42 CFR 438.100, 42 CFR 438.102

This Policy applies to the Division’s Administrative Services Subcontractors. This Policy establishes guidelines for AdSS regarding provider information requirements and the content of a AdSS’s website.

Definitions

A. Material Change to the Provider Network - Any change that affects, or can reasonably be foreseen to affect, the AdSS’s ability to meet the performance and/or provider network standards as required in contract including, but not limited to, any change that would cause or is likely to cause more than 5% of the members in a GSA to change the location where services are received or rendered.

B. Provider - Any person or entity that contracts with the Division, AHCCCS, or an AdSS for the provision of covered services to members according to the provisions A.R.S. § 36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. § 36-2901.

C. Subcontractor –

1. A provider of health care who agrees to furnish covered services to members.

2. A person, agency or organization with which the AdSS has contracted or delegated some of its management/ administrative functions or responsibilities.

3. An individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or leases of real property) to obtain space, supplies equipment or services provided under the Division agreement.

The Contract contains multiple requirements for communications between AdSS and the AdSS’s provider network. The information below instructs the AdSS on content and timing of these communications. The information below does not supersede any additional requirements that may be outlined in Contract.
Provider Manual

The AdSS must develop, distribute, and maintain a provider manual. The AdSS must ensure that each contracted provider is made aware of the provider manual available on the AdSS’s website or, if requested, issued a hard copy of the provider manual. The AdSS is encouraged to distribute a provider manual to any individual or group that submits claim and encounter data.

The AdSS remains liable for ensuring that all providers, whether contracted or not, meet the applicable Division and AHCCCS requirements with regard to covered services, billing, etc.

At a minimum, the AdSS's provider manual must contain information on the following:

A. The ability of the member’s PCP to treat behavioral health conditions within the scope of their practice.

B. Introduction to the AdSS which explains the AdSS’s organization and administrative structure,

C. Provider responsibility and the AdSS's expectation of the provider,

D. Overview of the AdSS's Provider Services department and its function, including but not limited to the expected response times for provider calls,

E. Listing and description of covered and non-covered services, requirements, and limitations including behavioral health services,

F. Emergency Department use (appropriate and non-appropriate use of the emergency department),

G. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services - screenings include a comprehensive history, developmental/behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings and immunizations. EPSDT providers must document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program,

H. Description of dental services coverage and limitations,

I. Description of Maternity/Family Planning services,

J. Criteria and process for referrals to specialists and other providers, including access to behavioral health services,

K. Grievance system process and procedures for providers and enrollees,

L. Billing and encounter submission information,

M. AdSS policies and procedures relevant to the providers including, but not limited to:
1. Utilization management,
2. Claims submission,
3. Criteria for identifying provider locations that accommodate members with physical or cognitive disabilities, and
4. Primary Care Provider (PCP) assignments.

N. Division Policies relevant to providers including, but not limited to:
1. Payment responsibilities as outlined in AdSS Operations Policy 432
2. Description of the Change of Contractor policies. See AdSS Operations Policy 401, and

O. Reimbursement, including reimbursement for members with other insurance, including dual eligible members (i.e., Members who have Medicare and Medicaid),

P. Cost sharing responsibility,

Q. Explanation of remittance advice,

R. Criteria for the disclosure of member health information,

S. Medical record standards,

T. Prior authorization and notification requirements, including a listing of services that require authorization,

U. Requirements for behavioral health out of state placements for children and young adults,

V. Claims medical review,

W. Concurrent review,

X. Coordination of care requirements, including designation of an Employment Coordinator as the statewide point of contact for the referral of members requesting employment services from the Division,

Y. Credentialing and re-credentialing activities,

Z. Fraud, waste and abuse as specified in AdSS Operations Policy 103,

AA. Prescribing and monitoring psychotropic medications, including specific protocols for opioids and psychotropic medications, including, at a minimum, prior authorization and limits specified in AdSS Medical Policy 310-V, the AdSS
monitoring process for prescribers in AdSS Medical Policy 310-FF, and informed consent requirements in AdSS Medical Policy 320-Q.

BB. The AHCCCS Drug List and the AHCCCS Behavioral Health Drug List information available in a machine readable file and format, including:
   1. How to access the drug lists electronically or by hard copy upon request,
   2. How and when updates to these lists are communicated

CC. Division and AHCCCS appointment standards,

DD. Requirements pertaining to duty to warn and duty to report as outlined in Division Medical Manual, Policy 960,

EE. Information for behavioral health providers on their responsibilities for submitting to the Division demographic information according to the AHCCCS Demographic and Outcomes Data Set User Guide.

FF. Americans with Disabilities Act (ADA) and Title VI requirements, as applicable,

GG. How to notify the AdSS and the Division when the provider changes address, contact information or other demographic information.

HH. Eligibility verification,

II. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other than English, including Sign Language, as specified in AdSS Operations Policy 405.

JJ. Peer review and the dispute process,

KK. Medication management services as specified in the Contract,

LL. A member’s right to be treated with dignity and respect, as specified in 42 CFR 438.100, which includes the right to:
   1. Be treated with dignity and respect
   2. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand
   3. Participate in treatment decisions regarding his or her health care, including the right to refuse treatment
   4. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
   5. Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and
applicable state law

6. Exercise his or her rights without adversely affecting service delivery to the member.

MM. That the AdSS has no policies that prevent the provider from advocating on behalf of the member as specified in 42 CFR 438.102,

NN. How to access or obtain Practice Guidelines and coverage criteria for authorization decisions,

OO. General and informed consent for treatment requirements,

PP. Advanced directives,

QQ. Transition of members,

RR. Encounter validation studies,

SS. Pre-petition screening, court ordered evaluations, and court ordered treatment,

TT. Behavioral health assessment and service planning requirements and Serious Mental Illness (SMI) eligibility determination,

UU. Housing criteria for individuals determined to have SMI,

VV. How providers assist members in obtaining a Member Handbook and other new member materials,

WW. Outreach, engagement, re-engagement and closure activities,

XX. Requirements for grant funded services provided to Special Populations,

YY. Behavioral health crisis intervention service requirements,

ZZ. Partnership requirements with families and family-run organizations in the children and adult behavioral health system,

AAA. Seclusion, restraint, and emergency response reporting requirements,

BBB. Incidents, accidents, and deaths reporting requirements,

CCC. Training requirements, and

DDD. Peer support/recovery training, certification, and clinical supervision requirements.
417 APPOINTMENT AVAILABILITY, MONITORING AND REPORTING

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 8-512.01; 42 CFR 438.206; ACOM 417 Attachment A

DELIVERABLES: Appointment Availability Review; Appointment Availability Review Methods; Appointment Availability, Monitoring and Reporting - Annual Summary

PURPOSE: This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes a common process for the AdSS to monitor and report appointment accessibility and availability in order to ensure compliance with Division network sufficiency standards. This policy does not apply to emergency conditions.

Definitions

1800 Report - An AHCCCS-generated document, provided quarterly, that identifies Primary Care Providers (PCPs) with a panel of more than 1,800 AHCCCS members.

Established Patient - A member who has received professional services from the physician or any other physician with that specific subspecialty that belongs to the same group practice within the past three years from the date of appointment.

New Patient - A member who has not received any professional services from the physician or another physician with that specific specialty and subspecialty that belongs to the same group practice within the past three years from the date of appointment.

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

Monitoring Appointment Standards

A. The AdSS must provide services that are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. To ensure this, the AdSS must provide a comprehensive provider network that provides access to all services covered under the contract for all members. If the AdSS’ network cannot provide medically necessary services required under contract, the AdSS must adequately and timely cover these services through an out-of-network provider until a network provider is contracted.

B. The AdSS must ensure the following contractual appointment and accessibility standards are met (42 CFR 438.206).

C. The AdSS must use the results of appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department use.

D. The AdSS must have written policies and procedures educating its provider network regarding appointment time requirements. The AdSS must develop a corrective action plan when appointment standards are not met. In addition, the AdSS must develop a corrective action plan in conjunction with the provider when appropriate
General Appointment Standards for All Contractors

A. Primary Care Provider Appointments:
   1. Urgent care appointments as expeditiously as the member’s health condition requires but no later than two business days of request.
   2. Routine care appointments within 21 calendar days of request.

B. Specialty Provider Appointments, including Dental Specialty:
   1. Urgent care appointments as expeditiously as the member’s health condition requires but no later than three business days of referral
   2. Routine care appointments within 45 calendar days of referral.

C. Dental Provider Appointments:
   1. Urgent appointments as expeditiously as the member’s health condition requires, but no later than three business days of request
   2. Routine care appointments within 45 calendar days of request.

D. Maternity Care Provider Appointments (Initial prenatal care appointments):
   1. First trimester within 14 calendar days of request
   2. Second trimester within seven calendar days of request
   3. Third trimester within three business days of request
   4. High-risk pregnancies as expeditiously as the member’s health condition requires but no later than three business days of identification of high risk by the AdSS or maternity care provider, or immediately if an emergency exists.

General Behavioral Health Appointment Standards for AdSS and TRBHA Contractors

A. Behavioral Health Provider Appointments:
   1. Urgent Need appointments as expeditiously as the member’s health condition requires but within 24 hours from identification of need.
   2. Routine care appointments:
      a. Initial assessment within seven calendar days of referral or request for service.
      b. The first behavioral health service following the initial assessment as expeditiously as the member’s health condition requires but no later
than 23 calendar days after the initial assessment

c. All subsequent behavioral health services as expeditiously as the
member’s health condition requires but no later than 45 calendar days
from identification of need.

B. Referrals for Psychotropic Medications:

1. Assess the urgency of the need immediately.

2. If clinically indicated, provide an appointment with a Behavioral Health
Medical Professional within a timeframe that ensures the member does not
run out of needed medications, or does not decline in his/her behavioral
health condition prior to starting medication, but no later than 30 days from
the identification of need.

Provider Appointment Availability Review

On a quarterly basis, the AdSS must conduct provider appointment availability reviews to
assess the availability of Routine and Urgent appointments for Primary Care, Specialist,
Dental, and Behavioral Health providers. The AdSS must also review these standards for
Maternity Care providers relating to the first, second and third trimesters, as well as high-
risk pregnancies.

The AdSS must conduct provider appointment availability reviews in sufficient quantity to
ensure results are meaningful and representative of the AdSS’ network. Appropriate
methods include:

A. Appointment schedule review where the AdSS independently validate appointment
availability;

B. Secret shopper phone calls where the AdSS anonymously validate appointment
availability; and

C. Other methods approved by the Division.

The AdSS may supplement these efforts by targeting specific providers identified
through performance monitoring systems such as:

- The 1800 report generated by AHCCCS that identifies PCPs with a
  panel of more than 1,800 AHCCCS members
- Quality of care concerns
- Complaints, grievances and the credentialing process

To obtain approval for any additional methods the AdSS must submit a request for
approval outlining details (including scope, selection criteria, and any tools used to
collect the information) to the Division prior to implementing the proposed method.
Tracking and Reporting

Providers in compliance with AHCCCS appointment standards when survey is delivered receive a pass for their survey result. The overall goal for compliance percentage must meet 90% or above when all passing surveys are totaled per provider type:

- PCP, Specialists, Dental: urgent appointments and routine appointments
- Maternity Care
- Behavioral Health

On a quarterly basis the AdSS must:

A. Monitor and track provider compliance with appointment availability for all provider and appointment types using the AHCCCS reporting template, as adopted by the Division, ACOM 417 Attachment A, Appointment Availability Provider Report.

B. Submit this information as identified in Section F3, Contractor Chart of Deliverables.

C. Include a cover letter that, at a minimum:
   1. Summarizes the data entered into the ACOM 417 Attachment A;
   2. Describes how the survey methodology represents appointment standards across the AdSS’ network;
   3. Explains significant trending in either direction (positive or negative);
   4. Describes any interventions applied to areas of concern (including corrective action plans);
   5. Includes the Division’s Appointment Availability Template which provides previous quarters overall passed survey compliance percentages by provider type and appointment type, current reporting of overall passed survey compliance percentages by provider type and appointment type, compliance percentage change between the previous and current quarter and arrow indicating an increase or decrease in meeting 90% passed survey standard; and
   6. Explanation of the Divisions Appointment Availability Template addressing findings, root causes why 90% standard not met, identified root causes for increase or decrease over last quarter and any interventions to take place before the next quarter in order to meet compliance.
### Appointment Availability Monitoring and Review

<table>
<thead>
<tr>
<th>Category</th>
<th>Goal</th>
<th>PASS Surveys % (Previous reporting quarter &amp; year)</th>
<th>PASS Surveys % (Current reporting quarter &amp; year)</th>
<th>% change</th>
<th>Increase/Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP, Specialist, Dental</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>URGENT NEED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP, Specialist, Dental</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ROUTINE NEED</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Column 2 enter DD Standard 90%
2. Columns 3 and 4 provide percentage of total survey’s passed. Surveys passed total include:
   a. PCP, Specialists and Dental new and established for Urgent appointments and Routine appointments.
   b. Maternity Care first trimester, second trimester, third trimester and high-risk pregnancy.
   c. Behavioral Health urgent, routine (initial assessment), routine (subsequent Behavioral services) and referrals for psychotropic medications.
3. In order to obtain total surveys passed percentage, divide the number of surveys passed by the number of surveys taken in each section of the ACOM 417 Attachment A template. **Example**: 1,115 surveys, 950 surveys passed = 950/1,115 = 0.8520\times 100 = 85.20%.
4. Column 5 insert the percentage change from current quarter reporting percentage to previous quarter reporting percentage. **Example**: 94.00 (previous quarter total compliance percentage) minus 88.00 (current quarters total compliance percentage) = 6% increase over last quarter.
5. Column 6 enter arrows accordingly, ↑ if the percentage from current reporting quarter and previous reporting quarter has increased and ↓ if the percentage has decreased.
6. If the percentage change has decreased or DD standard is not being met, provide root cause and interventions to increase percentage next quarter.
D. Annually the AdSS must summarize the results, trends, and interventions as a component of the Network Development and Management Plan. See Division Operations Manual, Policy 415, for additional guidelines for the submission of the Network Development and Management Plan.

E. The AdSS’ contractor submission of the Network Development and Management Plan to the Division must also include an attestation affirming the validity of the methodologies used and significance of the results, along with any planned changes to the methodologies for the coming year.

F. The Division may review AdSS monitoring and corrective action plans implemented as a result of provider non-compliance with appointment standards.
418 PROVIDER AND AFFILIATE ADVANCE AND LOAN REQUEST

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901
DELIVERABLES: Equity Distributions; Provider Advances and Loans

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). It establishes guidelines for the provision of advances and loans by the AdSS to providers and affiliates (related parties), including another line of business or fund within the AdSS organization.

Definitions

A. **Affiliate (Related Party)** - A party that has, or may have, the ability to control or significantly influence a contractor, or a party that is, or may be, controlled or significantly influenced by a contractor. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the offeror and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

B. **Advance** – Includes, but is not limited to, payment to a provider or affiliate by a contractor that is based on an estimate of Received but Unpaid Claims (RBUCS), an estimate of the value of erroneous claim denials (including underpayments), a loan, or as otherwise defined by the contractor.

C. **Affiliate (Related Party) Transactions** - Transactions with a party that has, or may have, the ability to control or significantly influence a contractor, or a party that is, or may be, controlled or significantly influenced by the contractor. Control, for purposes of this definition, means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an enterprise through ownership, by contract, or otherwise. "Related parties“ or “Affiliates” include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or persons.

D. **Day** - Calendar day unless otherwise specified.

E. **Provider** - Any person or entity that contracts with the AdSS for the provision of covered services to members consistent with A.R.S. § 36-2901, or any subcontractor of a provider delivering services consistent with A.R.S. § 36-2901.

Advances and Loans

A. Individual and Cumulative Provider Advances

The AdSS must submit a written request for approval to the Division for any individual or cumulative provider advances in excess of $50,000 per provider Tax Identification Number (TIN) within a contract year. All requests for prior
approval are to be submitted to the Division’s Compliance Unit. In extenuating circumstances, the Division may waive the 10-day notification requirement.

All requests for approval must be in the format detailed below:

1. A detailed letter of explanation must be submitted that describes:
   a. The provider(s) name(s) and AHCCCS Identification Number(s)
   b. The date the provider and AdSS initiated discussions relating to the need for the advance
   c. The systemic organizational causes resulting in the need for an advance
   d. The process that will be utilized to reconcile the funds against claims payments
   e. The anticipated timeline for the project
   f. The corrective action(s) that will be implemented to avoid future occurrences; and,
   g. The total advance amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.

2. A copy of the written communication that will serve as notification to the affected provider(s).

3. Upon completion of the advance(s), the Division may request that the AdSS make available within three working days a listing of the payments to be advanced, organized by provider TIN if multiple providers are affected, that includes the following:
   a. AHCCCS Member ID
   b. Date of Service
   c. Original AHCCCS Claim Number
   d. Date of payment
   e. Amount paid
   f. Amount advanced
   g. Balance Due to/from the provider.
B. Individual and Cumulative Provider Loans

The AdSS must submit written notification to the Division of any individual or cumulative provider loan equal to or in excess of $50,000 per provider TIN within a contract year. All requests for prior approval are to be submitted to Division’s Compliance Unit. In extenuating circumstances, the Division may waive the 10-day notification requirement.

1. All requests for approval must include:
   a. A detailed letter of explanation must be submitted that describes the:
      i. Provider(s) name(s) and AHCCCS Identification Number(s)
      ii. Date the provider and contractor initiated discussions relating to the need for the loan
      iii. Systemic organizational causes resulting in the need for a loan
      iv. Process that will be utilized to reconcile the funds against claims payments
      v. Anticipated timeline for the project
      vi. Corrective action(s) that will be implemented to avoid future occurrences
      vii. Total loan amount, and if applicable, the percentage that the advance amount is of total estimated amount that should have been paid, and range of dates (month/year) for the impacted claims.
   b. A copy of the written communication that will serve as notification to the affected provider(s).

2. Upon completion of the loan(s), the Division may request that the AdSS make available within three working days a listing of the payment(s) loaned, organized by provider TIN if multiple providers are affected, that includes the following:
   a. AHCCCS Member ID
   b. Date of service
   c. Original AHCCCS Claim Number
   d. Date of payment
   e. Amount paid
   f. Amount loaned
g. Balance due to/from the provider

C. Routine/Scheduled Advances or Loans to Providers and Any Advances or Loans to Affiliates

Routine/scheduled advances or loans to providers as a result of contractual arrangements, or any advance or loans to an affiliate, must be submitted to the Division for prior approval. The request for approval must be submitted to the Division’s Compliance Unit.

The Division may request additional information or periodic reconciliations related to these advances.

D. Routine/Scheduled Advances, Distributions, Loans, Loan Guarantees or Affiliates

The AdSS must submit a written request for approval to the Division for any advances, equity distributions, loans, loan guarantees, or investments in/to related parties or affiliates, including to another fund or line of business within its organization, within a contract year. Prior approval requests must be submitted 30 days prior to the anticipated date of distribution.

All approval requests must be submitted in the format of a detailed letter of explanation that describes the:

a. Related Party or Affiliate name
b. Amount
c. Type of request
d. Purpose or reason for request
e. Expected date of investment or distribution.

**Division Responsibility and Authority**

The Division reserves the right to evaluate and present all proposed advances, loans, loan guarantees, distributions, and investments, to the affected providers(s), related parties, or affiliates, as part of the approval and/or notification process. Communication will be at the timing and discretion of the Division.

The Division evaluates all advance and loan requests for appropriateness and to resolve any future occurrences with accurate and timely claims payment. A written determination will be sent to the AdSS by electronic mail contingent upon receipt of all required information from the AdSS.
421 CONTRACT TERMINATION: NURSING FACILITIES AND ALTERNATIVE HOME AND COMMUNITY BASED SETTINGS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-28-101 et seq.; 42 CFR 483; AMPM Chapter 1200, Section 1230

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division). This policy is limited to, and defines, the relationship between a Nursing Facility (NF) and/or an Alternative Home and Community Based Setting (AHCBS) and an AdSS following the termination of a contract between these entities, regardless of which entity terminates the contract or the reason for contract termination. This policy delineates how the AdSS, NF, and AHCBS collaborate to provide for the needs of the members residing in the facility at the time of contract termination.

Definitions

A. Add-On - Generally refers to contract standards that an AdSS may have with a NF to establish criteria for additional payment to the Class 1, 2, or 3 levels determined by the Universal Assessment Tool (UAT).

B. Alternative Home and Community Based Setting - Under the Home and Community Based Services (HCBS) program, members may receive certain services while they are living in an alternative HCBS setting. HCBS settings as defined in A.A.C. R9-28-101 et seq., and AMPM Chapter 1200, Section 1230. Alternative residential settings include but are not limited to Assisted Living Centers (ALC), Assisted Living Homes (ALH), Behavioral Health Residential Facilities, and Behavioral Health Supportive Homes.

C. Bed Hold Day - A 24 hour per day unit of service that is authorized by the Division Support Coordinator or the AdSS, which may be billed despite the member’s absence from the facility for the purposes of short term hospitalization leave and/or therapeutic leave.

1. Short Term Hospitalization Leave – This service may be authorized for members residing in a Nursing Facility (NF), Intermediate Care Facility for individuals with intellectual disabilities (ICF/IID) or Residential Treatment Center (RTC) that is licensed as a Behavioral Health Inpatient Facility when short-term hospitalization is medically necessary. The total number of days available for each member per year is limited to 12 days per contract year except as in #3 below.

2. Therapeutic Leave – If included in the member’s care plan, this service may be authorized for members residing in an NF, ICF/IID or RTC that is licensed as a Behavioral Health Inpatient Facility due to a therapeutic home visit to enhance psychosocial interaction or on a trial basis as a part of discharge planning. The total number of therapeutic leave days available for each member per year is limited to nine days per contract year except as in #3 below.
3. Members under 21 years of age may use any combination of bed hold days and therapeutic leave days per contract year with a limit of 21 days per year.

D. Nursing Facility (NF) - A health care facility that is licensed and Medicare/Medicaid certified by the Arizona Department of Health Services in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician. Contracted NFs are those facilities that have a contract with an AdSS. Non-contracted NFs are those facilities that do not have a contract with an AdSS.

E. Subacute or Specialty Care - Generally refers to contract standards that an AdSS may have with a NF to establish criteria for paying a rate higher than the Class 1, 2 and 3 levels determined by the UAT.

F. Uniform Assessment Tool (UAT) - A standardized tool that is used by the AdSS to assess the acuity of NF residents and commonly used for HCBS residents residing in Assisted Living Centers (ALC) or Assisted Living Homes (ALH) settings. The use of the UAT is not intended to impact how the AdSS determine authorizations for specialty levels of care (e.g., wandering dementia, medical sub-acute and behavioral management). This tool is located in Chapter 1600 of the AHCCCS Medical Policy Manual.

Policy

A. Member/Resident Options When an NF or AHCBS Contract is Terminated

Affected members residing in an NF and/or HCBS at the time of a contract termination may continue to reside in that facility until their open enrollment period, at which time they must either choose an available AdSS that is contracted with the facility, or move to a setting that is contracted with their current AdSS.

A meeting between the AdSS, NF and/or HCBS and the Division will be held prior to the effective date of the contract termination to plan all aspects related to the change in contract status and impact on members and representatives.

The AdSS in collaboration with the NF and/or AHCBS and the Division must develop a member/representative communication plan. The purpose of the communication plan is to provide affected or impacted members and/or their representatives with consistent information regarding the contract termination. The AdSS must receive approval of their member/representative communication plan from the Division.

The plan must be submitted to the Division within five business days of the termination decision. All member communications must be consistent with guidelines found in the AdSS Operations Manual, Policy 404.
B. Reimbursement

1. Nursing Facilities

The AdSS must reimburse the NF at the previously contracted rates or the AHCCCS fee for service schedule rates, whichever are greater. Should AHCCCS increase its fee schedule, the AdSS must reimburse the NF at the greater of the increased AHCCCS fee for service schedule rates or the AdSS’s previously contracted rates. Should AHCCCS reduce its fee schedule, the AdSS must reduce its previously contracted rates by the same percentage, and pay the greater of the adjusted rates.

If the AdSS had in place a provision for subacute, specialty care or add-on rates at the time of the contract termination, then the AdSS must apply those rates. If AHCCCS adjusts its fee schedule, the AdSS will adjust its subacute or add-on rate(s) by the average adjustment to the NF fee schedule rates.

2. Alternative Home and Community Based Settings

The AdSS must reimburse the Alternative Home and Community Based Setting at the previously contracted rate. If AHCCCS adjusts its HCBS Fee Schedule rates, the AdSS will adjust its ARS rates by the average percentage that the HCBS Fee Schedule rates are adjusted.

C. Quality of Care

If an AdSS or other entity, such as Arizona Department of Health Services (ADHS) Licensure, the Division, or AHCCCS identifies instances where the overall quality of care delivered by an NF or AHCBS places residents in immediate jeopardy, the AdSS will inform members/representatives of the problems and offer members alternative placement. Members may have the option to continue to reside in the NF or AHCBS.

In some cases, ADHS, the Division, or AHCCCS may require that the AdSS find new placements for members. In such cases, the AdSS must work with the members/representative to identify an appropriate placement that meets the needs of the member. The Division may require the AdSS to increase monitoring of facilities identified as having health or safety issues until the Division is assured that the issues have been resolved or members have been transitioned to a placement setting that can meet their needs.

In the event of a bankruptcy or foreclosure order of an NF or HCBS, the AdSS must notify the Division. In these instances, the AdSS should review the financial, health and safety status prior to placing a member in a placement owned by the same entity. If an AdSS identifies a member specific quality of care concern, the AdSS must identify the concern to the NF or ARS for resolution. The AdSS must also report to external entities and to the Division as required by Division Medical Policy Manual Chapter 900.
D. Admissions/Discharges/Readmissions

1. NFs or AHCBSs are not required to accept new admissions of members who are not enrolled with the AdSS.

2. NFs are required to otherwise follow admission, readmission, transfer, and discharge rights, as specified in 42 CFR 438.12.

3. The AdSS may authorize bed hold days up to the allowed limit as specified in 9 A.A.C. 28.
FINANCIAL RESPONSIBILITY FOR COURT ORDERED TREATMENT FOR DUI/DOMESTIC VIOLENCE OR OTHER CRIMINAL OFFENSES

EFFECTIVE DATE: October 1, 2019
DELIVERABLES: Monthly Outpatient Court Ordered Treatment

This Policy applies to Division’s Administrative Services Subcontractors (AdSS). The purpose of this Policy is to provide clarification regarding the financial responsibility for the provision of specific mental health treatment/care when such treatment is ordered because of a judicial ruling.

Definitions

Court-Ordered Alcohol Treatment - Detoxification services or treatment provided according to A.R.S. Title 36, Chapter 18, Article 2.

DUI Client - An individual who is ordered by the court to receive DUI screening, DUI education, or DUI treatment as a result of an arrest or conviction for a violation of A.R.S. §§28-1381, §28-1382, or §28-1383.

DUI Education - A program in which a person participates in at least sixteen hours of classroom instruction relating to alcohol or other drugs.

DUI Screening - A preliminary interview and assessment of an offender to determine if the offender requires alcohol or other drug education or treatment. (A.R.S. §28-1301)

DUI Services - DUI Screening, DUI education, or DUI treatment provided to a member eligible for the Division.

DUI Treatment - A program consisting of at least twenty hours of participation in a group setting dealing with alcohol or other drugs in addition to the sixteen hours of education. (A.R.S. §28-1301)

Driving Under The Influence (DUI)

The AdSS is responsible for covering and reimbursing for services when the services are Division or AHCCCS covered, medically necessary services described in Statute, Rule, Contract or Policy. A court order is not necessarily a substitute for the AdSS obligation to determine the amount, duration and scope of medically necessary services. The AdSS should not assume that a court or administrative agency ordering DUI screening, education or treatment services is aware of the scope of the Division or AHCCCS covered services or of how medical necessity is defined for purposes of the Medicaid program. Nevertheless, the AdSS may take into consideration, the medical information and factual findings of the court or administrative agency in making the AdSS determination of medical necessity.

When a DUI screening, education or treatment is ordered by the court for a person who has been charged for driving under the influence pursuant to A.R.S. §36-2027, the cost
of the screening, education and/or treatment is the responsibility of the county, city, town, or charter city whose court ordered the screening, education and/or treatment. See A.R.S. §36-2027 (E). The county, city or town is a source of third party liability for any court ordered evaluation and/or treatment services that are also Division or AHCCCS covered services. Upon receipt of the claim, the AdSS should deny the claim and return it to the provider with directions to bill the responsible county, city or town.

**Domestic Violence Offender Treatment**

When a person is convicted of a misdemeanor domestic violence offense, pursuant to A.R.S. §13-3601, the sentencing judge must order the person to complete a domestic violence offender treatment program that is provided by a facility approved by the Department of Health Services or a probation department. Pursuant to A.R.S. §13-3601.01. A person who is ordered to complete a domestic violence offender treatment program must pay the cost of the program.

Although a judge may determine that court ordered domestic violence offender treatment (including educational classes to meet the requirements of the court order) is the financial responsibility of the offender under A.R.S. §13-3601.01, a member eligible for the Division cannot be considered a legally responsible third party with respect to themselves. As a result, it is the Division’s expectation that the AdSS responsible for the provision of behavioral health services will provide domestic violence offender treatment when the service is deemed medically necessary. The member is not a source of first or third party liability as defined in A.A.C. R9-22-1001 when required prior authorization is obtained and/or the service is provided by an in-network provider. The AdSS must provide medically necessary services and ensure that the member’s medical record includes documentation to justify the medical necessity for the services rendered.

**Court Ordered Treatment For Persons Accused Of Other Crimes**

Pursuant to A.R.S §36-2027, a court may order evaluation and treatment at an approved treatment facility of a person who is brought before the court and charged with a crime if:

A. It appears the person is an alcoholic, and

B. Such person chooses the evaluation and treatment procedures. The court cannot order the person to undergo treatment and evaluation for more than 30 days.

The cost of evaluation and treatment of an indigent patient treated pursuant to a court order under A.R.S. §36-2027 is the responsibility of the county, city, town or charter city whose court issued the order for evaluation.

When evaluation or treatment is ordered pursuant to this statute, the county, city, town or charter city whose court issued the order for evaluation is responsible for the cost of services to the extent ordered by the court. To the extent those services are
also Division covered services and the AdSS receives a claim for the services, the AdSS may direct the provider to bill the appropriate county, city, town or charter city.

Financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of court-ordered evaluation is outlined in this Policy Manual, Policy 437.
424 VERIFICATION OF RECEIPT OF PAID SERVICES

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 433.116, 42 CFR 455.20 and 232; AHCCCS Contractor Operations Manual, Policy 424-Attachment A; Section F3, Contractor Chart of Deliverables

DELIVERABLES: AHCCCS Required Survey Results; Verification of Receipt of Paid Services

Purpose

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). AdSS are responsible for verifying member receipt of paid services according to federal and contractual requirements, to identify potential service/claim fraud. The AdSS are expected to perform surveys as required in this policy through member contact and to report the results of these surveys to the Division in accordance with the timeframes specified in Section F3, Contractor Chart of Deliverables.

General Requirements

A. The AdSS must perform, at a minimum, quarterly surveys to determine member receipt of paid services.

B. A Quarterly Verification of Services Survey Report, is due as specified in Section F3, Chart of Deliverables. The AdSS will submit this information, using the format in AHCCCS Contractor Operations Manual, Policy 424-Attachment A, Quarterly Verification of Services Audit Report.

Sampling

A. The sampling must be from claims with Dates of Services (DOS) from the reporting quarter and not more than 45 days from date of payment pursuant to 42 CFR 455.232 and 433.116(e). For example, the July 15th report would be for paid claims with DOS for January through March. Surveys can be performed at any point after claims have been paid.

B. Members who are surveyed must be eligible for the Division and enrolled with the AdSS during the period under review.

C. The sampling must consist of claims that resulted in payment.

D. The sampling must be proportionally selected from the entire range of services available under the contract (e.g. inpatient, outpatient, nursing facility).

E. The sample size must be at least 100 claims randomly selected based on the qualifications above. The minimum sampling size for an AdSS with less than 2,000 members must be 50 claims (the minimum sample size refers to completed surveys).

Methodology

A. The audit can be performed by mail, telephonically, or in person. Concurrent review will be allowed; however, if used it must be recorded and tied back to a
successfully adjudicated claim.

B. Survey language should be in an easily understood language, including the description of services (e.g., x-ray, surgery, blood tests, counseling) when validating the receipt of paid services.

C. Individual survey results indicating that paid services may not have been received must be referred to the AdSS’s fraud and abuse department for review and to the AHCCCS Office of the Inspector General (AHCCCS-OIG) department.

**Reporting**

A. The AdSS must submit a report that includes the total number of surveys sent out, total number of surveys completed, total services requested for validation, number of services validated, and number of services referred to AHCCCS-OIG for further review (AHCCCS Operations Policy Manual, Policy 424-Attachment A, Quarterly Verification of Services Audit Report).

B. A cover letter should accompany the report that discusses the number of surveys that resulted in a referral to the AdSS’s corporate compliance program and, as a result, any referrals to AHCCCS-OIG and analysis and interventions where appropriate.
425 SOCIAL NETWORKING

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.10 and 438.104; 45 CFR 164.500 et seq; ACOM Policy 425 - Attachment A, Social Networking Attestation Statement; Section F3, Contractor Chart of Deliverables
DELIVERABLES: Communications Administrator (Name and Contact Information); Social Networking Administrator (Name and Contact Information); Social Networking Applications Listing with URLs; Social Networking Attestation

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The AdSS may choose whether to engage in Social Networking activities; should they choose to participate this policy and its requirements apply. This policy establishes the requirements for the Division’s AdSS regarding social networking activities.

Definitions

A. Broadcast - Video, Audio, or text transmitted through Social Networking Applications, via internet, cellular or wireless network for display on any device (e.g., comments, podcasts, blogs).

B. Friends/Followers - Persons who choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

C. Marketing - Any communication from an AdSS to a member of the Division who is not enrolled with that AdSS that can reasonably be interpreted as intended to influence enrollment in that particular AdSS, or to not enroll in, or to disenroll from, another AdSS.

D. Social Networking Activities - The use of Social Networking Applications, the development of AdSS-specific Social Networking Application sites/pages, and Broadcast activities.

E. Social Networking Application - Web based services/platforms (excluding the AdSS’s State mandated website content, member portal, and provider portal) for online collaboration that provide a variety of ways for users to interact, such as e-mail, comment posting, image sharing, invitation and instant messaging services – collectively also referred to as social media (e.g., Facebook).

F. Tags/Tagging - Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.

G. Username - An identifying pseudonym associating the author to messages or content generated.

Social Networking Activities

A. AdSS must participate in Social Networking Activities to support learning and engagement.
B. All Social Networking material must comply with the requirements of this Policy, as well as the requirements for member information as outlined in AdSS Operations Manual, Policy 404. Any changes or amendments to previously approved member informational materials used in Social Networking Activities must be resubmitted to the Division in accordance with AdSS Operations Manual, Policy 404.

C. The AdSS is responsible for reviewing and continuous monitoring of its Social Networking Activities to ensure adherence to Division policy including, but not limited to, marketing restrictions, member information guidelines, and adherence to HIPAA Privacy Rules and provisions regarding safeguarding of Protected Health Information (PHI) [42 CFR 438.104, 42 CFR 438.10, 45 CFR Part 164, Subpart E].

D. The Division reserves the right to monitor the activities of the AdSS, including but not limited to, AdSS’s oversight of its Social Networking Activities, to ensure ongoing compliance with this policy. The Division may perform audits as deemed necessary.

**Social Networking Requirements**

The AdSS must adhere to the following requirements when engaging in Social Networking Activities. The AdSS must:

A. Address programs and services of the Division program in support of the mission and delivery of services.

B. Safeguard member privacy information from unauthorized use or disclosure, which includes the security of Protected Health Information (PHI) and adherence to all HIPAA Privacy Rules, Division policies and contractual requirements.

C. Designate a Social Networking Administrator who is responsible for policy development, implementation and oversight of all social networking activities.

D. Use all available security features to prevent fraud and unauthorized access.

E. Ensure all connections must be initiated by the external user and not the AdSS.

F. Ensure all Social Networking Application sites and Broadcasts are clear, direct, professional, accurate, and presented in a well-organized manner. The AdSS should make every effort to maintain the information at a 6th grade reading level as measured on the Flesch-Kincaid scale.

G. Comply with copyright and intellectual property law and reference or cite sources appropriately.

H. Have a presence on Social Networking Application sites and must include an Avatar and/or a Username that clearly indicates what company is being represented.

I. Develop an internal company policy, based on the requirements of this policy, for the use of Social Networking and Broadcasts with regard to the Division’s lines of
business. The policy must include a statement of purpose/general information explaining how the AdSS uses Social Networking and Broadcasting and how the AdSS continuously monitors Social Networking Activities. The AdSS must ensure applicable staff receives instruction and/or training on the Division and AdSS social networking policies before using social networking applications and broadcasts on behalf of the AdSS.

**Social Networking Restrictions**

The AdSS must adhere to the following restrictions regarding Social Networking Activities:

A. Social networking applications and broadcasts for the purposes of Marketing are prohibited.

B. The AdSS must not solicit feedback from members via social networking applications or broadcasts.

C. External user-generated content (comments/posts) is not permitted unless the AdSS has an intermediary review process in place in which the AdSS ensures all postings are appropriate and are in compliance with this policy.

D. The AdSS must not post information, photos, videos, links/URLs or other items online that reflect negatively on any individual(s), members of the Division enrolled with the AdSS, AHCCCS, the Division, or the state.

E. The AdSS is prohibited from tagging photographic or video content and must promptly remove all tags placed by others upon discovery unless written consent by those tagged has been obtained.

F. The AdSS must not identify members by name, or post, share, or publish information, including a member photo, that may lead to the identification of a member unless written consent has been obtained by the member.

G. The AdSS is prohibited from posting ads, whether targeted or general, on Social Networking Application platforms.

H. No affiliate/referral links or banners are permitted. This includes links to other non-Medicaid lines of business that the AdSS or a corporate affiliate is engaged in. When using any Social Networking Application which may automatically generate such linkage, recommendation, or endorsement on side bars or pop-ups (e.g., Facebook), the AdSS’s Social Networking Application page must contain a disclaimer message prominently displayed in the area under the AdSS’s control stating that such items, resources, and companies are NOT endorsed by the AdSS, the Division, or AHCCCS.

I. The use of the Department of Economic Security logo, AHCCCS logo, or State of Arizona seal is prohibited.

J. The use of materials that are inaccurate, misleading, or that otherwise make misrepresentations are prohibited.
AdSS Reporting Requirements

The AdSS must submit ACOM 425 Attachment A-Social Networking Attestation Statement, as specified in Section F3, Contractor Chart of Deliverables. Attachment A must include a listing of all Social Networking Applications used in the contract year with associated URLs.
CHILDREN’S REHABILITATIVE SERVICES APPLICATION, DESIGNATION AND COVERAGE

EFFECTIVE DATE: October 1, 2018
DELIVERABLES: CRS Members With Completed Treatment

This Policy applies to the Division’s Administrative Services Subcontractors (AdSS). This Policy defines the processes used to accept and process applications for a Children’s Rehabilitative Services (CRS) designation, and delineates the responsibility for coverage and payment of CRS conditions as well as other services that are the responsibility of the AdSS.

Definitions

A. Active Treatment - A current need for treatment of the CRS qualifying condition(s) or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition(s) will be needed within the next 18 months from the last date of service for treatment of any CRS qualifying condition (A.A.C. R9-22-1301).

B. CRS Application - A submitted form with additional documentation required by the AHCCCS Division of Member Services (DMS) in order to make a determination whether an AHCCCS member is medically eligible for a CRS Designation.

C. CRS Condition - Pursuant to A.R.S. § 36-2912, those covered conditions that are medically disabling or potentially disabling and which qualify for CRS medical eligibility as specified in A.A.C. R9-22-1303.

D. Redetermination - A decision made by the AHCCCS DMS regarding whether a member continues to meet the requirements in A.A.C. R9-22-1305.

Policy

The AdSS must provide covered services to members under the age of 21 who have been confirmed to have a CRS condition requiring active treatment, as described in A.A.C. R9-22-1303. Members with a CRS qualifying condition will receive a CRS designation as determined by the Division of Member Services (DMS). AHCCCS may request, at any time, that the AdSS submit medical documentation to assist with review of a current CRS designation. DMS is responsible for processing and responding to requests for CRS designations and will accept and process an application in accordance with this Policy.

A. Application

1. Form Requirements – A CRS application must be submitted to DMS for a medical eligibility determination described in A.A.C. R9-22 Article 13. A copy of the required CRS application form and instructions are available on the AHCCCS website.

   a. The completed Application for AHCCCS CRS Designation may be faxed, mailed, or delivered in person to DMS as indicated on the AHCCCS website.
b. Upon submitting the completed CRS application to AHCCCS DMS, the AdSS must:
   
   i. Notify in writing the member or his/her parent/guardian/designated representative that an application for a CRS designation has been submitted on the member's behalf.
   
   ii. Inform the member or his/her parent/guardian/designated representative that the member will be referred to a specialist for an evaluation of the CRS condition.

   c. If a CRS application is submitted to AHCCCS by a provider acting on the member’s behalf, the AdSS must work with the provider to ensure the AdSS is made aware of the application submission. Once the AdSS is made aware a provider has submitted an application, notification must be sent in accordance with b. above, and

   d. The following documentation is required with submission of the application:
   
   i. Documentation from a specialist who diagnosed the member, stating the member's diagnosis and the need for active treatment
   
   ii. Diagnostic testing results that support the medical diagnosis.

2. Processing

   a. DMS will verify Title XIX/XXI enrollment.
   
   b. If further information is needed in order to make a determination of medical eligibility, DMS will contact the appropriate parties to request the information.

3. Determination and Notification

   a. For members meeting medical eligibility criteria, DMS will identify the member with a CRS designation, effective on the same date as the determination, including those members who may be hospitalized at the time.

   b. When a determination of CRS medical eligibility is made, DMS will notify the following parties:

      i. Member/guardian/designated representative
      
      ii. The entity who submitted the application (if authorized)
      
      iii. The AdSS.
c. For members not meeting medical eligibility criteria, DMS will notify the member/guardian/designated representative and the AdSS of the decision.

The member’s right to appeal the determination of medical eligibility, and the process for doing so, will be described in the DMS member notification.

d. It is the responsibility of the AdSS to ensure that the information provided by DMS is made available to the appropriate areas and staff within its organization who may need the information.

B. Members Turning 21

At least 90 days prior to a member with a CRS designation turning 21 years of age, the AdSS must notify the member that his/her CRS designation ends upon his/her 21st birthday. The AdSS must ensure specialty services related to the member’s CRS condition(s) are completed, as clinically appropriate, prior to the member’s 21st birthday. The AdSS must continue to ensure appropriate service delivery and care coordination is provided, regardless of the member’s CRS designation ending.

C. AdSS Responsibilities for CRS Services

The member may elect to use his/her private insurance network (providers) or Medicare providers to obtain health care services, including those for treatment of the CRS condition(s). AdSS responsibilities for payment of services for treatment of the CRS condition(s), when a member uses private insurance or Medicare, are further outlined in AdSS Operations Manual, Policies 201 and 434.

D. Termination of the CRS Designation

DMS may end a member's CRS designation for one of the following reasons:

1. The member loses Title XIX/XXI enrollment
2. The member no longer meets the medical eligibility criteria for CRS
3. The member has completed treatment for the CRS condition(s)
4. The Member turns 21 years of age. Refer to Section B of this Policy.

E. Request for Removal of the CRS Designation

In response to a member/guardian/designated representative’s request for removing a CRS designation, DMS will send a CRS Designation Removal Form to the member/guardian/ designated representative for signature. Upon receipt of the signed form, DMS will end date the CRS designation.
F. Monitoring of the CRS Designation

Continued review of the CRS designation must be determined by verifying active treatment status of the CRS condition as described in A.A.C. R9-22-1305 and as follows:

1. AdSS Notification
   a. The AdSS is responsible for notifying AHCCCS of members under the age of 21 with a CRS designation who are no longer requiring active treatment for the CRS qualifying condition(s), including medical records indicating treatment has been completed,
   b. The AdSS must transmit to AHCCCS the members with Completed Treatment Report, for any member with a CRS designation who has completed treatment, and
   c. The above-referenced report must be sent as specified in Contract.

2. AHCCCS Notification
   a. If DMS determines that a CRS member is no longer medically eligible for CRS, DMS will end date the CRS designation in the member’s record, and
   b. DMS will notify the member/guardian/designated representative that the member’s CRS designation is inactive with AHCCCS.
431 COPAYMENT

EFFECTIVE DATE: October 1, 2019

Members eligible for the Division of Developmental Disabilities and the ALTCS Program must not be billed copayments for any medical service, including prescriptions. Members are exempt from mandatory and optional copayments.
433 MEMBER IDENTIFICATION CARDS

EFFECTIVE DATE: October 1, 2019
REFERENCES: 9 A.A.C. 22, Article 1

This policy applies to the Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division). This policy establishes the Division of Developmental Disabilities (Division) expectations for the AdSS regarding the development, approval, and distribution of Member Identification Cards (Member ID Cards) and replacement Member ID Cards to members eligible for the Division (including newly enrolled members). Member ID Cards must meet the formatting, timeliness, and prior approval guidelines outlined in this policy.

The Member ID Card is used by the Division member when presenting for Medicaid services.

Program Requirements

The AdSS must ensure all members receive appropriate Member ID Cards in a timely manner.

A. Members requiring Member ID Cards must be identified as a result of the 834 Transaction File, a nightly transaction file, provided by the Arizona Health Care Cost Containment System (AHCCCS), that identifies newly enrolled members and changes to existing members. The AdSS must mail Member ID Cards as indicated below:

1. For new members, within 12 business days starting from the business day following AHCCCS making the 834 Transaction File available to the contractor

2. For other members, within five business days of the request.

Note: For AdSSs issuing Member ID Cards as a result of an 834 Transaction file, a business day is from 7:00 am to 7:00 am of the following morning. If the next day is a weekend or a holiday, the ending time is 7:00 am of the morning of the day following the weekend or holiday.

B. The AdSSs must monitor adherence to the timeliness standards in this policy for the Member ID Cards it issues directly.

C. If the AdSS replaces all Member ID Cards with a new version, members must receive their new Member ID Cards at least two calendar weeks prior to the card going into effect. When a new AdSS initiates services in the state, the Division will determine the timelines for issuing Member ID Cards.

D. An AdSS serving members dually enrolled in Medicare and the Division may issue a combined Medicare/ALTCS Member ID Card. The format for the combined Member ID Cards must meet the Centers for Medicare and Medicaid Services (CMS) requirements for Member ID Cards and be approved by the Division. For the requirement of an ID Number, the AdSS may adopt additional formatting.
features included in this policy or prescribed by CMS if they do not conflict with this policy’s minimum requirements.

**Format of Member ID Cards**

Member ID Cards must meet the format standards outlined in this policy. The following formatting standards may apply:

A. Front of Card

The front of the card must include:

1. Department of Economic Security/Division of Developmental Disability (Division) Logo, in the approved color or black and white version. The approved logo is available from the Division. The AdSS must not edit or alter the approved logo, except as noted above.

2. AHCCCS Logo, in the approved color or black and white version. It can be no smaller than 1” long by .333” inches wide. If a larger version of the logo is used, the logo must maintain a 3:1 length to height ratio. The approved logo is available from AHCCCS. The AdSS must not edit or alter the approved logo, except as noted above.

3. In Arial font no smaller than 11 points:

   “Arizona Health Care Cost Containment System”

   The inclusion of “Arizona Health Care Cost Containment System” within the approved AHCCCS logo does not fulfill this requirement.

4. In Arial font no smaller than 8 points.

   - Member’s name
   - AHCCCS ID number ()
   - AdSS name
   - AdSS telephone number
   - Phone number for members who are deaf or hard of hearing
   - Contact telephone number for accessing services from the Behavioral Health Entity.

B. Back of Card

In Arial font no smaller than 7 points:

1. The back of the Member ID Card or the card holder (a printed sheet, enclosing the Member ID Card, that is used during the mailing to the member) must include the following text:
“Carry this card with you at all times. Present it when you get service. You may be asked for a picture ID. Using the card inappropriately is a violation of law. This card is not a guarantee for services. To verify benefits visit <insert appropriate website address>.”

2. The back of the Member ID Card, or the card holder, or an insert included in the card’s mailing to the member if a card holder is not used, must contain the following text:

“To help protect your identity and prevent fraud, AHCCCS is adding pictures to its on-line verification tool that providers use to verify your coverage. If you have an Arizona driver’s license or state issued ID, AHCCCS will get your picture from the Arizona Department of Transportation Motor Vehicle Division (MVD). When providers pull up the AHCCCS eligibility verification screen, they will see your picture (if available) with your coverage details.”

C. The Member ID Card or card holder may include additional information (e.g., plan logos, contact information for contracted hospitals, or after-hours clinics) identified as appropriate, subject to the approval requirements of this policy.

Any new Member ID Card mailing must also include the most recent version of the AHCCCS Notice of Privacy Practices (NPPS).

**Approval of Member ID Cards, and Other Compliance Requirements**

A Member ID Card, the card holder, any letters or information mailed to the member with the card, and any changes to these items must be submitted and obtain prior approval by the Division.

If the AdSS issues more than one version of a Member ID Card to its Division members, an example of each version must be submitted for approval.

Any third party subcontracted to produce or distribute Member ID Cards qualifies as an Administrative Services Subcontract. Direct Division contractors must obtain approval prior to implementation of the subcontract and identify the AdSS in the *Annual Subcontractor Assignment and Evaluation Report* as outlined in Policy 438 in the Division Operations Manual.
**434 COORDINATION OF BENEFITS AND THIRD PARTY LIABILITY**

**EFFECTIVE DATE:** October 1, 2019


**DELIVERABLES:** Total Plan Case Settlement Reporting via Monthly File (When reporting, Contractors must use the monthly file or the ad hoc form)

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

**Purpose**

Federal law 42 U.S.C.1396a(a)(25)(A) requires Medicaid to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid members. The purpose of this policy is to delineate the AdSS’s requirements for Coordination of Benefit (COB) activities and Third Party Liability (TPL) recoveries.

**Definitions**

A. **COB** - 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.

B. **Copayment** – A monetary amount that a member pays directly to a provider at the time a covered service is rendered (A.A.C. R9-22-711).

C. **Cost Avoidance** - To deny a claim and return the claim to the provider for a determination of the amount of third-party liability. Refer to A.A.C.R9-22 -1001 et seq.

D. **Post-Payment Recovery** - Subsequent to payment of a service by a contractor, efforts by that contractor, to retrieve payment from a liable third-party. Pay and Chase is one type of post-payment recovery.

E. **Third Party** - 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 [42 CFR 433.136].

F. **TPL** - The legal obligation of third parties (e.g., certain individuals, entities. insurers or programs) to pay part or all of the expenditures or medical assistance furnished under a Medicaid state plan.

**Policy**

A. The AdSS is the payor of last resort unless specifically prohibited by applicable state or federal law. This means AdSS must be used as a source of payment for covered services only after all other sources of payment have been exhausted. The AdSS must take reasonable measures to identify potentially legally liable third-party sources. The AdSS is responsible for making third party payer information available through the AdSS’s verification systems for use. Third party payor information may
also be obtained through DDD Systems. The AdSS is responsible for communicating TPL responsibilities to subcontractors per A.A.C. R9-22-1003.

B. The AdSS must coordinate benefits in accordance with 42 CFR 433.135 et seq., A.R.S. §36-2903, and A.A.C. R9-22-1001 et seq., so that costs for services otherwise payable by the AdSS are cost avoided or recovered from a liable third party.

C. AdSS is not the payor of last resort when the following entities are the third party:

1. Indian Health Services (IHS/638), contract health
2. Title IV-E
3. Arizona Early Intervention Program (AZEIP)
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 U.S.C. 300ff et seq.
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart G

The two methods used for COB are Cost Avoidance and Post-Payment Recovery. The AdSS must use these methods as described in A.A.C. R9-22-1001 et seq., federal and state law, and DDD policy.

**Cost Avoidance**

The AdSS must cost avoid a claim if it has determined the probable existence of a liable party at the time the claim is filed. Determining liability takes place when the AdSS receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member.

**Post-Payment Recovery**

Pay and Chase – The AdSS must pay the full amount of the claim according to the AdSS service rate or specified contracted rate and then seek reimbursement from any third party if the claim is for any of the following:

A. Prenatal care for pregnant women, including services that are part of a global OB package

B. Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program
C. Services covered by TPL that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

**Retroactive Recoveries Involving Commercial Insurance Payor Sources**

Tagging – For a period of two years from the date of service, the AdSS must engage in retroactive recovery efforts for claims paid to verify if there are commercial insurance payor sources that were not known at the time of payment. In the event a commercial insurance payor source is identified, the AdSS will seek recovery from the commercial insurance. The AdSS is prohibited from recouping payments from providers or requiring the involvement of providers in any way, unless the provider was paid in full from both the AdSS and the commercial insurance.

The AdSS has two years from the date of service to recover payments for a particular claim, or to identify (tag) claims having a reasonable expectation of recovery. A reasonable expectation of recovery is established when the AdSS has affirmatively identified a commercial insurance payor source and has begun the process of recovering payment prior to the end of the AdSS’ two-year recovery period. The AdSS must identify tagged claims in a monthly claims match-off file submitted to DDD as outlined in the AHCCCS Technical Interface Guidelines (TIG).

The timeframe for submission of claims for recovery is limited to three years from the date of service consistent with A.R.S. §36-2923 and the Deficit Reduction Act of 2005 (Public Law 109-171).

Encounter Adjustments Flagging – Although all encounters related to the AdSS’ retroactive recovery efforts outlined above must be adjusted, these adjustments cannot be completed through the normal encounter adjustment process as the AdSS is prohibited from requesting adjustments from, or adjusting related payments to, providers.

Instead, the AdSS must submit an external replacement file (via an AHCCCS approved vendor using a prescribed AHCCCS file format) in order to directly update impacted encounters. This external replacement file must be submitted within 120 days from completion of the recovery project.

In order to submit an external replacement file, the AdSS must contact the Division Encounter Unit at the completion of the recovery project for a list of approved vendors as well as the acceptable external replacement file format, and to coordinate submission of these files.

Encounters will not be adjusted when recoveries occur as a result of AHCCCS’ efforts. AHCCCS will instead flag all encounters that are impacted by retroactive commercial insurance recoveries and will develop and maintain a database to store recovery payments.

Using the data from the replacement file submitted by the AdSS, and the database used to store AHCCCS’ recoveries, AHCCCS will adjust prior and current payment reconciliations and reinsurance payments when appropriate.
Other Third-Party Liability Recoveries

The AdSS must identify the existence of other potentially liable third parties through a variety of methods, including referrals and data mining related to the following:

A. Motor vehicle cases
B. Other casualty cases
C. Tortfeasors
D. Restitution recoveries
E. Workers’ compensation cases

AdSS Discovery and Reporting of a Liable Third-Party

Reporting Requirements (Involving Commercial Insurance Payor Sources)

If the ADSS discovers the probable existence of a liable third party that is not known to AHCCCS/ Division, or identifies any change in coverage, the AdSS must report the information via the TPL Leads File or the TPL Referral Web Portal as specified in Section F3, Contractor Chart of Deliverables.

Reporting Requirements (Referrals and Data Mining)

Upon the identification of a potentially liable third party via referrals or data mining as described above, the AdSS must report the potentially liable third parties to AHCCCS’ TPL contractor for determination of a mass tort case, total plan case, or joint case. AHCCCS’ TPL contractor will refer total plan cases to the AdSS to be processed in accordance with AHCCCS, state, and federal laws and policies.

The AdSS must report total plan case settlement information to the Division, using Attachment A, the AHCCCS-approved casualty recovery Total Plan Case Settlement Notification Form, within 10 business days from the settlement date or in a monthly file approved by the Division.

Reporting Cost Avoidance and Recovery Activity

The AdSS must submit quarterly updates regarding cost avoidance/recovery activity as specified in Section F3, Contractor Chart of Deliverables.
435  TELEPHONE PERFORMANCE STANDARDS AND REPORTING

EFFECTIVE DATE: October 1, 2019
REFERENCES: ACOM Policy 435; Attachments A and B; Section F3, Contractor Chart of Deliverables
DELIVERABLES: Telephone (Administrative) Performance Measures

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes AdSS standards and reporting requirements regarding the AdSS’s performance when handling member and provider telephone calls. This policy does not include performance requirements for Crisis Services Response.

Definitions

A. Average Speed of Answer (ASOA) - The average online wait time in seconds that the member/provider waits from the moment the call is connected in the AdSS’s phone switch until the call is picked up by a AdSS’s representative or Interactive Voice Recognition System (IVR).

B. Daily First Contact Call Resolution Rate (DFCCR) - The number of calls received in a 24-hour period for which no follow-up communication or internal phone transfer is needed, divided by the total number of calls received in the 24-hour period.

C. Monthly Average Abandonment Rate (MAAR) - This is determined by the number of calls abandoned in a 24-hour period, divided by the total number of calls received in the same 24-hour period, summed for each day of the month and then divided by the number of days in the monthly reporting period.

D. Monthly Average Service Level (MASL) - The total of the month’s calls answered within 45 seconds divided by the sum of the following: all calls answered in the month, all calls abandoned calls in the month and all calls receiving a busy signal in the month (if available).

E. Monthly First Contact Call Resolution Rate (MFCCR) - The sum of the DFCCRs divided by the number of business days in the reporting period.

Telephone Performance Standards

The AdSS is required to track all of the following Telephone Performance Standards for member and provider calls monthly:

A. The ASOA must be 45 seconds or less.

B. The MAAR must be 5% or less.

C. The MFCCR must be 70% or better.

D. The MASL must be 75% or better.
**Telephone Performance Measure Reports**

The AdSS must submit a quarterly Telephone Performance Measures Report showing the AdSS’s performance based on the above standards. The report must include both of the following AHCCCS attachments adopted by the Division for use by the AdSS:

- ACOM Policy 435, Attachment A, Telephone Performance Measures Template to document the ASOA, MAAR, MFCCR, and MASL as described in this Policy
- ACOM Policy 435, Attachment B, Centralized Telephone Line Down Time Template, to report the down time for its centralized telephone lines, the dates of the occurrences, and the length of time they were out of service. The AdSS must complete separate templates for each month of the quarter.

The report must cover the AdSS’s performance during the previous twelve months and must be submitted as specified in Section F3, Contractor Chart of Deliverables.

The AdSS must separately document performance for calls of the following types:

A. Member Calls
B. Provider Calls.

The AdSS must document the number of days in a month one or more of the standards were not met by type of call. If a current month’s number of days where the standard was not met was more than two standard deviations greater than the average of the previous nine months, the AdSS must explain why the increase occurred, and summarize the steps it is taking to reduce the non-compliant calls.

If the AdSS is non-compliant with any standard on this deliverable, or the Division has concerns regarding the content reported during the reporting quarter, the Division may require the AdSS begin submitting this report monthly. The AdSS may submit a request to the Division’s Compliance Coordinator to return to quarterly reporting after three consecutive months of compliance have been achieved.
436 NETWORK STANDARDS

EFFECTIVE DATE: October 1, 2019


DELIVERABLES: Minimum Network Requirements Verification Template; Proposed Alternative Multispecialty Interdisciplinary Care Providers

This policy applies to the Division’s Administrative Services Subcontractors (AdSSs). The AdSS must develop and maintain a provider network that is sufficient to provide all covered services to members eligible for the Division [42 CFR 438.206(b)(1)]. This policy establishes AdSS network standards for all AdSSs. Unless otherwise noted, the AdSS must assess its network against its entire membership for the purposes of complying with these standards. If established network standards cannot be met, it must be explained in the Network Development and Management Plan. See Policy 415 in the Division Operations Manual.

All references in this policy to exhibits and attachments in the AHCCCS Contractor’s Operations Manual (ACOM) have been adopted by the Division for use by the AdSS.

Definitions

A. Behavioral Health Counselor, Adult - A behavioral health professional or behavioral health technician who provides interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral health problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts. For the purposes of this Policy, a Behavioral Health Counselor, Adult is defined as a provider licensed to operate with the AHCCCS provider types: 11 “Psychologist,” A4 “Licensed Independent Substance Abuse Counselor,” 85 “Licensed Clinical Social Worker,” 86 “Licensed Marriage & Family Therapist,” 87 “Licensed Professional Counselor,” or BC “Board Certified Behavioral Analyst.”

The time and distance for these providers is measured using the AdSS’s population of members aged 18 years or older.

B. Behavioral Health Counselor, Pediatric - A behavioral health professional or behavioral health technician who provides interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral health problems or conflicts, and provide support, education or understanding for the person, group or family to resolve or manage the current problem or conflict and prevent, resolve or manage similar future problems or conflicts. For the purposes of this Policy, a Pediatric Behavioral Health Counselor is defined as a provider licensed to operate with the AHCCCS provider types 11 “Psychologist,” A4 “Licensed Independent Substance Abuse Counselor,” 85 “Licensed Clinical Social Worker,” 86 “Licensed Marriage & Family Therapist,” 87 “Licensed Professional Counselor,” or BC “Board
Certified Behavioral Analyst.”

The time and distance for these providers is measured using the AdSS’s population of members under the age of 18 years old.

C. **Behavioral Health Outpatient and Integrated Clinic** - A class of health care institution without inpatient beds that provides physical health services or behavioral health services for the diagnosis and treatment of patients. For the purposes of this policy, a Behavioral Health Outpatient and Integrated Clinic is defined as facility licensed to operate using the AHCCCS provider types 77 “Mental Health Outpatient Clinic” and IC “Integrated Clinic.”

D. **Behavioral Health Residential Facility** – A health care institution that provides treatment to an individual experiencing a behavioral health issue, as defined in A.A.C. R9-10-101 et seq. A behavioral health residential facility provides a structured treatment setting with 24 hour supervision and counseling or other therapeutic activities for persons with behavioral needs. For the purposes of this policy, a behavioral health residential facility is defined as a facility licensed to operate using the AHCCCS provider type B8 “Behavioral Health Residential Facility.”

E. **Cardiologist, Adult** - A medical doctor who specializes in the diagnosis and treatment of diseases of the heart and blood vessels or the vascular system. For the purposes of this Policy, an adult Cardiovascular Specialist is defined as a provider licensed to operate with the AHCCCS provider types 08 “Physician,” or 31 “Osteopath,” and with the specialty code 62 “Cardiovascular Medicine.”

The time and distance for these providers is measured using the AdSS’s population of members aged 21 years or older.

F. **Cardiologist, Pediatric** - A medical doctor who specializes in the study or treatment of heart diseases and heart abnormalities. For the purposes of this Policy, an Pediatric Cardiologist is defined as a provider licensed to operate with the AHCCCS provider types 08 “Physician,” or 31 “Osteopath,” and with the specialty 151 "Pediatric Cardiologist.”

The time and distance for these providers is measured using the AdSS’s population of members under the age of 21 years old.

G. **Crisis Stabilization Facility** – An inpatient facility or outpatient treatment center licensed in accordance with A.A.C. R9-10, which provides crisis intervention services (stabilization). For the purposes of this policy, a Crisis Stabilization Facility is measured as a facility licensed to operate using the AHCCCS provider type 02 “Hospital” that has an organized psychiatric unit, 71 “Level I Psychiatric Hospital,” IC “Integrated Clinic,” 77 “Behavioral Health Outpatient Clinic” (24 hours per day, seven days per week access), B5 “Level I Subacute facility” (non-IMD), B6 “Level I Subacute facility” (IMD), and B7 “Crisis Service Provider.”

H. **Dentist, Adult** - A medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. § 32-1201 , Articles 2 and 3. For the purposes of this policy, Dentists are defined as a provider licensed to operate using
the AHCCCS provider type 07 "Dentist" without the specialty code "8-04-Dentist-Pediatric."

The time and distance for these providers is measured using the AdSS’s population of members aged 21 years or older.

I. Dentist, Pediatric - A medical professional regulated by the State Board of Dental Examiners and operating under A.R.S. §32-1201. For the purposes of this policy, Dentists are defined as a provider licensed to operate using the AHCCCS provider type 07 “Dentist” with the specialty code “804- Dentist-Pediatric.”

The time and distance for these providers is measured using the AdSS’s population of members under the age of 21 years old.

J. Hospital - A class of health care institution that provides, through an organized medical staff, inpatient beds, medical services, continuous nursing services, and diagnosis or treatment to a patient. Refer to A.A.C. R9-10-801 et seq, and A.R.S. 36-401 et seq, A.R.S. 36-421 et seq, and A.R.S. 36-436 et seq. For the purposes of measuring network sufficiency, a hospital is defined as a facility licensed to operate using the AHCCCS provider type 02 “Hospital” or C4 “Specialty Pier Diem Hospital.”

K. Multi-Specialty Interdisciplinary Clinic (MSIC) - An established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

L. Nursing Facility (NF) - A health care institution that provides inpatient beds or resident beds and nursing services to persons who need continuous nursing services but who do not require hospital care or direct daily care from a physician. For the purposes of this policy, a Nursing Facility is defined as a health care institution licensed to operate using the AHCCCS provider type 22 “Nursing Home.”

M. Obstetrician/Gynecologist (OB/GYN) - A healthcare practitioner responsible for the management of female reproductive health, pregnancy and childbirth needs. Or who possess special knowledge, skills and professional capability in the medical and surgical care of the female reproductive system and associated disorders. For the purposes of this Policy, an OB/GYN is defined as a provider licensed to operate using the following AHCCCS provider types:

Provider type 08 "Physician," 19 "Registered Nurse Practitioner" or 31 "Osteopath," and with at least one of the specialty codes:

1. 089 – Obstetrician/ Gynecologist
2. 090 – Gynecologist
3. 091 – Obstetrician
4. 095- Women’s HC/OB-GYN NP

N. Pharmacy - A facility regulated by the State Board of Pharmacy and operating under A.R.S. 32-1901. For the purposes of this policy, a Pharmacy is defined as a provider
licensed to operate using the AHCCCS provider type 03 “Pharmacy.”

O. **Primary Care Physician (PCP), Adult** - A healthcare practitioner responsible for the management of a member’s health care. For the purposes of this Policy, an Adult PCP is defined as a provider licensed to operate using the following AHCCCS provider types:

1. Provider type 08 “Physician” and 31 “Osteopath,” with the specialty codes:
   a. 050-Family Practice
   b. 055-General Practice
   c. 060-Internal Medicine
   d. 089-Obsterician and Gynecologist, or
   e. 091-Obstetrician

2. Provider type 19 “Registered Nurse Practitioner” with the specialty codes:
   a. 095-Women’s HC/OB-GYN NP, or

3. Provider type, 18 “Physician Assistant” with the specialty code:
   a. 798 – Physician’s Assistant.

The time and distance for these providers is measured using the AdSS’s population of members aged 21 years or older.

P. **Primary Care Physician (PCP), Pediatric** - A healthcare practitioner responsible for the management of a member’s pediatric health care needs. For the purposes of this Policy, a Pediatric PCP is defined as a provider licensed to operate using the following AHCCCS provider types:

1. Provider type 08 “Physician” or 31 “Osteopath,” and with at least one of the specialty codes:
   a. 050-Family Practice, or
   b. 150-Pediatrician, or

2. Provider type 19 “Registered Nurse Practitioner” with the at least one of the specialty codes:
   a. 084-RN Family Nurse Practitioner
   b. 87-RN Pediatric Nurse Practitioner

The time and distance for these providers is measured using the AdSS’s population of members under the age of 21.
Q. **Provider Affiliation Transmission (PAT) File** - A data file which provides details of the providers within the AdSS’s network and is used to measure compliance with this policy.

R. **Psychiatrist, Adult** - A medical doctor who specializes in mental health, including substance use disorders. For the purposes of this Policy, an adult Psychiatrist is defined as a provider licensed to operate with the AHCCCS provider types: 08 “Physician,” or 31 “Osteopath,” and with the specialty code 192 “Psychiatrist” or 195 “Psychiatrist and Neurologist.”

The time and distance for these providers is measured using the AdSS’s population of members aged 18 years or older.

S. **Psychiatrist, Pediatric** - A medical doctor who specializes in mental health, including substance use disorders. For the purposes of this Policy, a specialist Psychiatrist serving children is defined as a provider licensed to operate with the AHCCCS provider types 08 “Physician,” or 31 “Osteopath,” and with the specialty code 191 “Pediatric Psychiatrist,” 192 “Psychiatrist,” or 195 “Psychologist and Neurologist.”

The time and distance for these providers is measured using the AdSS’s population of members under the age of 18 years old.

**Statewide Time and Distance Network Standards**

For each county, the AdSS must have a network in place to meet time and distance standards outlined below:

A. **Behavioral Health Counselor, Adult**
   1. **Maricopa, Pima** - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence
   2. **All Other Counties** - 90% of membership does not need to travel more than 30 minutes or 20 miles from their residence

B. **Behavioral Health Counselor, Pediatric**
   1. **Maricopa, Pima** - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence
   2. **All Other Counties** - 90% of membership does not need to travel more than 30 minutes or 20 miles from their residence

C. **Behavioral Health Outpatient and Integrated Clinic**
   1. **Maricopa, Pima** - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence
   2. **All Other Counties** - 90% of membership does not need to travel more than 60 miles from their residence
D. Behavioral Health Residential Facility

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – See “Network Oversight Requirements” of this policy.

E. Cardiologist, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 30 minutes or 20 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 75 minutes or 60 miles from their residence

F. Cardiologist, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 60 minutes or 45 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 110 minutes or 100 miles from their residence

G. Crisis Stabilization Facility

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 45 miles from their residence

H. Dentist, Adult

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

I. Dentist, Pediatric

1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence

2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

J. Hospital

1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence
2. All Other Counties – 90% of membership does not need to travel more than 95 minutes or 85 miles from their residence

K. Nursing Facility
1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence
2. All Other Counties – 90% of membership does not need to travel more than 95 minutes or 85 miles from their residence

L. Obstetrician/ Gynecologist
1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence
2. All Other Counties – 90% of membership does not need to travel more than 90 minutes or 75 miles from their residence

M. Pharmacy Services
1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence
2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

N. PCP, Adult
1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence
2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

O. PCP, Pediatric
1. Maricopa, Pima - 90% of membership does not need to travel more than 15 minutes or 10 miles from their residence
2. All Other Counties – 90% of membership does not need to travel more than 40 minutes or 30 miles from their residence

P. Psychiatrist, Adult
1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence
2. All Other Counties – 90% of membership does not need to travel more than 75 minutes or 60 miles from their residence
Q. Psychiatrist, Pediatric

   1. Maricopa, Pima - 90% of membership does not need to travel more than 45 minutes or 30 miles from their residence

   2. All Other Counties – 90% of membership does not need to travel more than 75 minutes or 60 miles from their residence

**Other Statewide Network Standards**

In addition to the time and distance standards outlined above, AdSSs must document a sufficient network to meet the service needs of its members based upon the minimum network requirements delineated in Attachment A.

A. Multi-Specialty Interdisciplinary Clinic (MSIC) Network Standards

The AdSS-is expected to contract with all MSICs in the state, as well as any MSICs which have provided services to the AdSS’s members. The AdSS-must identify all contracted MSICs in Attachment A, including any multispecialty interdisciplinary care providers it has contracted with and the AHCCCS approval date. In the event the Contractor and an MSIC fail to negotiate a contract, the Contractor must continue to allow members to utilize the MSIC. In the absence of a contract, the Contractor shall reimburse the MSIC at the AHCCCS MSIC fee schedule.

**Network Oversight Requirements**

A. Minimum Network Standards Reporting Requirements

The AdSS must submit a completed ACOM 436 Attachment A reporting its compliance with time and distance standards, and the other statewide. The AdSS must report compliance with these requirements for each county in its assigned service area. A separate report must be submitted for each line of business.

The AdSS must analyze compliance with these network standards based upon the provider network reported through Provider Affiliation Transmission (PAT) and the Gap in Services Log. With the submission of Attachment A, the AdSS must include a summary identifying network gaps indicated by the analysis and the AdSS’s strategies and efforts to address any network gaps identified.70

The Division must report its compliance with the standards identified as applying to its ALTCS provider network, and submit separate attachments for each of its subcontracted health plans providing services measured under these standards.

B. Network Planning Requirements

AdSSs will take steps to ensure these networks standards are maintained. If established network standards cannot be met, the AdSS must identify these gaps and address short and long-term interventions in their Annual Network Development and Management Plan; as required by Policy 415 in this Manual.

AdSSs are expected to review their networks for compliance with this policy.
AdSSs must report to the Division their AdSS gaps and short-term and long-term interventions to address the gaps, in their annual Network Development and Management Plans.

The AdSS-must also conduct the following analysis of its behavioral health networks and report results in their Annual Network Development and Management Plan:

1. Behavioral Health Residential Facility Reporting
   For AdSS serving counties outside of Maricopa and Pima, for each county the AdSS must report the time and distance from their original residence that the 90th percentile of their membership must travel to reach a contracted facility that provides Behavioral Health Residential Facility services.

2. Behavioral Health Outpatient and Integrated Clinic Reporting
   For each county the AdSS must report performance with time and distance standards outlined above for Behavioral Health Outpatient and Integrated Clinics for each of the following populations:
   a. All members
   b. AHCCCS members enrolled with the Division
   c. Members determined to have a Serious Mental Illness
   d. Members over the age of 18 not determined to have a SMI, and
   e. Members under the age of 18.

3. Crisis Stabilization Facility Reporting
   For each county in their assigned service area, AdSS must report performance with time and distance standards outlined above for Crisis Stabilization Facilities for each of the following populations:
   a. All members
   b. AHCCCS members enrolled with the Division
   c. Members determined to have a Serious Mental Illness
   d. Members over the age of 18 not determined to have a SMI, and
   e. Members under the age of 18.
FINANCIAL RESPONSIBILITY FOR SERVICES AFTER THE COMPLETION OF COURT-ORDERED EVALUATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-501.33, 36-520 et seq, 36-533 et seq, 36-545.04, 36-545.06, 36-545.07

This Policy applies to the Division’s Administrative Services Subcontractors. The purpose of this Policy is to provide clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a Court-Ordered Evaluation (COE).

Definitions

A. Court-Ordered Evaluation - The proceedings and related services described in A.R.S. § 36-520 et seq (Title 36, Chapter 5, Article 4).

B. Court-Ordered Treatment - The proceedings and related services described in A.R.S. § 36-533 et seq (Title 36, Chapter 5, Article 5).

C. Medically Necessary Behavioral Health Services - Those behavioral health services necessary, in the judgment of a qualified medical practitioner, to treat an existing behavioral health condition or illness and/or to prevent the patient from potentially harming themselves or others.

D. Prepetition Screening - The review of each application requesting court-ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services pursuant to A.R.S. §36-501.33.

Policy

AdSS subject to this Policy are responsible for providing medically necessary, covered behavioral health services to members including services provided pursuant to court order under A.R.S. §36-533 et seq (Title 36, Chapter 5, Article 5). As a matter of state law (A.R.S. §36-545.04), the cost of services provided as part of a legal proceeding under A.R.S. §36-520 et seq (Title 36, Chapter 5, Article 4) (Court-Ordered Evaluation) is the financial responsibility of the county in which the individual resided or was found (i.e., the county of origin).

Under A.R.S. §36-545.06, the cost of pre-petition screening and court-ordered evaluation is a county responsibility unless the county has an agreement with AHCCCS under A.R.S. § 36-545.07 to provide those services for the county.

Absent such an agreement between the state and the county, the AdSS is responsible for medically necessary, covered behavioral health services other than services associated
with the pre-petition screening and court-ordered evaluation. Services are NOT considered the county’s responsibility after the earliest of the following events:

- The member decides to seek treatment on a voluntary basis.
- A petition for court ordered treatment is filed with the court.
- The member is released following the evaluation.

The issue of voluntarily participating in treatment is not, in and of itself, a factor in the determination of medical necessity. Furthermore, the refusal of a member eligible for Title XIX to accept medication is not, in and of itself, a factor in determining the medical necessity of the service, responding to a prior authorization request, or adjudicating the claim.

Services that are Medicaid covered for a Medicaid enrolled member that are separate from the COE services (such as case management) can continue to be paid with Title XIX funding during the COE time period.

The AdSS must accept and process timely claim submissions for medically necessary services for all members eligible for Title XIX receiving COE services in an inpatient setting for time periods that are not the county responsibility.

Fiscal responsibility for physical health services provided during the COE process remains with the AdSS with which the member is enrolled for the provision of physical health services, and is not the responsibility of the County of origin.
438 ADMINISTRATIVE SERVICES SUBCONTRACTS EVALUATION

EFFECTIVE DATE: October 1, 2019
DELIVERABLES: Administrative Services Subcontracts; Administrative Services Subcontractor Evaluation Report; Administrative Services Subcontractor Non-Compliance Reporting; Corporate Cost Allocation Plans and Adjustment in Management Fees

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). It establishes guidelines and requirements for the AdSS entering into Administrative Services Subcontracts, monitoring subcontractor performance, reporting performance review results, and notifying the appropriate entity of subcontractor non-compliance and Corrective Action Plans (CAPs).

Definitions

A. Administrative Services Subcontracts - An Administrative Services Subcontract is an agreement that delegates any of the requirements of the contract with the Division, including but not limited to:

1. Claims processing, including pharmacy claims
2. Credentialing, including those for only primary source verification (i.e. Credential Verification Organization)
3. Management Service Agreements
4. Service Level Agreements with the Division or Subsidiary of a corporate parent owner.

Providers are not AdSS.

B. Change in Organizational Structure - A change in organizational structure is any of the following:

1. Merger
2. Acquisition
3. Reorganization
4. Change in Articles of Incorporation
5. Joint Venture
6. Change in Ownership
7. Change of Management Services Agreement (MSA) Subcontractor
8. Other applicable changes that may cause:
a. A change in the Employer Identification Number/Tax Identification Number (EIN/TIN)

b. Changes in critical member information, including the website, provider handbook and member ID card

c. A change in legal entity name.

C. **Management Service Agreement** - A Management Service Agreement is a type of subcontract in which the owner of the AdSS delegates all or substantially all management and administrative services necessary for the provision of services as required in the contract with the Division.

D. **Provider** - A provider is any person or entity that contracts with the AdSS for the provision of covered services to members according to the provisions A.R.S. §36-2901 or any subcontractor of a provider delivering services pursuant to A.R.S. §36-2901.

E. **Approval of Subcontracts** - The AdSS must submit all Administrative Services Subcontracts to the Division for prior approval, 60 days before the effective date of the subcontract. A copy of the proposed Administrative Service Subcontract must be submitted with AHCCCS Contractor Operations Policy Manual (ACOM) Policy 438 Attachment A, Administrative Services Subcontract Checklist.

   1. The AdSS must retain the authority to direct and prioritize any delegated contract requirements.

   2. The AdSS must require that subcontractors meet any performance standards applicable to the delegated services as mandated by the Division and AHCCCS.

   3. The AdSS must ensure the agreement contains a provision stating that a merger, reorganization, or change in ownership requires a contract amendment and prior approval of the Division and AHCCCS.

   4. A Change in Organizational Structure of an Administrative Services Subcontractor requires prior approval of the Division and AHCCCS.

      a. The AdSS must follow the process for the review and approval of newly proposed Administrative Services Subcontracts as defined in this Policy.

      b. If the Change in Organizational Structure is related to the AdSS Management Service Agreement (MSA), to the extent management of all or substantially all plan functions has been delegated to meet the Division’s contractual requirements, the AdSS must submit the proposed change for prior approval as outlined in AdSS Operations Manual Policy 317.
**Monitoring and Reporting**

A. The AdSS must monitor its subcontractor’s performance on an ongoing basis and complete a formal review of its subcontractors at least annually. The formal review must include a review of delegated duties, responsibilities, and financial position.

B. If at any time during the period of the Administrative Service Subcontract, the subcontractor is found to be in non-compliance, the AdSS must notify the Division.

C. The notification must include:
   1. The subcontractor’s name
   2. Delegated duties and responsibilities
   3. Identified areas of non-compliance and whether the non-compliance affects member services or causes a quality of care concern
   4. The scope and estimated impact of the non-compliance upon members
   5. The known or estimated length of time that the subcontractor has been in non-compliance
   6. The subcontractor’s CAP or strategies to bring the subcontractor into compliance
   7. Sanction actions that may be taken because of the non-compliance

D. The Division reserves the right to request follow-up on any open CAP.

E. The results of a CAP must be communicated to the Division upon closure of the CAP.

**Evaluation Report**

The AdSS must submit a completed Administrative Services Subcontractor Evaluation Report annually, using ACOM Policy 438, Attachment B, Administrative Services Subcontractor Evaluation Report Template. The Administrative Services Subcontractor Evaluation Report must include the following:

A. The name of the subcontractor

B. The delegated duties and responsibilities

C. The date of the most recent formal review of the duties, responsibilities and financial position, as appropriate, of the subcontractor

D. A comprehensive summary of the evaluation of the performance (operational and financial as appropriate) of the subcontractor, including the type of review performed

E. The next scheduled formal review date
F. All identified areas of deficiency, including, but not limited to those that:
   1. Affect member services and/or
   2. Cause a quality of care concern

G. CAP Information, including:
   1. Any CAPs that occurred due to monitoring since the last Administrative Services Subcontractor Evaluation Report
   2. Any subcontractor CAPs resulting from the annual formal review; and
   3. Date reported to the Division.

Additional Requirements

A. All Administrative Services Subcontracts must reference and require compliance with the Minimum Subcontract Provisions available on the Division website.

B. In the event of a modification to Division Policy, guidelines and manuals, the AdSS must issue a notification of the change to its effected subcontractors of any effected subcontracts. Affected Administrative Services Subcontracts must be amended on their regular renewal schedule or within six calendar months of the update, whichever comes first.

C. In the event of a modification to Minimum Subcontract Provisions, the AdSS must issue a notification and amend Administrative Services Subcontracts.

D. All Administrative Services Subcontracts must reference and require compliance with the Disclosure of Ownership and Control and Disclosure of Information on Persons Convicted of Crimes requirements as outlined in the contract and 42 CFR 455.101 through 106, 42 CFR 436 and CMS document SMDL #09-001. AdSSs must disclose to the Division the identity of any excluded person.

E. All Administrative Services Subcontracts entered into by an AdSS are subject to review and approval by the Division.

F. All Administrative Services Subcontracts for services rendered to Medicaid recipients incorporate by reference the applicable terms and conditions outlined in the Division Contract.

G. The AdSS must maintain a fully executed original or electronic copy of all Administrative Services Subcontracts, which is to be accessible to the Division within five business days of the request by the Division according to contract requirements.

H. The AdSS must ensure that all member communications furnished by the AdSS include the Division’s name and comply with member notification requirements as outlined in AdSS Operations Manual, Policy 404.
I. Before entering into an Administrative Services Subcontract, the AdSS must evaluate the prospective subcontractor’s ability to perform the delegated duties.

J. If the AdSS terminates a subcontract, the AdSS must ensure compliance with all aspects of the Division contract notwithstanding the subcontractor termination, including availability and access to all covered services and provision of covered services to members within the required timeliness standards.

**ACOM 438 Attachment A, Administrative Services Subcontract Checklist**

The Division has adopted the use of this checklist; see the AHCCCS website’s ACOM webpage for Attachment A of this policy.

**ACOM 438 Attachment B, Administrative Services Subcontractor Evaluation Report Template**

The Division has adopted the use of this template; see the AHCCCS website’s ACOM webpage for Attachment B of this policy.
439 MATERIAL CHANGES: PROVIDER NETWORK AND BUSINESS OPERATIONS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-22-101; 42 CFR 438.10(f)(4) and 207; Contract
DELIVERABLES: Material Change to Business Operations; Material Change to Provider Network

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy establishes requirements for the AdSS regarding the identification and assessment of material changes to the AdSS’s provider network and business operations and the approval process for such changes.

Definitions

A. Administrative Services Subcontracts - An agreement that delegates any of the requirements of the contract with Division, including:
   1. Claims processing, including pharmacy claims
   2. Credentialing, including those for only primary source verification
   3. Management Service Agreements
   4. Service Level Agreements with any division or subsidiary of a corporate parent owner.

   Providers are not AdSSs.

B. Delegated Agreement - A type of subcontract agreement with a qualified organization or person to perform one or more functions required to be performed by the AdSS pursuant to this contract.

C. Geographical Service Area (GSA) - An area designated by the Division within which an AdSS of record provides, directly or through subcontract, covered health care services to a member enrolled with that AdSS of record, as defined in A.A.C. R9-22-101.

D. Management Services Agreement (MSA) - A type of subcontract with an entity in which the owner of the AdSS delegates some or all of the comprehensive management and administrative services necessary for the operation of the AdSS.

E. Material Change to Business Operations - Any change in overall operations that affects, or can reasonably be foreseen to affect, the AdSS’s ability to meet the performance standards as required in contract including, but not limited to, any change that would impact or is likely to impact more than 5% of total membership and/or provider network in a specific geographic region. Changes to business operations may include, but are not limited to, policy, process, and protocol, such as prior authorization or retrospective review. Additional changes may include the addition of, or change in:
• Pharmacy Benefits Manager (PMB)
• Dental Benefit Manager
• Transportation vendor
• Claims processing system
• System changes and upgrades
• Member ID card vendor
• Call center system
• Covered benefits delivered exclusively through the mail, such as mail order pharmaceuticals or delivery of medical equipment
• MSA
• Any administrative services subcontract.

F. **Material Change to the Provider Network** - Any change in composition of, or payments to, an AdSS’s provider network, that affects, or can reasonably be foreseen to affect, the AdSS’s adequacy of capacity and services necessary to meet the performance and/or provider network standards as required in contract. Changes to provider network may include, but not limited to:

• Any change that would cause, or is likely to cause, more than 5% of the members in a geographic region to change the location where services are received or rendered
• Any 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.

G. **Provider Group** - Two or more health care professionals who practice their profession at a common location (whether or not they share facilities, supporting staff, or equipment).

H. **Unexpected Material Change to the Provider Network or Business Operations** – A material change that was not anticipated by the AdSS.

Examples of unexpected changes to the provider network include providers giving less than 30 days’ notice to the AdSS that they would no longer serve Medicaid members, or the AdSS’s failure to reach an agreement with a provider on a contract renewal less than 30 days before the previous contract expires. An example of an unexpected Material Change to Business Operations includes the unexpected closure of a subcontractor.

The AdSS must have efficient and effective business operations and provider networks to ensure that performance and provider network standards are met to support a member’s
needs, as well as the needs of the membership as a whole. The AdSS must develop a process to determine when changes to business operations or to the provider network constitute a material change.

Division or AHCCCS-initiated changes, such as changes in reimbursement methodologies (e.g. APR-DRG) or changes to reference tables impacting claims payment, and industry-initiated changes, such as CPT/Diagnosis code changes, are excluded from these policy requirements.

**Identifying A Provider Network and/or Business Operations Material Change**

A. The AdSS is responsible for evaluating all business operational and provider network changes, including unexpected changes, to determine if the change is a material change.

B. For changes impacting members and/or providers regarding the provider network and/or business operations, the AdSS must:

1. Establish criteria and/or methodology for determining the impact of the change to members and providers.
2. Evaluate the impact of the change to its membership and provider network, by geographic region as specified by the Division and as a whole, using the established criteria and/or methodology.
3. Determine, based on the evaluation results, whether the change meets the definition of a material change as outlined in this policy, and determine whether it complies with contract and policy requirements.
4. Maintain documentation of evaluation of all provider network and business operations changes.

C. The Division may request and review documentation of established methodology, criteria, and evaluation results, for all provider network and business operations changes, even for those changes that the AdSS determines do not constitute a material change.

D. For all changes that have a member impact, the AdSS must provide member notification as outlined in Policy 404 in the AdSS Operations Policy Manual.

E. Implementation must be planned to ensure continuity of care to members.

F. A Material Change to Business Operations may also constitute a Material Change to the Provider Network.

G. The Division reserves the right to identify an operations or network change as a material change.

**Administrative Services Subcontractor Reporting Requirements**

A. The AdSS must request, in writing, prior approval of a Material Change to the
Provider Network or business operations in accordance with this policy. A request for approval must include a detailed description of the proposed change and all requirements outlined above and summarized in AHCCCS Operations Manual Policy 439 Attachment A, the Provider Network/Business Operations Material Change Plan Checklist, as adopted by the Division.

B. For all material changes, the AdSS must include an accessibility analysis of the services impacted by the provider change:

1. For services the member must travel to receive, the AdSS must provide the average time and distance that members in the impacted areas must travel for the service before and after the change.

2. For services provided in the member’s home, the AdSS must address the geographic coverage and sufficiency of providers in the impacted area before and after the change.

3. For transportation services, the AdSS must address the availability of vehicles dedicated to the AdSS line of business in the impacted area before and after the changes.

C. The AdSS must request prior approval, in writing, of a material change that involves major system changes and upgrades to the AdSS’s information system that, at a minimum, affects claims processing, payment, or other major business component, or system changes that impact member or provider interactions with the AdSS. A request for approval must include a system change plan that includes a timeline and milestones, and outlines adequate testing to be completed before implementation.

D. A material change in the provider network and/or business operations requires a 30-day advance written notice from the AdSS to members and providers [42 CFR 438.10(g)(4)].

E. If there is an unexpected Material Change to the Provider Network and/or to business operations, the AdSS must submit written notification to the Division no later than one business day of the AdSS becoming aware of the unexpected change. Notification must be submitted as specified in contract. The notification must include a detailed description of the change, address why it was unexpected, and include all of the requirements identified in AHCCCS Operations Manual Policy 439 Attachment A. If the AdSS is unable to provide some or all of the Attachment A requirements in its initial notification, the remaining requirements must be provided to the Division with one week of initial notification. The AdSS must also identify its plan for notifying members or providers of the unexpected change.

F. For any provider termination, when appropriate, the AdSS must make a good faith effort to give written notice to enrollees within 15 days after receipt or issuance of a provider termination notice, to each member who received their primary care from, or is seen on a regular basis by, the terminated provider [42 CFR 438.10(f)(1)].

G. The Division will review and respond to AdSS requests for approval within 30 days of the submission. Incomplete submissions will not be approved and additional
information may be requested. The approval process will be expedited upon request for emergency situations.

H. The AdSS may be required to provide periodic updates on the status of the change or implementation.

I. The AdSS may be required to conduct meetings with providers and/or members to provide general information or technical assistance, or to address issues related to changes to business operations, changes in policy, reimbursement matters, prior authorizations, and other matters as identified or requested by the Division.
MANAGED CARE EXPIRATION OR TERMINATION OF CONTRACT

EFFECTIVE DATES: October 1, 2019

This Policy applies to Division’s Administrative Services Subcontractors (AdSS). The purpose of this policy is to set forth requirements and responsibilities when the Contract between the Division and AdSS expires (contract expiration) or is terminated by either the Division or the AdSS (contract termination).

Definitions

A. **Contract** - A written agreement entered into between a person, an organization, or other entity and the Administration to provide health care services to a member under A.R.S. Title 36, Chapter 29.

B. **Contract Expiration** - The ending of the Contract pursuant to its terms without any action by a party to the agreement.

C. **Contract Termination** - The cancellation of the Contract, in whole or part (e.g. by GSA), as a result of an action taken by the Division or the AdSS.

D. **Incurred but Not Reported (IBNR)** - The liability for services rendered for which claims have not been received.

Policy

The AdSS is required to adhere to certain notification requirements and comply with specific responsibilities as outlined in Contract and this Policy in the event of Contract Expiration or Contract Termination. Upon determination of Contract Expiration/Termination, the Division will provide notice to the AdSS outlining the AdSS operational and reporting requirements for the Contract Expiration/Termination transition period as described below.

In either instance, Contract Expiration or Contract Termination, the AdSS is required to develop and submit a Plan to the Division for prior approval as described in the General AdSS Responsibilities section of this Policy. The Plan must clearly present the AdSS process for ensuring compliance with all contractual responsibilities through the transition period, regardless of whether a Contract expires or is terminated. AdSS are responsible to assist the Division in the transition of members.

AdSS Non-Renewal - General Notifications

A. If the AdSS elects not to renew the Contract, the AdSS provides the Division with at least a 180 day advance written notice prior to the Non-Renewal of the current Contract.

B. After receipt of the AdSS notification of intent not to renew, the Division will issue written notice to the AdSS specifying:

1. The effective date of termination
2. The AdSS operational and reporting requirements.
3. Timelines for submission of deliverables.

**The Division Non-Renewal – General Notification**

If the Division elects not to renew the Contract, the Division will provide written notice prior to the Non-renewal of the current Contract.

**Contract Terminations by Contract Termination by the Division - General Notification**

A. The Division may initiate termination actions for reasons, including but not limited to:

1. An AdSS notification of or refusal to sign a contract amendment.
2. Substantial failure to provide medically necessary services that the AdSS is required to provide under law or the terms of its contract to its enrolled members.
3. Failure to meet the Division Financial Viability Standards.
5. Failure to meet quality of care and quality management requirements.
6. Failure to comply with contract provisions or applicable state and federal laws or regulations.
7. For convenience, as stipulated in Contract.

B. In the event the Division initiates a Termination for Convenience action, pursuant to the Contract Terms and Conditions, the Division will provide written notice of the termination at least 90 days before the effective date of the termination. The notice will include the effective date of the termination and the AdSS operational and reporting requirements.

C. In the event the Division initiates a termination action of a Contract for failure to meet the requirements of Federal Law or the Contract the Division will provide the AdSS with notice of intent to terminate, the reason for termination and hearing rights [42 CFR 438.710].

1. In the event AdSS does not contest the intent to terminate the Contract, the Division will notify the AdSS in writing of:

   a. The effective date of termination
   b. The AdSS operational and reporting requirements
   c. Timelines for submission of deliverables.

2. In the event the AdSS files a request for a hearing to challenge the intent to terminate and the termination is upheld through the Administrative Hearing process, the Division will notify the AdSS in writing of:

   a. The effective date of termination
b. The AdSS operational and reporting requirements
c. Timelines for submission of deliverables.

D. The Division will provide AHCCCS with written notice no later than 30 days after the date of Contract termination, in accordance with 42 CFR 438.724.

**General AdSS Responsibilities**

For Contract expirations and terminations, the AdSS must adhere to the following:

A. Produce reports timely and perform all responsibilities through the dates specified in the Division notification.

B. Comply with all terms of the Contract including, but not limited to, the provision of all management and administrative services throughout the transition.

C. Maintain adequate staffing to perform all required functions as specified in Contract.

D. Designate an individual as Contract Transition Coordinator who must ensure the continuance of AdSS performance, operations, and member transitions through a time determined by AdSS, and provide this individual’s contact information with submission of the Contract Expiration or Termination Plan.

E. Participate in any meetings, workgroups, trainings, or other activities scheduled by the Division related to the transition of members, to support a seamless transition.

F. Be responsible for payment of all outstanding obligations for medical care rendered to members.

G. Be responsible for the provision of a monthly claims aging report including Incurred But Not Reported (IBNR) amounts (as outlined in the Division Notification).

H. Be responsible for the provision of Quarterly and Audited Financial Statements up to the date specified by the Division.

I. Be responsible for the provision of encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed. Cooperate with reinsurance audit activities on prior Contract years.

J. Cooperate with the Division to complete and finalize any open and pending reconciliations.

K. Be responsible for the submission of Quality Management and Medical Management reports as required by contract, as appropriate, to provide information on services rendered up to the date of contract expiration or termination including Quality Of Care (QOC) concern reporting and investigations based on the date of service.

L. Be responsible for participation in and closing out Performance Measures and Performance Improvement Projects as required.
M. Provide a monthly accounting and disposition of Member Grievances and Provider Claim Disputes as outlined in the Division notification.

N. Be responsible for the retention, preservation, and availability of all records, including, but not limited to those records related to member grievance and appeal records, litigation, base data, Medical Loss Ratio (MLR) reports, claims settlement and those covered under HIPAA, as required by Contract, State and Federal law, including but not limited to, 45 CFR 164.530(j) (2) and 42 CFR 438.3(u).

O. Be responsible for the completion of existing third-party liability cases or making any necessary arrangements to transfer the cases to the Division authorized Third Party Liability (TPL) Contractor.

P. Be responsible for the following activities pertaining to member services and transitions:
   1. Continue to serve enrolled members and provide all medically necessary covered services until the transition of all members is complete as specified by the Division.
   2. Conduct all member transition activities in accordance with the Division requirements.
   3. Cooperate with AdSS which are receiving members, to support seamless transition of all member services.
   4. Transfer member data to AdSS which are receiving members using a file format and dates for transfer of member data specified by the Division.
   5. The cost, if any, of reproducing and forwarding medical records.

Q. Return to the Division any funds advanced to the AdSS for coverage of members for periods subsequent to the date of termination within 30 days of the Contract termination.

R. Make available all data, information and reports collected or prepared by the AdSS in the course of performing its duties and obligations under the Contract to the Division within 30 days following expiration or termination of the Contract or such other period as specified by the Division.

For Contract terminations, the AdSS will, in addition to the above requirements:

   1. Be liable for costs incurred by the Division in re-procuring materials or services under the Contract.
   2. Be liable for costs associated with the transition of its members to a different AdSS.

**Contract Expiration or Termination Plan**

A. The AdSS must submit a Contract Expiration or Termination Plan to the Division, for approval. The Plan must be submitted to the designated Operations and Compliance Officer, within 30 days of the Division expiration/termination notice to the AdSS.
B. The Contract Expiration or Termination Plan must include, but is not limited to, the following:

1. A description of the AdSS process for ensuring compliance with all responsibilities delineated in the Contract including retention of sufficient staff to conduct business operations through the time period specified by the Division.

2. The designation of a Contract Transition Coordinator.

3. Timeline for submission of all required deliverables for the term specified by the Division.

4. Communications to all subcontractors and members related to the Contract expiration/termination, including a timeline for notification.

5. The method for transferring member data and disposition of any related medical records.

6. A Member Transition Plan to support a seamless transition of members including but not limited to members with:
   
   a. Significant medical or behavioral health conditions such as, a high-risk pregnancy or pregnancy within the last trimester, Serious Mental Illness (SMI), the need for organ or tissue transplantation, chronic illness resulting in hospitalization or nursing facility placement, etc.

   b. Ongoing services such as daily in home care, behavioral health services, dialysis, pharmacy, medical supplies, transportation, home health, chemotherapy and/or radiation therapy, or who are hospitalized at the time of transition.

   c. Conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the Neonatal Intensive Care Unit (NICU) after birth.

   d. Prior authorized services including but not limited to scheduled surgeries, post-surgical follow-up visits, out-of-area specialty services, nursing home admission or Home and Community Based (HCBS) Placements, Continuing prescriptions, Durable Medical Equipment (DME), and medically necessary transportation orders.

   e. Significant conditions or treatments such as pain control, hypertension, enteral feedings, oxygen, wound care, ventilator services.

   f. High needs/high costs.

7. In addition, the Member Transition Plan must also support a seamless transition for those members who present ongoing concerns to State and Federal entities and/or the media.
Release of AdSS Requirements after Contract Expiration or Termination

The AdSS remains responsible for all activities associated with the Contract expiration or termination until official written release from the Division has been granted.

A. The AdSS must submit to the Division, a written request for release.

B. The Division will provide an official written release upon satisfaction of activities associated with the Contract expiration or termination including, but not limited to, the following:

1. Audited Financial Statements inclusive of a balance sheet
2. Payment of all outstanding medical obligations for medical care rendered to members.
3. Encounter reporting until all services rendered prior to Contract expiration or termination have reached adjudicated status and data validation of the information has been completed.
4. Reinsurance audit activities on prior contract years.
5. Finalization of any open or pending reconciliations
6. Performance Bond or Bond Substitute.
445 SUBMISSION OF REQUEST FOR HEARING DOCUMENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. §36-2901, A.R.S. § 41-1092 et seq, ACOM Policy 445, Attachment A

This Policy applies to the Division’s Administrative Services Subcontractors (AdSS). This Policy describes the steps and processes the AdSS must take in submitting a request for a hearing to the AHCCCS Administration.

Definitions

A. AHCCCS - The AHCCCS Administration as defined in A.R.S. § 36-2901.

B. Appeal - A request for review of an action.

C. Claim Dispute – A dispute, filed by a provider or Contractor, whichever is applicable, involving a payment of a claim, denial of a claim, imposition of a sanction, or reinsurance.

D. Day - Calendar day unless otherwise specified.

E. Director’s Decision - The final administrative decision under A.R.S. § 41-1092(5).


Policy Overview

The AdSS is responsible for the submission of requests for hearing to the Division’s Office of Administrative Review. The Division will forward the hearing request file to the AHCCCS Office of Administrative Legal Services (OALS).

Documents must be submitted to the Division’s Office of Administrative Review using Attachment A with all pertinent documentation.

Hearing Request File Submission Timeframes

A. Expedited member appeal hearing requests must be submitted no later than one (1) business day from receipt of the expedited hearing request.

B. Standard member appeal hearing requests must be submitted no later than three (3) business days from receipt of the hearing request.

C. Claim dispute hearing requests must be submitted no later than three (3) business days from receipt of the hearing request.
**Hearing Request File Submission Method**

Each AdSS must submit the hearing request files to the Division’s Office of Administrative Review for member appeals and provider claim dispute hearing requests.

The AdSS must submit a standard Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) with the member appeal or provider claim dispute file.

**Hearing File Content**

Hearing files must be submitted with all of the following:

A. Submission of Request for Hearing Form (ACOM Policy 445, Attachment A)
B. Request for Hearing
C. Notice of Appeal Resolution or Notice of Decision
D. Appeal or Claim Dispute
E. Notice of Adverse Benefit Determination for member appeals, and
F. Signed Appointment of Representative for member appeals.

**Submission of Request for Hearing Form, Attachment A**

Each hearing file must include a Submission of Request for Hearing Form (ACOM Policy 445, Attachment A). The Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) must have all applicable fields completed. Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) must be the first page of the file submission.

Files submitted without an accurately completed Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) will not be accepted.

**Notice of Hearing and Submission of Supporting Documents**

The Submission of Request for Hearing Form (ACOM Policy 445, Attachment A) submitted by the AdSS will be used to identify the hearing issue and applicable citations. Once a hearing file is submitted to AHCCCS any future changes to the issue or citations must be filed by the AdSS with the Office of Administrative Hearing as a Motion to Amend the Notice of Hearing.

The Division and the AHCCCS OALS reserves the right to make changes to the issue and any legal citations for accuracy.

In order to properly include additional information or supporting documentation into the record in support of their decision or action, the AdSS must file exhibits with the Office of Administrative Hearing and copy the Office of Administrative Review. If submitted to the Division or AHCCCS this information will not be added to the Administrative record on the AdSS’s behalf.
446 GRIEVANCES AND INVESTIGATIONS CONCERNING PERSONS WITH SERIOUS MENTAL ILLNESS

EFFECTIVE DATE: October 1, 2019


This Policy applies to the Division’s Administrative Services Subcontractors and outlines the process related to grievances and investigations concerning persons with a Serious Mental Illness (SMI).

This Policy does not apply to grievances or requests for investigation asserted by, or on behalf of, persons with an SMI to the extent the allegation asserts a violation relating to the right to receive services, supports, and/or treatment that are state-funded and are no longer funded by the state due to limitations on legislative appropriation.

Definitions

A. Abuse - The infliction of, or allowance of, another person 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).

B. Administrative Appeal - An appeal to AHCCCS of a decision made by an AdSS as the result of a grievance.

C. Appeal - A request for review of an adverse decision by an AdSS.

D. Condition Requiring Investigation - An incident or condition that appears to be dangerous, illegal, or inhumane, including the death of a person with Serious Mental Illness.

E. Dangerous - A condition that poses or posed a danger or the potential of danger to the health or safety of a person with Serious Mental Illness.

F. Day – means calendar days, unless otherwise specified.

G. Grievance or Request for Investigation - A complaint that is filed by a person with Serious Mental Illness or other concerned person alleging a violation of an SMI member’s rights or a condition requiring an investigation.

H. Illegal - An incident or occurrence that is or was likely to constitute a violation of a state or federal statute, regulation, court decision, or other law.

I. Inhumane - An incident, condition, or occurrence that is demeaning to a person with
Serious Mental Illness or that is inconsistent with the proper regard for the right of the person to humane treatment.

J. Mental Health Agency - Includes a regional authority, service provider, inpatient facility, or an agency that conducts screening and evaluation under A.A.C. Title 9, Chapter 21, Article 5, and A.A.C. R9-21-101(B)(47).

K. Preponderance of Evidence - A standard of proof that it is more likely than not that an alleged event occurred.

L. Serious Mental Illness - A condition as defined in A.R.S. § 36-550 diagnosed in persons 18 years and older.

M. Special Assistance - The support provided to a person determined to have a Serious Mental Illness who is unable to articulate treatment preferences and/or participate effectively in the development of the Planning Document, Inpatient Treatment and Discharge Plan (ITDP), or grievance and/or appeal processes due to cognitive or intellectual impairment and/or medical condition.

Policy

For members who have been diagnosed with a Serious Mental Illness, the AdSS must conduct investigations into allegations of physical abuse, sexual abuse, and violations of rights, and conditions that are dangerous, illegal, or inhumane. Investigations may also be conducted in the event of a death of a member that occurs in a mental health agency or as a result of an action of a person employed by a mental health agency.

General Requirements

A. The AdSS must respond to grievances and requests for investigations in accordance with this Policy and the requirements and timelines contained in A.A.C. Title 9, Chapter 21, Article 4.

B. In computing any period of time prescribed or allowed by this Policy, the period begins the day after the act, event, or decision occurs and includes all calendar days and the final day of the period. If the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend or a legal holiday. If the period of time is not designated as calendar days and is less than 11 days, then intermediate Saturdays, Sundays, and legal holidays must not be included in the computation.

C. The AdSS must use a unique docket number for each grievance or request for investigation filed. The file and all correspondence generated must reference the docket number.
Resolving Grievances and Requests for Investigation

A. Grievances involving an alleged rights violation, or a request for investigation involving an allegation that a condition requiring investigation exists, which occurred in an agency operated by an AdSS or one of its subcontracted providers and which does not involve a member death or an allegation of physical or sexual abuse, must be filed with and investigated by the AdSS.

B. Grievances or requests for investigation involving physical or sexual abuse or death must be filed with, and investigated by, AHCCCS.

C. The AdSS or its subcontractor must immediately take whatever action may be reasonable to protect the health, safety and security of any member, complainant or witness when a grievance or request for investigation is pending.

Grievance and Request for Investigation Process

A. Timeliness and Method for Filing Grievances and Requests for Investigation

1. A grievance or a request for investigation must be submitted to the AdSS or its subcontracted providers, orally or in writing, no later than 12 months from the date on which the alleged violation or condition requiring investigation occurred. This timeframe may be extended for good cause as determined by AHCCCS or the AdSS, as applicable.

2. Within five days of receipt of a grievance or request for investigation, the AdSS must inform the person filing the grievance or request for investigation, in writing, that the grievance or request has been received.

3. Any employee or contracted staff of the AdSS or its subcontracted providers, must, upon request, assist a person receiving services, or his/her legal guardian, in making an oral or written grievance or request for investigation or direct the person to an available supervisory or managerial staff who will assist the person to file a grievance or request for investigation ((A.A.C. R9-21-403(F)).

4. If an AdSS or its subcontracted provider receives an oral grievance or request for investigation, it must accurately reduce it to writing on the AHCCCS Appeal or SMI Grievance Form (See ACOM Policy 446, Attachment A, Appeal or SMI Grievance Form, adopted by the Division for use by the AdSS).

B. Summary Disposition – AHCCCS or the AdSS may summarily dispose of a grievance or request for investigation without any notice or right for further review or hearing when:

1. The alleged violation occurred more than one year prior to the date the grievance or request is received, or

2. The grievance or request is primarily directed to the level or type of mental health treatment provided and can be fairly and efficiently addressed through the service planning or appeal process as described in A.A.C. Title 9, Chapter
21, Articles 3 and 4.

C. Disposition Without Investigation - Within seven days of receiving a grievance or request for investigation, it may be resolved without conducting a full investigation if the matter:

1. Involves no material dispute as to the facts alleged in the grievance or request for investigation

2. Is frivolous, meaning that it:
   a. Involves conduct that is not within the scope of A.A.C. Title 9, Chapter 21
   b. Is impossible on its face
   c. Is substantially similar to conduct alleged in two previous grievances or requests for investigation within the past year and which have been determined to be unsubstantiated, or

3. Is resolved fairly and efficiently within seven days without a formal investigation.

Within seven days of the receipt of the grievance or request for investigation, a written dated decision must be issued that explains the essential facts as to why the matter may be appropriately resolved without investigation and the resolution. The written decision must contain a notice of appeal rights and information to request assistance from the AHCCCS Office of Human Rights (OHR) and the State Protection and Advocacy System. Copies of the decision must be sent to the person filing the grievance or request for investigation, to the AHCCCS OHR for persons who need Special Assistance, and to other parties as required by A.A.C. Title 9 Chapter 21, Article 4.

D. Conducting Investigations of Grievances

1. Investigations must be conducted pursuant to A.A.C. R9-21-406. The investigator must:
   a. Interview the person who filed the grievance and the person receiving services who is identified as the subject of the violation or abuse (if different) prior to interviewing the person alleged to be the perpetrator of the rights violation, or physical or sexual abuse.
   b. If the person who is the subject of the investigation has been identified as needing Special Assistance, the investigator must contact the person’s advocate; or if no advocate is assigned, the investigator must contact AHCCCS OHR, and request that an advocate be present to assist the person during the interview and any other part of the investigation process.
   c. Request assistance from the AHCCCS OHR if the person receiving
services needs assistance to participate in the interview and any other part of the investigation process.

d. Prepare a written report that contains at a minimum:

i. A summary for each individual interviewed of information provided by the individual during the interview conducted

ii. A summary of relevant information found in documents reviewed

iii. A summary of any other activities conducted as a part of the investigation

iv. A description of any issues identified during the course of the investigation that, while not related to the allegation or condition under investigation, constitutes a rights violation or condition requiring investigation

v. A conclusion, describing those findings and/or factors that led to the conclusion, that the alleged violation or abuse is either substantiated or not substantiated based on a preponderance of the evidence, and

vi. Recommended actions or a recommendation for required corrective action, if indicated.

2. Within five days of receipt of the investigator’s report, AHCCCS’s Deputy Director or the AdSS’s CEO or designee will review the investigation case record and the report, and issue a written, dated decision that will:

a. Accept the report and state a summary of findings and conclusions, and any recommended actions or corrective action required, and send copies of the decision, subject to confidentiality requirements to the investigator, the AdSS, the person who filed the grievance, the person receiving services identified as the subject of the grievance (if different), the AHCCCS Office of Human Rights for a person in need of Special Assistance, and the applicable independent oversight committee. The decision will include a notice of the right to request an appeal of the decision within 30 days from the date of receipt of the decision. The decision will be sent to the grievant by certified mail or by hand-delivery, or

b. Reject the report for insufficiency of facts and return the matter for further investigation. The investigator must complete the further investigation and deliver a revised report within 10 days, absent extension.

3. Actions that may be taken or recommended, as indicated above, include:

a. Identifying training or supervision for, or disciplinary action against, an
individual found to be responsible for a rights violation or condition requiring investigation identified during the course of investigation

b. Developing or modifying a mental health agency’s practices or protocols

c. Notifying the regulatory entity that licensed or certified an individual according to A.R.S. Title 32, Chapter 33 of the findings from the investigation

d. Imposing sanctions that may include monetary penalties, according to the terms of a contract, if applicable.

4. A grievant or the member who is the subject of the grievance, who disagrees with the final decision of the AdSS, may file a request for an administrative appeal with AHCCCS within 30 days from the date of the receipt of the decision. The request for administrative appeal must specify the basis for the disagreement. Failure to specify the basis for the disagreement may result in a summary determination in favor of the Division’s decision.

5. If an administrative appeal is filed, the AdSS must forward the full investigation case record, which includes all elements described in A.A.C. R9-21-409(D)(1), to AHCCCS. The failure of the AdSS to forward a full investigation case record that supports the AdSS’s decision may result in a summary determination in favor of the person filing the administrative appeal. The AdSS must prepare and send, with the investigation case record, a memo that states:

   a. Any objections the AdSS has to the timeliness of the administrative appeal

   b. The AdSS’s response to any information provided in the administrative appeal that was not addressed in the investigation report, and

   c. The AdSS’s understanding of the basis for the administrative appeal.

6. Within 15 days of receipt of a timely filed administrative appeal, AHCCCS will review the appeal and the investigation case record and may discuss the matter with any of the persons involved or convene an informal conference, and prepare a written, dated decision that either:

   a. Accepts the investigator’s report with respect to the facts as found, and affirms, modifies, or rejects the decision of the AdSS with a statement of reasons. The decision, along with a notice of the right to request an administrative hearing within 30 days from the date of receipt of the decision, must be sent to the appealing party, with copies of the decision provided to the AdSS, AHCCCS OHR, and the applicable independent oversight committee; or

   b. Rejects the investigator’s report for insufficiency of facts and remands the matter with instructions to the AdSS for further investigation and
decision. The AdSS must conduct further investigation and complete a revised report and decision to AHCCCS within 10 days, after which AHCCCS will render a final decision. Or AHCCCS may reject the investigator's report for insufficiency of facts and remand the matter with instructions to the AdSS for further investigation and the issuance of a revised AdSS’s decision, directly to grievant or client who is the subject of the grievance, along with notification of the right to request a second administrative appeal to AHCCCS of the AdSS’s revised decision within 30 days from the date of receipt of the revised decision.

7. Extensions of Time - If an extension of any time frame related to the grievance process is needed, the extension must be requested and approved in compliance with A.A.C. R9-21-410(B). Specifically:
   a. The AdSS investigator or any other AdSS official responsible for responding to grievances must address the extension request to the AdSS Director or designee,
   b. The AHCCCS investigator or any other AHCCCS official responsible for responding to grievances must address the extension request to the AHCCCS Deputy Director or designee,
   c. An AdSS request for an extension to complete an investigation for grievances remanded pursuant to A.A.C. R9-21-407(B)(2) or any other time period established by AHCCCS decisions relating to a grievance must be addressed to the AHCCCS Deputy Director or designee, and
   d. Requests for extension must be in writing, with copies to all parties.

Request for an Administrative Hearing

A grievant or person who is the subject of the grievance who is dissatisfied with a decision of AHCCCS may request an administrative hearing before an administrative law judge, within 30 days of the date of receipt of the decision.

A. Upon receipt of a request for a hearing, the hearing is scheduled and conducted according to the requirements in A.R.S. §§ 41-1092 et seq.

B. After the expiration of the timeframes for administrative appeal and administrative hearing as described above, or after the exhaustion of all appeals, the AdSS will take any corrective action required and add to the record a written, dated report of the action taken. A copy of the report will be sent to the AHCCCS OHR for persons in need of Special Assistance.

Miscellaneous Matters Relating to the Grievance Process

A. In addition to a grievance or request for investigation that may be filed pursuant to this Policy and A.A.C. Title 9, Chapter 21, Article 4, a separate investigation into the death of a person receiving services must be conducted as described in Division Medical Policy Manual, Policy 960.
B. Grievance Investigation Records: The AdSS must maintain records in the following manner:

1. All documentation received related to the grievance and investigation process must be date-stamped on the day received.

2. A complete grievance investigation case record must be maintained for each case, and must include:
   a. The original grievance/investigation request letter and the Appeal or SMI Grievance Form
   b. Copies of all information generated or obtained during the investigation
   c. The investigator’s report, which will include:
      - A description of the grievance issue
      - Documentation of the investigative process
      - Names of all persons interviewed
      - Written documentation of the interviews
      - Summary of all documents reviewed
      - The investigator’s findings, and
      - Conclusions and recommendations.
   d. A copy of:
      - The acknowledgment letter
      - Final decision letter
      - Corrective action documentation, and
      - Any information/documentation generated by an appeal of the grievance decision.

C. The AdSS must maintain all grievance and investigation files in a secure designated area and retain for at least five years.

D. The AdSS must maintain a public log of all grievances or requests for investigation in accordance with A.A.C. R9-21-409(E).

E. The AdSS must maintain confidentiality and privacy of grievance and investigations records.

F. Notice must be given to a public official, law enforcement officer, or other person, as
required by law, that an incident involving death, abuse, neglect, or threat to a person receiving services has occurred, or that a dangerous condition or event exists. Refer to AMPM Policy 960.

G. The AdSS must notify the Deputy Director of AHCCCS, or designee, when: (Refer to AMPM Policy 960)

1. A person receiving services files a complaint with law enforcement alleging criminal conduct against an employee.

2. An employee or contracted staff files a complaint with law enforcement alleging criminal conduct against a person receiving services.

3. An employee, contracted staff, or person receiving services is charged or convicted of a crime related to a rights violation, physical or sexual abuse, or death of a person receiving services.
448 HOUSING

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-550; 24 CFR 582, 24 CFR 583, and the following:

- Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)
- ACOM Policy 448 Attachment A, AHCCCS Housing Application for Acquisition and/or Renovation or New Construction
- ACOM Policy 448 Attachment B, AHCCCS Housing Acquisition/Renovation Checklist,
- ACOM Policy 448 Attachment C, AHCCCS Declaration of Covenants, Conditions, and Restrictions
- ACOM Policy 448 Attachment D, AHCCCS Housing Acquisition and/or Renovation, or New Construction Operating and Funding Agreement,
- ACOM Policy 444, Notice of Appeal Requirements (Serious Mental Illness Appeals)
- ADSS-Operations Policy 446,-Grievances and Investigations Concerning Persons with Serious Mental Illness.

Purpose

This Policy applies to Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (DDD, or the Division) to provide a guideline for the delivery of housing services, the development, implementation and management of housing programs and related funds for the eligible populations. [24 CFR Part 582 and 24 CFR Part 583]

Definitions

A. Arizona Department of Housing (ADOH) – A department established for state government in Arizona to assist in addressing needs for homes for working families. ADOH administers programs for Housing Partners who apply to the department for funding. The majority of the agency’s programs are federally funded. The agency is also home to the Arizona Housing Finance Authority and the Arizona Home Foreclosure Prevention Funding Corporation.

B. Continuum of Care – A regional or local planning body that coordinates housing and services funding for homeless families and individuals as required by the U.S. Housing and Urban Development (HUD) Agency.

C. Department of Housing and Urban Development (HUD) – A U.S. government agency created in 1965 to support community development and home ownership. HUD does this by improving affordable home ownership opportunities, increasing safe and affordable rental options, reducing chronic homelessness, fighting housing discrimination by ensuring equal opportunity in the rental and purchase markets, and supporting vulnerable populations.
D. **Homeless (HUD Definition)** – A person is considered homeless only when he/she resides in one of the places described below:

- In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street)
- In an emergency shelter
- In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters
- In any of the above places but is spending a short time (up to 30 consecutive days) in a hospital or other institution
- Is being evicted within a week from a private dwelling unit and no subsequent residence has been identified and lacks resources and support networks needed to obtain housing
- Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing
  - For example, a person being discharged from prison after more than 30 days is eligible ONLY IF no subsequent residence has been identified and the person does not have money, family or friends to provide housing.
  - Is fleeing a domestic violence housing situation and no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing.

E. **Homeless (Persons in these situations are not included in the HUD definition of or funding purposes)** –

- Persons living in housing, even though they are paying an excessive amount for their housing, the housing is substandard and in need of repair, or the housing is crowded
- Persons living with relatives or friends
- Persons staying in a motel, including a pay-by-the-week motel
- Persons living in a Board and Care, Adult Congregate Living Facility, or similar place
- Persons being discharged from an institution that is required to provide or arrange housing upon release, or
- Wards of the State, although youth in foster care may receive needed supportive services which supplements, but does not substitute for, the state’s assistance.
F. **Housing Acquisition and/or Renovation Programs** – A housing program that provides State funding for the purchase and/or renovation of properties (house, condominium, duplex, apartment, new construction etc.). Eligible non-profit Housing providers work with the AdSS to locate properties, purchase and/or renovate them for the use of persons determined to have Serious Mental Illness following AHCCCS requirements, review and approval. The property is held for use of AHCCCS eligible members for an extended period of time through the use of filed Covenants, Conditions and Restrictions.

G. **Housing First** – A Housing approach that works to quickly and successfully to connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

H. **Housing Referral** – A written authorization from the AdSS for the provision of covered services to an eligible member. The Housing Referral will constitute the agreement of the provider to provide services identified in the tenant’s Individual Service Plan. Housing Referrals will be in such form and format determined by the AdSS.

I. **HUD Housing Choice Voucher Program** – The federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market. Individuals free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects.

Housing choice vouchers are administered locally by Public Housing Agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program.

J. **Independent Community Housing** – A setting where a person can live either alone or with a roommate in a home or apartment without on-going daily supervision from behavioral health providers. Options include:

- HUD Section 8 programs through local Public Housing Authorities
- Low-income subsidized housing through local non-profit organizations
- Supportive Housing Programs funded with federal grants and administered by AdSS contracted housing providers
- State subsidized rental units, and
- Permanent Houses and apartments purchased with state funding.

K. **Public Housing Authority (PHA)** – HUD funded unit of local government that provides independent housing for low-income individuals and families. Program includes Section 8, Housing Choice Vouchers, and low rent units.

L. **Rapid Housing** – An intervention, informed by a Housing First approach that is a critical part of a community’s effective homeless crisis response system. Rapid re-housing rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-
limited financial assistance and targeted supportive services. Rapid re-housing programs help families and individuals living on the streets or in emergency shelters solve the practical and immediate challenges to obtaining permanent housing while reducing the amount of time they experience homelessness, avoiding a near-term return to homelessness, and linking to community resources that enable them to achieve housing stability in the long-term. Rapid re-housing is an important component of a community’s response to homelessness. A fundamental goal of rapid rehousing is to reduce the amount of time a person is homeless.

M. Section 8 – Section 8 is the more common name for the Housing Choice Voucher Program which is sponsored by HUD. Qualified applicants receive vouchers which are used to subsidize the cost of housing. These vouchers are awarded to individuals who meet certain income requirements. The goal of these programs is to provide affordable low-cost housing to low income occupants.

N. Serious Mental Illness (SMI) – A condition as defined in A.R.S. §36-550 diagnosed in persons 18 years and older.

O. Sponsor-Based Rental Assistance – Sponsor-based rental assistance provides a subsidy for rental assistance through contracts between the grantee and contracted sponsor organization. A sponsor may be a private nonprofit organization, or a community mental health agency established as a public nonprofit organization. Participants reside in housing owned or leased by the sponsor.

P. Supporting Housing Services – Services, as defined in the AHCCCS Behavioral Health Services Guide, that are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person’s own home or apartments and homes that are owned or leased by a subcontracted provider. These services may include:

- Utility subsidies
- Relocation services to a person or family for the purpose of securing and maintaining housing
- Employment services
- Budget and finance counseling, and
- Eviction prevention.

Q. Supportive Housing – Housing, as defined in 24 CFR Part 583, in conjunction with supportive services are provided for tenants if the housing is safe and sanitary and meets any applicable State and local housing codes and licensing requirements in the jurisdiction in which the housing is located and the requirements of this part; and the housing is transitional housing; safe haven; permanent housing for homeless persons with disabilities; or is a part of, a particularly innovative project for, or alternative method of, meeting the immediate and long-term needs of homeless persons and families.

R. Tenant-Based Housing – A scattered-site program in which the tenant holds the lease and is directly responsible to the owner of the property. This program is comparable to the HUD Section 8 Housing Choice Voucher Program, but with modifications to meet the
needs of adults determined to have a Serious Mental Illness.

S. **Traditional Housing** – Housing services that facilitate the movement of homeless individuals and families to permanent housing. A homeless individual may stay in transitional housing for a period not to exceed 24 months.

**Policy**

A. **General Housing Contracts Requirements**

For the populations of persons determined to have a SMI or other eligible populations served by the AdSS (contingent upon available funding) and who are able to live independently, the AdSS must provide a number of programs to support independent living, such as rent subsidy programs, supportive housing programs and other transitional housing programs. Independent living must be supported with provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Housing programs must include rent subsidy programs, owner occupied home repairs, move-in assistance and eviction prevention programs coupled with needed supportive housing services to maintain independent living.

The Contractor AdSS must maintain a sufficient number of dedicated staffs of housing professionals with knowledge, expertise, experience and skills and require housing subcontractors to employ a sufficient number of staffs with knowledge, expertise and experience to participate in and administer a variety of affordable housing programs for members. The AdSS must:

1. Require housing subcontractors to employ a sufficient number of staffs with financial management, screening and referral skills, knowledge of federal wait lists, grant writing knowledge for applying for new funds, and supportive services as required by HUD to maintain current HUD grants as they come up for renewal, and to fund future grants.

2. Submit plans describing the AdSS housing programs and submit periodic reports on housing programs, as outlined in Contract.

3. Develop and submit an Annual Housing Needs Assessment, that includes:

   a. A brief summary of the AdSS’s Housing program history and/or current projects

   b. The specific eligibility group for any proposed new program and/or use of funds (e.g. SMI, GMH/SA, High Cost/High Needs Members) to include:

      i. A Program description

      ii. Barriers, trends and accomplishments in housing identified during the reporting period

      iii. Basis for need including supporting data and justification

      iv. Plan for identification of program candidates, and

      v. Collaborators.
4. Develop and submit for approval an Annual Housing Spending Plan for
development, maintenance, use and acquisition of housing properties in a format
specified by the Division and must at a minimum include:
   a. Project descriptions separated by population and funding source
   b. For each project the estimated number of new housing units and
      members housed and possible barriers
   c. Evidenced based best practices to be used improve housing capacity in
      responding to unmet housing needs and related issues; i.e. assessment
      scores
   d. All leveraged funds, their sources and collaborative efforts
   e. Project timeframes, and
   f. Monitoring and tracking process for each program.

5. Ensure that providers identify, and screen individuals determined to have SMI
   that satisfy Section 8 criteria and refer the prospective tenant to contracted
   Public Housing Authority.

6. Require providers to participate with the individual's treatment team in order to
   identify available housing units and to place the individual in an affordable
   appropriate living environment upon discharge from an institutional setting.

7. Comply with, requirements in ACOM Policy 444 for appeals related to supportive
   housing services.

8. Comply with AdSS Operations Policy Manual, Chapter 446 for Housing related
   grievances and requests for investigation for persons determined to have SMI.

B. Division Requirements for State Funding Supportive Housing Programs

The Division supports permanent supportive housing and has adopted the Substance
Abuse and Mental Health Services Administration (SAMHSA) model for permanent
supportive housing programs.

1. The 12 Key Elements of the SAMHSA Permanent Supportive Housing Program
   are:
   a. Tenants have a lease in their name, and, therefore, they have full
      rights of tenancy under landlord-tenant law, including control over
      living space and protection against eviction.
   b. Leases do not have any provisions that would not be found in leases
      held by someone who does not have a psychiatric disability.
   c. Participation in services is voluntary and tenants cannot be evicted for
      rejecting services.
   d. House rules, if any, are similar to those found in housing for people
      who do not have psychiatric disabilities and do not restrict visitors or
otherwise interfere with a life in the community.

e. Housing is not time-limited, and the lease is renewable at tenants’ and owners’ option.

f. Before moving into Permanent Supportive Housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.

g. Housing is affordable, with tenants paying no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.

h. Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities.

i. Tenants have choices in the support services that they receive. Tenants are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences.

j. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.

k. Support services promote recovery and are designed to help tenants choose, get, and keep housing, and

l. The provision of housing and the provision of support services are distinct.

2. The AdSS must comply with the following requirements to effectively manage limited housing funds in providing supportive housing services to eligible individuals. See the AHCCCS Covered Behavioral Health Services Guide for additional information on Supportive Housing. The AdSS must:

a. Accept all persons determined to have a SMI into a State Funded Housing Program subject to funding availability.

b. Utilize supportive housing allocations for eligible individuals and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for persons determined Title XIX/Non-Title XIX SMI persons, while another allocation may require it be used for those persons with GMH/SA eligibility.

c. Ensure safe and stable housing that is consistent with the member’s recovery goals and be the least restrictive environment necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.

d. Not actively refer or place individuals in a Homeless shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other
similar facilities.

e. Provide the tenant with a 30-day notice at the time of the tenant’s annual, recertification, if a rent payment is increased in state funded housing programs, The AdSS may charge up to, but not greater than, 30% of a tenant’s income towards rent.

f. Not use supportive housing allocations for room and board charges in Residential Treatment settings. However, the AdSS may allow Residential Treatment settings to establish policies which require that persons earning income contribute to the cost of room and board.

g. Not use supportive housing allocations or other funding received from AHCCCS (including block grant funds) to purchase furniture. However, move-in assistance and eviction prevention services may be provided to those members in permanent housing. When move-in assistance is provided, assistance with deposits and payment for utilities must be prioritized over other methods of assistance, such as move-in kits or items consisting of pots and pans, dishes, sheets, etc. Subcontract with a non-profit organization that is eligible to serve as a grantee for HUD funded grant programs.

h. Ensure that their subcontracted providers doing business with agencies that have HUD grants, report data to the local Homeless Management Information System (HMIS) project manager on contract, to administer the HMIS data collection.

i. Ensure that contracted providers deliver a range of housing services and present available options for housing to persons determined to have SMI consistent with the individual’s goals and needs in the Individual Service Plan.

j. Ensure that providers maintain all housing units currently in use, including units acquired through the State of Arizona housing funds specifically for members determined to have a SMI or other eligible populations served by the AdSS as funding permits.

k. Collaborate with State, County and local government agencies to support housing initiatives and resolve housing issues, concerns and complaints that affect members.

l. Develop new housing capacity, program initiatives and options when needed in collaboration with Division, ADOH and local HUD Continuum Of Care (COC).

m. Participate in the AHCCCS Quarterly Housing Meetings.

3. AdSSs awarded HUD funding are required to participate in the Homeless Management Information System (HMIS), a software application designed to record and store client-level information on the characteristics and service needs of homeless persons. The HMIS is used to coordinate care, manage program operations, and better serve clients.
4. The AdSS must develop and make available to providers the AdSS’s contact information to receive additional guidance and requirements regarding these programs.

5. AdSS housing programs are required to include specialized housing units to meet the needs of persons who are difficult to place in the community partly due to crime free/drug free ordinances and specific behavioral health related service need including substance use disorders.

6. The AdSS must provide persons determined to have SMI who are discharged from the Arizona State Hospital, supervisory care homes or unlicensed board and care homes, with housing options that promote independent living.

7. The AdSS must require providers to participate with the member’s treatment team in order to identify available housing units and to place the member in an affordable appropriate living environment upon discharge from an institutional setting.

8. The AdSS must advocate for persons determined to have SMI who are homeless and those released from Residential Treatment and Board and Care facilities to obtain housing units.

9. The AdSS must develop and make available to the providers policies and procedures regarding specific housing programs/funding and related requirements.

C. AdSS Monitoring Requirements of Subcontractors

The AdSS must monitor Housing subcontractors through the following activities:

1. Monitor providers for compliance with federal requirements of the SAMHSA Permanent Supportive Housing Fidelity Monitoring and HUD homeless grants.

2. Conduct regular inspections of housing units including tenant living situations to determine whether the individual has access to basic needs and whether the living environment is safe, secure and the least restrictive environment consistent with the treatment goals in the Individual Service Plan. Ensure contracted housing providers conduct these inspections also, and

3. Conduct a Housing Inventory of housing providers and tenants. This inventory must be submitted in the format and time required by the Division and must include:
   a. The number and types of housing programs.
   b. Number of units.
   c. Fund source for those units, and
   d. Populations served for each unit.
4. Develop and maintain an accounting system of all individuals in its housing program and of its housing and support service providers, and when requested or by Division Contract requirements, submit the data in a format approved by the Division.

5. Demonstrate that the AdSS’s staff and provider housing program staff have received training and can demonstrate competency in the following:

**Clinical & Administrative Managers** will demonstrate:

Knowledge of the basic concepts found in the Federal Fair Housing Law and the Arizona Landlord Tenant Act as they apply to members and their contracted providers by passing a post-test conducted after an orientation session.

**Behavioral Health Professionals (BHP's), Behavioral Health Technicians (BHT's) & Behavioral Health Paraprofessionals (BHPP’s)** will demonstrate competency, by passing a post-test after training, in the following areas:

a. Knowledge of basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords

b. The general rights of members afforded by these laws, and

c. The principles and availability of Housing support services.

**Case Managers** will demonstrate that they capably:

Understand the basic concepts found in the Arizona Landlord Tenant Act and Federal Fair Housing Laws describing the rights of tenants and landlords.

a. Explain lease requirements and rights of tenancy to Members in language they understand and can act upon,

b. Visit members and schedule service appointments at their homes consistent with the law,

c. Determine eviction risk and arrange for skill and or support service assistance to Members in coordination with Housing Providers,

d. Document and involve the Member in investigating complaints originated by the Member or Landlord, and

e. Pass a post test conducted after training and thereafter during routine clinical supervision.

**Housing Specialists and Case Managers** will also demonstrate that they can capably conduct and use the current and emerging tools and best practices such as the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) by passing a post test conducted after Specialized Training program and thereafter during routine clinical supervision.
D. Requirements for Collaboration and Partnerships with Federal Housing Programs

1. The US Department of Housing and Urban Development (HUD) provides funding for adults who are homeless and disabled. On May 20, 2009, a law was enacted to reauthorized HUD’s McKinney-Vento Homeless Assistance Programs which in part outlined assistance programs for the homeless. The bill, known as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, made numerous changes to HUD’s homeless assistance programs to include the following:

   a. Significantly increased resources to prevent homelessness,
   b. Established incentives on the use of rapid re-housing programs, especially for homeless families,
   c. A revised definition of “Permanent Supportive Housing” for people experiencing chronic homelessness to establish an industry standard, and to add “families” to the definition of “chronically homeless”, and
   d. The option for rural communities to apply under a different set of guidelines that may offer increased flexibility and assistance with capacity building.

2. The purpose of the COC Homeless Assistance Program is to reduce the incidence of homelessness in COC communities, by assisting homeless individuals and families in quickly transitioning to self-sufficiency and permanent housing, as authorized under Title IV of the McKinney–Vento Homeless Assistance Act. The HUD HEARTH COC became effective August 31, 2012 and includes:

   a. Codifying the COC process
   b. Expanding the definition of homelessness,
   c. Focusing selection criteria more on performance,
   d. The HEARTH Act consolidates the programs formerly known as the Supportive Housing Program (SHP), the Shelter Plus Care (S+C) Program, and the Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) Program into one grant program: the COC program,
   e. The COC Program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness,
   f. The AdSS is required to work in collaboration with the Arizona Department of Housing (ADOH), the Division and all Arizona HUD COCs to ensure the revised requirements of the HEARTH Act are met, allowing Arizona to maximize the HUD COC Homeless Assistance Programs awarded
throughout the State including but not limited to the HUD Housing Choice Voucher Program, and

g. AdSS’s who administer the federal HUD Housing Choice Voucher Program must ensure the following:

i. Tenants pay 30% of their adjusted income towards rent.

ii. Vouchers are portable throughout the entire country after one year.

iii. Permanent housing is obtainable for individuals following program rules.

iv. The program is accessed through local Public Housing Authorities through a waiting list.

v. Initial screening is conducted by the Public Housing Authority; however, the final decision is the responsibility of the landlord, and


E. AHCCCS Requirements for State Housing Acquisition and/or Renovation Programs

The AHCCCS Housing Acquisition and/or Renovation program provides State funding for the purchase and/or renovation of properties (house, condominium, duplex, apartment, new construction etc.). The AdSS subcontracts with eligible non-profit Housing providers to locate properties, purchase and/or renovate them for the use of Division members in accordance with Division requirements, review and approval. The property is held for use of Division eligible members for an extended period of time through the use of filed Covenants, Conditions and Restrictions.

1. The following conditions apply:

a. The AdSS must administer the AHCCCS Property Acquisition and Renovation Program through subcontracts with or partnerships with non-profit entities that have the capacity, experience, and knowledge of low-income housing programs, available funding streams and resources for supportive housing for adults determined to have SMI, and other eligible populations served by the AdSS (contingent upon available funding).

b. The AdSS must have prior approval from the Division if the property purchase and related approved costs are to be reimbursed with funds provided through the Division, and

c. For Acquisition and/or renovation of real property purchased by the AdSS’s subcontractors with funds provided by the Division, excluding net profits earned under the Contract, the AdSS must complete the following:

i. Attachment A, the AHCCCS Housing Application for Acquisition and/or Renovation or New Construction
ii. All required documents to include the funding source used, prior to the purchase of any new property leveraged with funds provided through the Division, and when applicable, a Notice of Real Property Transaction, which must include the following:

- Copies of Attachment C, AHCCCS Declaration of Covenants, Conditions, and Restrictions (CC&Rs) recorded with the County Recorder’s Office (the CC&Rs will cover a period of extended as indicated in the CC&R table based on use and costs)
- The funding source(s) used to purchase the property, specifically whether the purchase is to be made with funds provided through the Division and/or other matched funds
- The financing arrangements made prior to purchase the property
- Prior approval from the Division if the property purchase and related approved costs are to be reimbursed with funds provided through the Division
- A deed containing the use restrictions and covenants, conditions, or restrictions that ensures the property is used solely for the benefit of members and that failure to comply with the use restrictions allows the State to take title to the property or otherwise enforce the restrictions, and
- All documents as required in Attachment B, AHCCCS Housing Acquisition/Renovation Checklist.

d. The Division requires that the AdSS adopt Attachment D, AHCCCS Housing Acquisition and/or Renovation, or New Construction Operating and Funding Agreement as minimum requirements for all agreements for Housing Acquisition and/or Remodel or New Construction made between the AdSS and Housing Contractors using State Funds.
449 BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN DEPARTMENT OF CHILD SAFETY CUSTODY AND ADOPTED CHILDREN

EFFECTIVE DATE: October 1, 2018
REFERENCES: A.R.S. § 8-451, A.R.S. § 8-512.01; Section F3, Contractor Chart of Deliverables
DELIVERABLES: DCS & Adopted Children’s Services Reporting: Access to Services; DCS & Adopted Children's Services Reporting: Calls and Reconciliation

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The purpose of this policy is to ensure the timely provision of medically necessary behavioral health services to children eligible for Title XIX services who are in out-of-home placement and in the legal custody of the Department of Child Safety (DCS) and to adopted children in accordance with A.R.S. § 8-512.01.

Definitions

A. Adoptive Parent - Any adult or adults who are residents of Arizona, whether married, unmarried or legally separated, who have adopted a child. For purposes of this policy, the Adoptive Parent is that of a child who is eligible under Title XIX of the social security act.

B. Arizona Department of Child Safety (DCS) - The department established pursuant to A.R.S. § 8-451 to protect children and to perform the following:
   1. Investigate reports of abuse and neglect.
   2. Assess, promote and support the safety of a child in a safe and stable family or other appropriate placement in response to allegations of abuse or neglect.
   3. Work cooperatively with law enforcement regarding reports that include criminal conduct allegations.
   4. Without compromising child safety, coordinate services to achieve and maintain permanency on behalf of the child, strengthen the family and provide prevention, intervention and treatment services pursuant to this chapter.

C. Crisis - An acute, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

D. Crisis Services - Services provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior.

E. Out-of-Home Placement - For the purposes of this Policy out-of-home-placement means a foster home, kinship foster care, a shelter care provider, a receiving home or a group foster home.
The AdSS must ensure timely provision of all behavioral health services including, crisis services, 72-hour rapid response, urgent need response, assessment, and ongoing behavioral services, including screening and evaluation, for adopted children and children in out-of-home placement. The AdSS must provide coordinated care between the out-of-home placement or adoptive parent(s), all providers, and DCS, as appropriate.

**General Requirements**

In order to meet the needs of adopted children and children in out-of-home placement, the AdSS must:

A. Ensure services are provided in accordance with Policy 417 in this Policy Manual.

B. Ensure the availability of a telephone line, with designated staff, that is responsible for handling incoming calls after business hours related to delivery of services, including failure of an assessment team to respond within two hours. Designated staff must be adequately trained on the provisions of this Policy and the procedures in place to address calls prior to actively answering calls. There must be processes in place for staff to:

   1. Address barriers to care.
   2. Directly contact the crisis services vendor and/or provider.
   3. Track and report calls as indicated in Section I of this Policy.
   4. Report the above information to the Behavioral Health Coordinator.

**Request for Behavioral Health Out-of-Home Treatment**

The AdSS must ensure a determination is made, as expeditiously as the member’s health condition warrants but no later than, 72 hours after a request is made by the out-of-home placement or adoptive parent for placement of the member in a behavioral health out-of-home treatment setting due to the child displaying dangerous or threatening behaviors. These settings include, but are not limited to, Behavioral Health Residential Facilities, and Behavioral Health Therapeutic Homes. If the AdSS determines there is insufficient information to make a determination, the AdSS must document all concerted efforts to obtain required information within the 72-hour timeframe.

A. If the member is hospitalized prior to a determination on the request for behavioral health out-of-home treatment setting, the AdSS must coordinate with the hospital to ensure an appropriate and safe discharge plan. The discharge plan must include recommended follow-up services, including recommendations made by the Child and Family Team. For additional requirements regarding discharge planning refer to Division Medical Policy Manual, Policy 1020.
B. The AdSS must collaborate with DCS and the Support Coordinator to ensure an appropriate alternative placement for the member to be discharged when:

1. It is unsafe for the member to return to the out-of-home placement or adoptive family, and/or
2. It is unsafe for the out-of-home placement or adoptive family for the member to return.

C. The AdSS must issue a Notice of Adverse Benefit Determination (NOA) in accordance with Policy 414 in this Policy Manual for any adverse action related to the request for placement of the member in a behavioral health out-of-home treatment setting.

D. The AdSS is responsible for reimbursement to the inpatient psychiatric hospital for all medically necessary care including days where inpatient criteria was not met but there was not a safe discharge plan in effect to meet the needs and safety of the member and the out-of-home placement or adoptive family. In these cases the AdSS is responsible for payment regardless of principal diagnosis on the claim and may negotiate with the hospital for an appropriate rate.

E. If the request for a behavioral health out-of-home treatment setting is denied, the AdSS must ensure medically necessary alternative services are provided.

**Behavioral Health Appointment Standard**

A. The AdSS must ensure services are provided in accordance with Policy 417 in this Policy Manual.

B. Upon notification from an out-of-home placement or adoptive parent that a recommended behavioral health service is not provided to a member per the Policy 417 in this Policy Manual, behavioral health appointment standards for children in DCS custody, the AdSS must:

1. Notify the caller of the requirement to also report the failure to receive the approved behavioral health services to Division’s Customer Service Center at 602-542-0419 or email at DDDCustomerServiceCenter@azdes.gov. Notify the caller that the member may receive services directly from any AHCCCS-registered provider, regardless of whether the provider is contracted with the AdSS.

2. Obtain the name and contact information of the identified non-contracted provider of service, if applicable to verify their AHCCCS registration.

3. Obtain information needed to determine medical necessity of requested services not received.
C. For services provided by a non-contracted provider, the AdSS must:
   1. Not deny claims submitted based solely on the billing provider being out of the AdSS’s network
   2. Reimburse clean claims at the lesser of 130% of the AHCCCS FFS Rate or the provider’s standard rate and in accordance with Policy 203 in this Policy Manual.

D. The member may continue to receive services from the non-contracted provider regardless of the availability of an in-network provider.

**Continuity of Services**

The AdSS is responsible for continuation and coordination of services the member is currently receiving. If a member moves into a different county because of the location of the out-of-home placement, the AdSS must allow the member to continue any current treatment in the previous county and/or seek any new or additional treatment in the out-of-home placement’s county of residence regardless of the AdSS’s provider network.

**Behavioral Health Coordinator**

A. The AdSS must designate a key staff person whose primary role is to:
   1. Serve as the member’s single point of contact,
   2. Accept and respond to:
      a. Inquiries from the out-of-home placement, adoptive parent, or providers,
      b. Issues and concerns related to the delivery of and access to behavioral health services for members in out-of-home placements or with adoptive parents.
   3. Collaborate with the out-of-home placement and adoptive parents to address barriers to services, including nonresponsive crisis providers, and
   4. Resolve concerns received in accordance with grievance system requirements.

B. The Behavioral Health Coordinator must:
   1. Provide the number for crisis services and after hour’s telephone line in their outgoing voicemail message and email,
   2. Provide an expected timeframe for return calls in their outgoing voicemail message and email,
   3. Respond to all inquiries as indicated by need or safety but no later than one business day, and
4. Follow up on all calls received by the after hour telephone line.

C. The AdSS must ensure the Behavioral Health Coordinator’s contact information is:
   1. Provided to DDD and DCS for distribution,
   2. Prominently placed on the member page of the AdSS’s website

D. The AdSS must ensure calls received by the Behavioral Health Coordinator that meet the definition of a grievance are reported in accordance with the Grievance System Reporting requirements as outlined in Contract.

**Education**

The AdSS is responsible for ongoing education to providers, members, families, and other parties involved with the member’s care, including but not limited to the following:

A. Rights and responsibilities as delineated in A.R.S. § 8-512.01
B. Trauma-informed care
C. Navigating the behavioral health system
D. Coordination of Care as outlined in this Policy
E. Covered services
F. Referral process
G. The role of the AdSS
H. The role of DDD and DCS
I. Additional trainings identified by the Member Advisory Council.

All AdSS member information must be in accordance with Division Administrative Services Subcontractor Policy 404.

The Division reserves the right to verify education programs when performing operational reviews of the AdSS.

**Tracking and Reporting**

A. Monitor on a monthly basis and submit quarterly, or upon request by the Division, as specified in Section F3, Contractor Chart of Deliverables, the AdSS must submit ACOM, Chapter 449, Attachment A in the AHCCCS Operations Manual, Children in Out-of-Home Placement and in the Legal Custody of DCS and Adopted Children Services Reporting Access to Services, which includes the following:
   1. Access to Services as specified in the reporting template
2. Provider terminations

List of providers that were formerly contracted with the AdSS but terminated their contract and provided services at the lesser of 130% of the AHCCCS FFS Rate or the Provider's standard service rate, and the amount spent on those services.

B. On a monthly basis, as specified in Section F3, Contractor Chart of Deliverables, the AdSS must submit a report using ACOM, Chapter 449, Attachment B in the AHCCCS Operations Manual, Children in Out-of-Home Placement and in the Legal Custody of DCS and Adopted Children Services Reporting-Calls and Emails, on the 30th day after the reporting month as specified in the reporting template. The Division will provide a monthly listing to the AdSS's Behavioral Health Coordinator of children placed in DCS custody. The AdSS must report to the Division information on a monthly basis regarding members in DCS custody who have not received rapid response services. The AdSS must perform a reconciliation of members placed within DCS custody against those who have received a rapid response service. For any identified members in DCS custody who have not been engaged in behavioral health services, the AdSS must ensure a rapid response service is delivered. The AdSS must submit a DCS Rapid Response Monthly Reconciliation Report as specified in the reporting template.

C. Member Advisory Council Plan

On an annual basis, as specified in Section F3, Contractor Chart of Deliverables, the AdSS must submit on December 15th a Member Advisory Council Plan to the Division. The Plan must outline the schedule of Council meetings, membership, trainings, goals and objectives, including an evaluation of the previous year.
470 MANAGEMENT AND MAINTENANCE OF RECORDS RELATED TO THE MEDICAID LINE OF BUSINESS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 12-2297; 45 CFR 164.530(j)(2)

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The AdSS will maintain all records for five years from the date of final payment under contract with the Division unless a longer period of time is required by law.

For retention of the member’s medical records, the AdSS will ensure compliance with A.R.S. § 12-2297, which provides, in part, that a health care provider must retain the member’s medical records according to the following:

A. If the member is an adult, the AdSS will retain the member’s medical records for at least six years after the last date the adult member received medical or health care services from the AdSS.

B. If the member is under 18 years of age, the AdSS will maintain the member’s medical records either for at least three years after the child’s 18th birthday or for at least six years after the last date the child received medical or health care services from the AdSS, whichever date occurs later.

The AdSS will comply with the record retention periods specified in HIPAA laws and regulations, including, but not limited to, 45 CFR 164.530(j) (2).

If the AdSS contract with the Division is completely or partially terminated, the records relating to the work terminated must be preserved and made available for five years from the date of any such termination. Records that relate to grievances, disputes, litigation or the settlement of claims arising out of the performance of the AdSS contract with the Division, or costs and expenses of the AdSS contract with the Division to which exception has been taken by the Division, must be retained by the AdSS for five years after the date of final disposition or resolution thereof.
MEDICAL POLICY MANUAL

Chapter 300 Medical Policy for Acute Services

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>310-B</td>
<td>Behavioral Health Services</td>
</tr>
<tr>
<td>310-D1</td>
<td>Dental Services for Members 21 Years of Age and Older</td>
</tr>
<tr>
<td>310-D2</td>
<td>Arizona Long Term Care System Adult Dental Services</td>
</tr>
<tr>
<td>310-G</td>
<td>Eye Examinations/Optometry Services</td>
</tr>
<tr>
<td>310-I</td>
<td>Home Health Services</td>
</tr>
<tr>
<td>310-J</td>
<td>Hospice Services</td>
</tr>
<tr>
<td>310-K</td>
<td>Hospital Inpatient Services</td>
</tr>
<tr>
<td>310-M</td>
<td>Immunizations</td>
</tr>
<tr>
<td>310-P</td>
<td>Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services)</td>
</tr>
<tr>
<td>310-R</td>
<td>Nursing Facility Services</td>
</tr>
<tr>
<td>310-V</td>
<td>Prescription Medication/Pharmacy Services</td>
</tr>
<tr>
<td>310-DD</td>
<td>Covered Transplants and Related Immunosuppressant Medications</td>
</tr>
<tr>
<td>310-FF</td>
<td>Monitoring Controlled and Non-controlled Medication Utilization</td>
</tr>
<tr>
<td>310-GG</td>
<td>Nutritional Assessments and Nutritional Therapy</td>
</tr>
<tr>
<td>310-HH</td>
<td>End of Life Care and Advance Care Planning</td>
</tr>
<tr>
<td>320-H</td>
<td>Medical Foods</td>
</tr>
<tr>
<td>320-I</td>
<td>Telehealth and Telemedicine</td>
</tr>
<tr>
<td>320-O</td>
<td>Behavioral Health Assessments and Treatment Planning</td>
</tr>
<tr>
<td>320-P</td>
<td>Serious Mental Illness Eligibility Determination</td>
</tr>
<tr>
<td>320-Q</td>
<td>General and Informed Consent</td>
</tr>
<tr>
<td>320-R</td>
<td>Special Assistance for Persons with Serious Mental Illness</td>
</tr>
<tr>
<td>320-S</td>
<td>Applied Behavior Analysis</td>
</tr>
<tr>
<td>320-U</td>
<td>Pre-petition Screening, Court Ordered Evaluation and Court Ordered Treatment</td>
</tr>
<tr>
<td>320-V</td>
<td>Behavioral Health Residential Facilities</td>
</tr>
<tr>
<td>Chapter 400 Medical Policy for Maternal and Child Health</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>400 Chapter Deliverables</td>
<td></td>
</tr>
<tr>
<td>410 Maternity Care Services</td>
<td></td>
</tr>
<tr>
<td>420 Family Planning</td>
<td></td>
</tr>
<tr>
<td>430 Early Periodic Screening, Diagnosis and Treatment Services</td>
<td></td>
</tr>
<tr>
<td>431 Oral Health Care (EPSDT-Age Members)</td>
<td></td>
</tr>
<tr>
<td>450 Out-of-State Placements for Children or young Adults for Behavioral Health Treatment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 500 Care Coordination Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>510 Primary Care Providers</td>
</tr>
<tr>
<td>520 Member Transitions</td>
</tr>
<tr>
<td>540 Other Care Coordination Issues</td>
</tr>
<tr>
<td>541 Coordination of Care with Other Government Agencies</td>
</tr>
<tr>
<td>560 CRS Care Coordination and Service Plan Management</td>
</tr>
<tr>
<td>580 Behavioral Health Referral and Intake Process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 600 Provider Qualifications and Provider Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>640 Advance Directives</td>
</tr>
<tr>
<td>670 Federally Qualified Healthcare Centers and Rural Health Clinics Reimbursement</td>
</tr>
<tr>
<td>680-C Pre-Admission Screening and Resident Review</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 900 Quality Management and Performance Improvement Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>900 Deliverables</td>
</tr>
<tr>
<td>910 Quality Management/Performance Improvement Program Administrative Requirements</td>
</tr>
<tr>
<td>920 Quality Management/Performance Improvement (QM/PI) Program Scope</td>
</tr>
<tr>
<td>930 Member Rights and Responsibilities</td>
</tr>
<tr>
<td>940 Medical Records and Communication of Clinical Information</td>
</tr>
<tr>
<td>950 Credentialing and Recredentialing Processes</td>
</tr>
<tr>
<td>960 Tracking and Trending of Member and Provider Issues</td>
</tr>
<tr>
<td>970 Performance Measures</td>
</tr>
<tr>
<td>980 Performance Improvement Projects</td>
</tr>
</tbody>
</table>
Chapter 1000 Medication Management

1000 Chapter Deliverables
1010 Medical Management Administrative Requirements
1020 Medical Management Scope and Components
  Diabetic Diagnosis Report
  Emergency Department (ER) Diversion Reporting Tool
  Notification of All Hospital Admissions
  Pressure Ulcer Report
1050 Coordination of Care with Other Government Entities for Behavioral Health Services
1060 Training Requirements for Behavioral Health Providers

Chapter 1200 Services and Settings

1210 Institutional Services and Settings
1240-D Emergency Alert System
1250-E Therapies (Rehabilitative and Habilitative)
1250-F Customized Durable Medical Equipment, and Appliances
BEHAVIORAL HEALTH SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9- 22-210.01; AMPM Chapter 100, AMPM Exhibit 310-1

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

The Division covers behavioral health services (mental health and/or substance abuse services) for members eligible for ALTCS and the Division.

Amount, Duration and Scope

Covered behavioral health services include, but are not limited to:

A. Inpatient hospital services
B. Inpatient Behavioral Health facility services
C. Institution for mental disease with limitations (refer to AMPM Chapter 100)
D. Behavioral health counseling and therapy, including electroconvulsive therapy
E. Psychotropic medication
F. Psychotropic medication adjustment and monitoring
G. Respite care
   The combined total of short-term and/or continuous respite care cannot exceed 600 hours per benefit year.
H. Partial care (supervised day program, therapeutic day program and medical day program)
I. Behavior management (behavioral health home care training, behavioral health self-help/peer support)
J. Psychosocial rehabilitation (skills training and development, behavioral health promotion/education, psycho-educational services, ongoing support to maintain employment, and cognitive rehabilitation)
K. Screening, evaluation and assessment
L. Case management services
M. Laboratory, radiology, and medical imaging services for diagnosis and psychotropic medication regulation
N. Emergency and non-emergency medically necessary transportation
O. Behavioral health supportive home care services.
A provider is not required to obtain prior authorization for emergency services. Regarding emergency services, refer to AMPM Exhibit 310-1 for a reprint of A.A.C. R9- 22-210.01 that describes general provisions for responsible entities, payment and denial of payment, notification requirements and post-stabilization requirements.

The AdSS must ensure that any Behavioral Health entity/provider, that develops a Behavior Plan for a member, trains family members and all staff to implement the plan with fidelity.
310-D1 DENTAL SERVICES FOR MEMBERS 21 YEARS OF AGE AND OLDER

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2907, A.R.S. § 14-5101; A.A.C. R9-22-207; AMPM 310-D2

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy. This policy establishes requirements for the provision of medically necessary dental services for members of the Division of Developmental Disabilities (Division) who are age 21 and older. (Dental services for members under 21 years of age are covered as specified in Division Medical Policy 431.)

The Division requires the AdSS to cover the following dental services provided by a licensed dentist 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 a result of A.R.S. § 36-2907. The emergency dental services are described in Emergency Dental Services Coverage for Persons Age 21 Years and Older (below).

B. Medical and surgical services furnished by a dentist only to the extent such services may be performed under state law either by a physician or by a dentist and such services would be considered a physician service if furnished by a physician (A.A.C. R9-22-207).

C. These services must relate to treatment of a medical condition such as acute pain (excluding Temporomandibular Joint Dysfunction [TMJ] pain), infection, or fracture of the jaw. Covered services include a limited problem focused examination of the oral cavity, required radiographs, complex oral surgical procedures such as treatment of maxillofacial fractures, administration of an appropriate anesthesia and the prescription of pain medication and antibiotics. Diagnosis and treatment of TMJ is not covered except for reduction of trauma. Services described in this paragraph are not subject to the $1,000 adult emergency dental limit.

D. Exception for Transplant Cases

For members needing medically necessary dental services as a prerequisite to Division-covered organ or tissue transplantation, covered dental services are limited to the elimination of oral infections and the treatment of oral disease, which include dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations. For purposes of this policy, a simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. The Division covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. These services are not subject to the $1,000 adult emergency dental limit.

E. Exception for Cancer Cases

Prophylactic extraction of teeth in preparation for radiation treatment of cancer of...
the jaw, neck or head is covered. These services are not subject to the $1,000 adult emergency dental limit.

**Emergency Dental Services Coverage for Persons Age 21 and Older**

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

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

1. Emergency oral diagnostic examination (limited oral examination – problem focused)
2. Radiographs and laboratory services, limited to the symptomatic teeth
3. Composite resin due to recent tooth fracture for anterior teeth
4. Prefabricated crowns, to eliminate pain due to recent tooth fracture only
5. Recementation of clinically sound inlays, onlays, crowns, and fixed bridges
6. Pulp cap, direct or indirect plus filling
7. Root canals and vital pulpotomies when indicated for the treatment of acute infection or to eliminate pain
8. Apicoectomy performed as a separate procedure, for treatment of acute infection or to eliminate pain, with favorable prognosis
9. Immediate and palliative procedures, including extractions if medically necessary, for relief of pain associated with an oral or maxillofacial condition
10. Tooth reimplantation of accidentally avulsed or displaced anterior tooth, with favorable prognosis
11. Temporary restoration which provides palliative/sedative care (limited to the tooth receiving emergency treatment)
12. Initial treatment for acute infection, including, but not limited to, periapical and periodontal infections and abscesses by appropriate methods
13. Preoperative procedures and anesthesia appropriate for optimal patient management
14. Cast crowns limited to the restoration of root canal treated teeth only.

Follow-up procedures needed to stabilize teeth due the emergency service are covered and subject to the $1,000 limit.
**Adult Emergency Dental Services Limitations for Persons age 21 Years and Older**

The following adult dental services are not covered:

A. Maxillofacial dental services provided by a dentist, 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 for non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection

E. Fixed bridgework to replace missing teeth

F. Dentures.

**AdSS and FFS Program Responsibilities**

A. The Division requires the AdSS to provide at least the following:

1. Coordination of covered dental services for enrolled Division members
2. Documentation of current valid contracts with dentists who practice within the AdSS service area(s)
3. Primary care provider to initiate member referrals to dentist(s) when the member is determined to need emergency dental services, or members may self-refer to a dentist when in need of emergency dental services
4. Monitoring of the provision of dental services and reporting of encounter data to the Division
5. Assurance that copies of adult emergency dental policies and procedures have been provided to contracted dentist(s).

B. The annual $1,000 adult emergency dental limit is member specific and remains with the member if the member transfers between AdSSs or between Fee-For-Service and an AdSS. Dental services provided within an IHS/638 facility are also subject to the $1,000 adult emergency dental limit. The AdSS or Tribal Case Manager transferring the member must notify the accepting entity regarding the current balance of the dental benefit. The relinquishing AdSS must use ALTCS Enrollment Transition Information (ETI) (DDD-1541A) and Division Medical Policy 520 for reporting dental benefit balance to the receiving AdSS.

1. 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.
2. The member is NOT permitted to "carry-over" unused benefit from one year to the next.

3. A year begins on October 1st and ends September 30th.

C. Prior authorization for emergency dental services is not required for members enrolled with either FFS or Managed Care.

Notification Requirements for Charges to Members

Emergency dental services of $1,000 per contract year are covered for Division members age 21 years and older. Billing of Division members for emergency dental services in excess of the $1000 annual limit is permitted only when the provider meets the requirements of A.A.C R9-22-702 (for acute members) and A.A.C. R9-28-701.10 (for ALTCS members).

In order to bill the member for emergency dental services exceeding the $1,000 limit, the provider must first inform the member in a way s/he understands, that the requested dental service exceeds the $1,000 limit and is not covered by the Division. Before providing the dental services that will be billed to the member, the provider must furnish the member with a document to be signed in advance of the service, stating that the member understands that the dental service will not be fully paid by the Division and that the member agrees to pay for the amount exceeding the $1,000 emergency dental services limit, as well as services not covered by the Division.

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

Facility and Anesthesia Charges

The Division expects that in rare instances a member may have an underlying medical condition which necessitates that services provided under the emergency dental benefit be provided in an Ambulatory Service Center or an Outpatient Hospital and may require anesthesia as part of the emergency service. In those instances, the facility and anesthesia charges are subject to the $1,000 emergency dental limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1,000 emergency dental limit.

Physicians performing GA on members for a dental procedure will bill medical codes and the cost will count towards the $1,000 emergency dental limit.

Informed Consent

Informed consent is a process by which the provider advises the member/guardian/designated representative 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.

A. Informed consents for oral health treatment include:
1. A written consent for examination and/or any treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment.

2. A separate written consent for any irreversible, invasive procedure (e.g., dental fillings, pulpotomies). In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/guardian/designated representative receiving a copy of the complete treatment plan.

B. All providers must complete the appropriate informed consents and treatment plans for Division members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member/guardian/designated representative. This requirement extends to all AdSS mobile unit providers. Consents and treatment plans must be in writing and signed/dated by both the provider and the patient, or patient’s representative, if under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. §14-5101). Completed consents and treatment plans must be maintained in the members’ chart and are subject to audit.
310-D2 ARIZONA LONG TERM CARE SYSTEM ADULT DENTAL SERVICES

EFFECTIVE DATES: October 1, 2019

This Policy applies the Division’s Administrative Services Subcontractors (AdSS). This Policy establishes requirements regarding the provision of medically necessary dental services for members in the Long Term Care Program.

**Policy**

In accordance with A.R.S. § 36-2939, Arizona Long Term Care System (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. The dental policy for members under age 21 is specified in AdSS Medical Policy 430 (Early Periodic Screening, Diagnostic and Treatment Services).

Members are also eligible for services as specified in AdSS Medical Policy 310-D1 (Dental Services for Members 21 Years of Age and Older). The services described in AdSS Medical Policy 310-D1 do not count towards the ALTCS $1,000 limit.

A. **AdSS Responsibilities**

1. The AdSS provides at least the following:
   a. Coordination of covered dental services for enrolled members;
   b. Documentation of current valid contracts with dentists who practice within the AdSS service area(s);
   c. Primary care provider to initiate member referrals to dentist(s) when the member is determined to be in need of dental services, or members may self-refer to a dentist when in need of dental services,
   d. Monitoring of the provision of dental services and reporting of encounter data to the Division; and
   e. Assurance that copies of dental policies and procedures have been provided to contracted dentist(s).

2. The annual dental benefit limit is member specific and remains with the member if the member transfers between Managed Care Organizations or between Fee-For-Service and Managed Care. It is the responsibility of the AdSS transferring the member to notify the receiving AdSS regarding the current balance of the dental benefit. The ALTCS Enrollment Transition Information (ETI) form, AMPM Policy 1620, Exhibit 1620-9 must be utilized for reporting any dental benefit balance. Dental services provided within an Indian Health Service (IHS) or 638 Tribal Facility are also subject to the ALTCS dental benefit $1,000 limit.
The member is not permitted to “carry-over” unused benefit from one contract year to the next.

Frequency limitations and services that require prior authorization apply.

The AdSS must refer to AdSS Medical Policy 431 (Oral Health Care (EPSDT-Age Members) for the Dental Uniform Prior Authorization List.

B. **Facility and Anesthesia Charges**

In rare instances a member may have an underlying medical condition which necessitates that services provided under the dental benefit be provided in an Ambulatory Service Center or an Outpatient Hospital and may require anesthesia. In those instances, the facility and anesthesia charges are subject to the $1,000 limit.

Dentists performing General Anesthesia (GA) on members will bill using dental codes and the cost will count towards the $1,000 limit.

Physicians performing GA on a patient for a dental procedure will bill medical codes and the cost will count towards the $1,000 limit.

C. **Informed Consent**

Informed consent is a process by which the provider advises the member/guardian/designated representative 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.

1. Informed consents for oral health treatment include:
   
   a. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below. This consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment.

   b. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy, etc. In addition, a written treatment plan must be reviewed and signed by both parties, as described below, with the member/guardian/designated representative receiving a copy of the complete treatment plan.

2. All providers must complete the appropriate informed consents and treatment plans for members as listed above, in order to provide quality and consistent care, in a manner that protects and is easily understood by the member/guardian/designated representative. This requirement extends to all AdSS mobile unit providers. Consents and treatment plans must be in writing and signed and dated by both the provider and the patient, or patient’s representative, if under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as specified in A.R.S. § 14-
5101). Completed consents and treatment plans must be maintained in the members’ chart and are subject to audit.

D. **Notification Requirements for Charges to Members**

Providers must provide medically necessary services within the $1,000 dental benefit allowable amount. In the event that 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.

In accordance with A.A.C. R9-28-701(10) and R9-22-702 (Charges to Members), the provider must inform/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 $1,000 limit. If the member agrees to pursue the receipt of services:

1. The provider must supply the member a document describing the service and the anticipated cost of the service.

2. Prior to service delivery, the member must sign and date a document indicating that he/she understands that he/she will be responsible for the cost of the service to the extent that it exceeds the $1,000 limit.
310–G EYE EXAMINATIONS/OPTOMETRY SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Eye and optometric services are covered for members eligible for ALTCS when provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

Emergency eye care which meets the definition of an emergency medical condition is covered for all members eligible for ALTCS. For members who are 21 years of age or older treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered. Vision examinations and the provision of prescriptive lenses are covered for members under the Early and Periodic Screening, Diagnosis and Treatment Program, and for adults when medically necessary following cataract removal. Refer to Division Medical Policy Manual, Chapter 400 for detailed information regarding coverage of eye exams and prescriptive lenses for children.

Cataract removal is covered for all members eligible for ALTCS. Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

A. Visual acuity that cannot be corrected by lenses to better than 20/70 and is reasonably attributable to cataract

B. In the presence of complete inability to see posterior chamber, vision is confirmed by potential acuity meter reading

C. For the Division’s American Indian Health Plan (Fee-For-Service) members, who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist to demonstrate medical necessity may be required. Refer to the Contractors regarding requirements for their enrolled members.

Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the member will achieve improved visual functional ability when visual rehabilitation is complete.

Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures, or the member's medical status. Admission to the hospital may be deemed safer due to age, environmental conditions, or other factors.

Other cases that may require medically necessary ophthalmic services include, but are not limited to:

A. Phacogenic Glaucoma

B. Phacogenic Uveitis.
310-I HOME HEALTH SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-10-1201 et seq.

This policy applies to:

- The Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSS) and Qualified Vendors
- Fee-For-Services (FFS) Programs, including Tribal Arizona Long Term Care System (ALTCS), the American Indian Health Program (AIHP), and all FFS populations.

This policy does not apply to Federal Emergency Services (FES); for information regarding FES, see Division Medical Manual Chapter 1100. This policy establishes requirements regarding Home Health Services.

Definitions

A. Home Health Agency - A public or private agency or organization, or part of an agency or organization, that is licensed by the state and meets requirements for participation in Medicare, including the capitalization requirements under 42 CFR 489.28 [42 CFR 440.70].

B. Home Health Services - Nursing services, home health aide services, therapy services, and medical supplies, equipment, and appliances as described in 42 CFR 440.70, when provided to a member at his/her place of residence and on his/her physician's orders as part of a written plan of care [42 CFR 440.70].

C. Place of Residence - A member’s place of residence, for home health services, does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), except for home health services in an ICF/IID facility that are not required to be provided by the facility under subpart I of part 483. For example, a registered nurse may provide short-term care for a beneficiary in an intermediate care facility for Individuals with Intellectual Disabilities during an acute illness to avoid the beneficiary’s transfer to a nursing facility.

Policy

The Division covers medically necessary home health services provided in the member’s place of residence as a cost-effective alternative to hospitalization. Covered services, within certain limits, include: home health nursing visits, home health aide services, medically necessary medical equipment, appliances and supplies, and therapy services for Division members. Home health services are covered when ordered by the member’s treating physician.

ALTCS covers home health services for members receiving home and community based services. Refer to Division Medical Policy 1240-G for additional information.

A. Home Health Nursing and Home Health Aide Services
Home health nursing and home health aide services are provided on an intermittent basis as ordered by a treating physician.

B. Physical Therapy, Occupational Therapy, Speech Therapy, and Audiology Services

Physical therapy, occupational therapy, speech therapy, and audiology services provided by a licensed home health agency are covered for members as specified in Division Medical Policy 310-X.

C. Medical Equipment, Appliances and Supplies

Medical equipment, appliances, and supplies provided by a licensed home health agency are covered for members.

D. Face-to-Face Encounter Requirements

1. Face-to-face encounter requirements apply to FFS only.

2. For initiation of home health services, a face-to-face encounter between the member and practitioner that relates to the primary reason the individual requires home health services is required within no more than 90 days before or within 30 days after start of services.

3. The face-to-face encounter must be conducted by one of the following:
   a. The ordering physician
   b. A nurse practitioner or clinical nurse specialist working in collaboration with the physician in accordance with state law
   c. A certified nurse midwife as authorized by state law
   d. A physician assistant under the supervision of the ordering physician, or
   e. For members admitted to home health immediately after an acute or post-acute stay, the attending acute or post-acute physician.

4. The non-physician practitioner specified above who performs the face-to-face encounter must communicate the clinical findings of the face-to-face encounter to the ordering physician.

5. The clinical findings must be incorporated into a written or electronic document in the member’s record.

6. Regardless of which practitioner performs the face-to-face encounter related to the primary reason that the individual requires home health services, the physician responsible for ordering the services must document the practitioner who conducted the encounter, the date of the encounter, and that the face-to-face encounter occurred within the required timeframes.

The face-to-face encounter may occur through telehealth.
310–J    HOSPICE SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 36-2907 and 2989, 42 CFR 418.20 and 70, Arizona’s Section 115(a) Medicaid Demonstration Extension.

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Hospice services are covered for members eligible for AHCCCS. Hospice services are allowable under A.R.S. §§ 36-2907 and 2989, and 42 CFR 418.20, for terminally ill members who meet the specified medical criteria/requirements. Hospice services provide palliative and support care for terminally ill members and their family members or caregivers in order to ease the physical, emotional, spiritual, and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

Hospice services are provided in the member’s own home, an alternative residential setting, or the following inpatient settings when the conditions of participation are met as specified in 42 CFR 418:

A. Hospital
B. Nursing care institution
C. Freestanding hospice.

Providers of hospice must be Medicare certified, licensed by the Arizona Department of Health Services (ADHS), and have a signed AHCCCS provider agreement.

As directed by the Affordable Care Act, members receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) may continue to receive curative treatment for their terminal illness while receiving hospice services. Adult members age 21 and older who elect hospice services must forgo curative care.

For dual eligible members, Medicare is the primary payer of hospice services.

Definitions

The following definitions apply to Hospice Services:

A. Continuous home care - hospice provided during periods of crisis for a minimum of eight hours per 24-hour day (the hours do not have to be continuous). To qualify as home care under this section, the care must be predominantly nursing care, provided by a registered nurse or a licensed practical nurse. Homemaker and home health aide services may also be provided to supplement the care. Continuous home care is only furnished during brief periods of crisis and only as necessary to allow terminally ill hospice-eligible members to maintain residence in their own home or an alternative residential setting. Continuous home care is not available to members residing in a Nursing Facility (NF) Medicaid certified bed.

B. Inpatient respite care - services provided in an inpatient setting, such as an NF, on a short-term basis to relieve family members or other caregivers who provide care to
members eligible for hospice who have elected to receive hospice care and who reside in their own home or, home and community based (HCB) alternative residential setting.

C. General inpatient care - services provided, in an inpatient setting such as a hospital, to members eligible for hospice who have elected to receive hospice. These services are provided for such purposes as pain control or acute or chronic symptom management, which cannot be performed in another setting.

D. Period of crisis - a period in which the hospice-eligible member requires continuous care to achieve palliation or management of acute medical symptoms.

E. Routine home care - short-term, intermittent hospice including skilled nursing, home health aide and/or homemaker services provided to a hospice-eligible member in his or her own home or an alternative residential setting. Routine home care services may be provided on a regularly scheduled and/or on-call basis. The member eligible for hospice must not be receiving continuous home care services as defined in this section at the time routine home care is provided. Routine home care is available to members residing in an NF Medicaid certified bed.

**Amount, Duration and Scope**

Prior to the member receiving hospice services, the physician must provide, to the Administrative Services Subcontractor (AdSS), certification stating that the member’s prognosis is terminal with the member’s life expectancy not exceeding six months. Due to the uncertainty of predicting courses of illness, the hospice benefit is available beyond six months provided additional physician certifications are completed.

The physician certification is permitted for two 90-day periods; thereafter, an unlimited number of physician certifications for 60-day periods are permitted.

The AdSS must notify the Division’s Health Care Services within five business days of any approval or denial of Hospice services. The AdSS must also notify the Support Coordinator that a referral has been made.

State licensure standards for hospice care require providers to include skilled nursing, respite, and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services, and inpatient services, available as necessary to meet the member’s needs. The following components are included in hospice service reimbursement, if they are provided in approved settings:

A. Bereavement services, including social and emotional support provided by the hospice provider, to the member’s family both before and up to twelve months following the death of that member

B. Continuous home care (as specified in this policy), which may be provided only during a period of crisis

C. Dietary services, which include a nutritional evaluation and dietary counseling when necessary
D. Home health aide services

E. Homemaker services

F. Nursing services provided by or under the supervision of a registered nurse

G. Pastoral/counseling services provided by an individual who is qualified through the completion of a degree in ministry, psychology, or a related field, and who is appropriately licensed or certified

H. Hospice respite care services that are provided on an occasional basis, not to exceed more than five consecutive days at a time

   (Hospice respite care services may not be provided when the member is residing in a nursing facility or is receiving services in an inpatient setting indicated above.)

I. Routine home care, as specified in the definition of hospice services

J. Social services provided by a qualified social worker

K. Therapies that include physical, occupational, respiratory, speech, music, and recreational therapy

L. Twenty-four hour on-call availability to provide services such as reassurance, information and referral, for members and their family members or caretakers

M. Volunteer services provided by individuals who are specially trained in hospice and who are supervised by a designated hospice employee

   (Under 42 CFR 418.70, if providing direct patient care, the volunteer must meet qualifications required to provide such services.)

N. Medical supplies, appliances, and equipment, and pharmaceuticals used in relationship to the palliation or management of the member’s terminal illness. Appliances may include durable medical equipment such as wheelchairs, hospital beds or oxygen equipment.
310-K  

HOSPITAL INPATIENT SERVICES

EFFECTIVE DATE: October 1, 2019  
REFERENCES: A.R.S. § 32-801 through 871

The Division of Developmental Disabilities (Division) covers medically necessary inpatient hospital services, provided by a licensed participating hospital, for all members eligible for ALTCS. Inpatient hospital services are medically necessary services delivered or directed by a Primary Care Provider (PCP), a specialist physician, practitioner or dentist. These services are ordinarily furnished in an acute care hospital, except for services in public or correctional facilities, or Behavioral Health settings.

Inpatient hospital services for members include, but are not limited to, the following:

A. Hospital accommodation, and appropriate staffing, supplies, equipment and services for any or all of the following:
   1. Acute physical care and behavioral health care
   2. Intensive care and coronary care
   3. Neonatal intensive care
   4. Maternity care including labor, delivery and recovery rooms, birthing centers, and nursery and related services
   5. Nursery for newborns and infants
   6. Surgery including surgical suites and recovery rooms, and anesthesiology services
   7. Nursing services necessary and appropriate for the member's medical condition, including assistance with activities of daily living as needed
   8. Medical detoxification and treatment services
   9. Behavioral health forensic services
   10. Dietary services
   11. Medical supplies, appliances and equipment consistent with the level of accommodation
   12. Perfusion and perfusionist services.

B. Ancillary Services

Ancillary services include any or all of the following:

1. Audiology services
2. Chemotherapy
3. Dental surgery for members in the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

4. Dental surgery for members 21 years of age and older within limitations as described in Division Medical Policy 310-D

5. Dialysis

6. Laboratory services

7. Pharmaceutical services and prescribed drugs

8. Radiological and medical imaging services

9. Rehabilitation services including physical, occupational and speech therapies

10. Respiratory therapy

11. Behavioral health assessments, and behavioral health therapy (including electroconvulsive therapy)

12. Services and supplies necessary to store, process, and administer blood and blood derivatives

13. Total parenteral nutrition


**Limitations and Exclusions**

The Division covers semiprivate inpatient hospital accommodations, except when the member's medical condition requires isolation.

The Division does not separately cover home-based services, such as Attendant/Personal Care, while the member is in inpatient settings.
310–M IMMUNIZATIONS

EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM Chapter 400

Immunizations are covered as appropriate for age, history, and health risk, for adults and children.

The Division of Developmental Disabilities (Division) follows recommendations as established by the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP). Covered immunizations for adults include, but are not limited to:

A. Diphtheria-tetanus
B. Influenza
C. Pneumococcus
D. Rubella
E. Measles
F. Hepatitis-B
G. Pertussis, as currently recommended by the CDC or ACIP
H. Zoster vaccine, for members 60 and older
I. HPV vaccine, for females and males up to age 26 years. Covered immunizations for children are identified in AMPM Chapter 400.

Immunizations for passport or visa clearance are not covered.

The Division does not require prior authorization for medically necessary immunization services performed by Fee-For-Service providers.
310-P MEDICAL EQUIPMENT, MEDICAL APPLIANCES AND MEDICAL SUPPLIES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy. The purpose of this policy is to outline requirements for coverage of medically necessary medical equipment, appliances and medical supplies. Medical equipment and appliances are often referred to as Durable Medical Equipment (DME).

Definitions

A. Medical Equipment and Appliances - Any item, appliance, or piece of equipment (pursuant to 42 CFR 440.70) that is not a prosthetic or orthotic, and meets all of the following requirements:
   1. Is customarily used to serve a medical purpose, and is generally not useful to a person in the absence of an illness, disability, or injury
   2. Can withstand repeated use
   3. Can be reusable by others or removable.

   For purposes of this policy, the term “medical equipment” refers to both medical equipment and appliances.

B. Medical Supplies - Supplies are health care-related items that are consumable or disposable, or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury [42 CFR 440.70].

C. Setting in Which Normal Life Activities Take Place - A setting other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Coverage Guidelines

A. The AdSS must cover medically necessary medical equipment and medical supplies (including incontinence briefs), under the home health services benefit, that are suitable for use in any setting in which normal life activities take place, as explained in this policy, when the following conditions are met:
   1. Provided at the member’s place of residence
   2. Ordered by the member’s physician as a part of the plan of care and is reviewed by the physician annually
   3. Authorized as required by the Division or the AdSS.
B. Medical equipment and medical supplies cannot be limited to members who are homebound.

C. Related Services, Devices, and Requirements:
   1. Nursing and home health aide home health services
   2. Rehabilitation Therapies (Occupational, Physical and Speech)
   3. Orthotic and Prosthetic Devices
   4. Prior Authorization Requirements
   5. Institutional Services and Settings.

D. Examples of medically necessary medical supplies and medical equipment are:
   1. Medical supplies – incontinence briefs, surgical dressings, splints, casts and other consumable items, which are not reusable, and are designed specifically to meet a medical purpose
   2. Medical equipment – wheelchairs, walkers, hospital beds, and other durable items that are rented or purchased.

Coverage Determinations

A. Coverage of medical equipment is not restricted to the items covered as durable medical equipment in the Medicare program. Coverage of medical equipment and supplies cannot be contingent upon the member needing nursing or therapy services.

B. The AdSS make timely determinations of coverage. The AdSS must not refuse to render a timely determination based on the member’s dual eligibility status or the providers’ contract status with the AdSS.

C. The following must be used in determining coverage of medical equipment and medical supplies:
   1. Services must be determined to be medically necessary, cost effective, and federally and state reimbursable.
   2. Services must be provided at the member’s place of residence and on the member’s physician’s orders as part of a plan of care.
   3. The member’s need for medical equipment and supplies must be reviewed by a physician annually. The frequency of further physician review for the member’s continuing need for services is determined on a case-by-case basis based on the nature of the prescribed item.
D. Services must be authorized, set up, and maintained to maximize the member’s independence and functional level in the most appropriate setting in which normal activities take place other than a hospital, nursing facility, ICF/IID, or any other setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

E. The AdSS must ensure the provider network includes a choice of vendors for customized medical equipment and corrective appliances for members with special healthcare needs. The AdSS must include, in the contract with the vendor, timeliness standards for creation, repair and delivery of customized equipment and appliances. The AdSS must monitor the standards and take action when the vendor is found to be out of compliance.

F. Medical equipment may be purchased or rented only when there are no reasonable alternative resources from which the medically necessary medical equipment can be obtained at no cost. Additionally, the total expense of rental cannot exceed the purchase price of the item.

G. Rental fees must terminate no later than the end of the month in which the member no longer needs the medical equipment, or when the member is no longer eligible or enrolled with the AdSS, except during transitions as specified by the Division’s Chief Medical Officer or designee.

H. Reasonable repairs or adjustment of purchased medical equipment are covered when necessary to make the equipment serviceable and when the cost of the repair is less than the cost of rental or purchase of another unit.

**Incontinence Briefs**

A. Incontinence Briefs for Members 21 years of age and older

Incontinence briefs, including pull-ups and incontinence pads, are covered when necessary to treat a medical condition. The Division may require prior authorization.

For ALTCS members 21 years of age and older, incontinence briefs, including pull-ups and incontinence pads, are also covered as specified in A.A.C. R9-28-202 in order to prevent skin breakdown when all the following are met:

1. The member is incontinent due to a documented medical condition that causes incontinence of bowel and/or bladder.

2. The Primary Care Provider (PCP) or attending physician has issued a prescription ordering the incontinence briefs.

3. Incontinence briefs – including pull-ups and incontinence pads – do not exceed 180 in any combination per month, unless the prescribing physician presents evidence of medical necessity for more than 180 per month.

4. The member obtains incontinence briefs from vendors within the AdSS’s network.
5. Prior authorization has been obtained as appropriate. AdSS must not require a new prior authorization to be issued more frequently than every 12 months.

B. Incontinence Briefs for Members under the Age of 21 Years
   a. AHCCCS covers incontinence briefs when necessary to treat a medical condition.
   b. In addition, AHCCCS also covers incontinence briefs for preventative purposes for members over the age of three and under 21 years of age as described in Division Medical Policy Manual, Policy 430 and A.A.C. R9-22-212.

Limitations

A. Except for incontinence briefs as specified in this policy, personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition.

B. First aid supplies are not covered unless they are provided in accordance with a prescription.
310-R   NURSING FACILITY SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division of Developmental Disabilities (Division) covers medically necessary services rehabilitative services provided in Nursing Facilities (NF) for members who are eligible for Arizona Long Term Care System (ALTCS) with acute medical needs and who need nursing care 24 hours a day but who do not require hospital care under the daily direction of a physician. NF service providers must be state licensed and Medicare certified. Religious nonmedical health care institutions are exempt from licensure or certification requirements. Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

See Chapter 1210 of this manual regarding Institutional Services for members who are ALTCS eligible.

The Division covers services for members who have acute medical needs and are eligible for ALTCS. The following requirements apply:

A. The medical condition of the member must be such that if NF services are not provided, hospitalization of the individual will result or the treatment is such that it cannot be administered safely in a less restrictive setting (i.e., home with home health services). While convalescent care should be considered short-term, the Contractor shall extend NF coverage as medically necessary. The AdSS must contact the Division by Day 45 of the member’s placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in Chapter 1210 of this manual, the AdSS must obtain approval from the Division.

B. For members enrolled in the ALTCS Transitional Program whose health status indicates that the member will likely require NF placement for longer than 90 days, the AdSS shall provide notification to the Division’s assigned Support Coordinator. The Support Coordinator shall notify AHCCCS for consideration of continued enrollment in the Transitional Program or a change to ALTCS status.

Services that are not covered separately when provided in an NF include:

A. Nursing services, including:
   1. Administration of medication
   2. Tube feedings
   3. Personal care services
   4. Routine testing of vital signs and blood glucose monitoring
   5. Assistance with eating
B. Basic patient care equipment and sickroom supplies such as bedpans, urinals, diapers, bathing and grooming supplies, walkers and wound dressings or bandages

C. Dietary services including, but not limited to, preparation and administration of special diets, and adaptive tools for eating

D. Administrative physician visits made solely for meeting state certification requirements

E. Non-customized durable equipment and supplies such as manual wheelchairs, geriatric chairs, and bedside commodes

F. Rehabilitation therapies ordered as a maintenance regimen

G. Administration, Medical Director Services, plant operations, and capital

H. Over-the-counter medications and laxatives

I. Social activity, recreational and spiritual services

J. Any other services, supplies or equipment that are state or county regulatory requirements or are included in the NF’s room and board charge.
310-V PREScription Medication/Pharmacy Services

EFFECTIVE DATE: October 1, 2019


This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division covers medically necessary, cost effective, and federally and state reimbursable medications prescribed by a physician, physician’s assistant, nurse practitioner, dentist, or other AHCCCS-registered practitioner, and dispensed by an Arizona Health Care Cost Containment System (AHCCCS)-registered licensed pharmacy, for members consistent with A.A.C. R9-22-201 et seq., R9-28-201 et seq., and R9-31-201 et seq. and for persons who have a diagnosis of Serious Mental Illness, pursuant to ARS § 36-550. At a minimum, items listed in the Division’s Formulary must be included as covered benefits for members who are eligible for ALTCS.

Psychotropic drugs for behavioral health symptoms must be covered according to AHCCCS Rules.

Prescriptions must be dispensed with a 30-day supply of medication, if authorized by the prescriber.

Pharmaceutical services must be available to members during customary business hours and must be located within reasonable travel distance.

Definitions

A. Adverse Drug Event (ADE) - An injury resulting from medical intervention related to a drug including harms that occur during medical care that are directly caused by the drug including but not limited to medication errors, adverse drug reactions, allergic reactions, and overdose.

B. AHCCCS Behavioral Health Drug List - A list of preferred behavioral health medications that are to be used by all contractors responsible for the administration of behavioral health pharmacy benefits, including but not limited to Long Term Care, Children’s Rehabilitative Services, and RBHAs, which are. This drug list is limited to federally and state reimbursable behavioral health medications that are supported by current evidence-based medicine. The AHCCCS Behavioral Health Drug List was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective behavioral health medications.

C. AHCCCS Drug List - A list of preferred drugs used by all contractors responsible for the administration of acute and long-term care pharmacy benefits. This drug list identifies specific federally and state reimbursable medications and related products, which are supported by current evidence-based medicine. The AHCCCS Drug List was developed to encourage the use of safe, effective, clinically appropriate, and the most cost-effective medications.
D. AHCCCS Drug Lists – Refers to both the AHCCCS Drug List and the AHCCCCS Behavioral Health Drug List

E. Biosimilar - A biological drug approved by the FDA based on a showing that it is highly similar to an FDA-approved biological drug, known as the reference product, and has no clinically meaningful differences in terms of safety and effectiveness from the reference product.

F. Generic Drug - A drug that contains the same active ingredient(s) as a brand name drug and the FDA has approved it to be manufactured and marketed after the brand name drugs patent expires. Generic drug substitution must be completed in accordance with Arizona State Board of Pharmacy rules and regulations.

G. Medication Error - The inappropriate use of a drug that may or may not result in harm; such errors may occur during prescribing, transcribing, dispensing, administering, adherence, or monitoring of a drug.

H. Non-Preferred Drug - A medication that is not listed on the AHCCCS Drug List or the AHCCCS Behavioral Health Drug List. Non-Preferred drugs require prior authorization.

I. Pharmacy and Therapeutics (P&T) Committee - The advisory committee to the AHCCCS Administration, which is responsible for developing, managing, updating, and administering the AHCCCS Drug List and AHCCCS Behavioral Health Drug List. The P&T Committee is primarily comprised of physicians, pharmacists, nurses, and other health care professionals.

J. Preferred Drug - A medication that has been clinically reviewed and approved by the AHCCCS P&T Committee for inclusion on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List as a preferred drug due to its proven clinical efficacy and cost effectiveness.

K. Serious Mental Illness (SMI) - A diagnosis of, a condition defined in A.R.S. § 36-550 and diagnosed in a person 18 years of age or older.

L. Step Therapy – The practice of initiating drug therapy for a medical condition with the most cost-effective and safest drug, and stepping up through a sequence of alternative drug therapies as a preceding treatment option.

**Drug Lists**

Each AdSS must maintain its own drug list to meet the unique needs of the members they serve. At a minimum, the AdSS’s drug list must include all drugs listed on the AHCCCS Drug Lists.

The AHCCCS Drug Lists are not all-inclusive lists of medications. AdSSs must cover all medically necessary, clinically appropriate, and cost-effective medications that are federally and state reimbursable regardless of whether these medications are included on these lists.
A. Preferred Drugs

The Division and its Administrative Services Subcontractors (AdSSs) must maintain preferred drug lists which include each and every drug exactly as listed on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List, as applicable. When the AHCCCS Drug List and/or AHCCCS Behavioral Health Drug List specify a preferred drug(s) in a particular therapeutic class, the Division and AdSSs are not permitted to add other preferred drugs to their preferred drug lists in those therapeutic classes.

The Division and AdSSs must inform their Pharmacy Benefit Managers (PBM) of the preferred drugs and must require the PBM to institute point-of-sale edits that communicate back to the pharmacy the preferred drug(s) of a therapeutic class whenever a claim is submitted for a non-preferred drug. Preferred drugs recommended by the AHCCCS P&T Committee and approved by AHCCCS will become effective on the first day of the first month of the quarter following the P&T Meeting unless otherwise communicated by AHCCCS.

AdSSs must approve the preferred drugs listed for the therapeutic classes contained on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List, as appropriate, before approving a non-preferred drug, unless:

a. The member has previously completed step therapy using the preferred drug(s), or

b. The member’s prescribing clinician supports the medical necessity of the non-preferred drug over the preferred drug for the particular member.

The Division and AdSSs are not required to provide a Notice of Adverse Benefit Determination when the prescribing clinician is in agreement with the change to the preferred drug. A prior authorization request may be submitted for the non-preferred drug when the prescribing clinician is not in agreement with transition to the preferred drug. The Division and AdSSs must issue a Notice of Adverse Benefit Determination in accordance with Division Operations Manual Policy 414 for Service Authorizations when a prior authorization request is denied or a previously approved authorization is terminated, suspended, or reduced.

B. Grandfathering of Non-preferred Drugs

Grandfathering of non-preferred drugs refers to the continued authorization of non-preferred drugs for members who are currently using non-preferred drugs without having completed step therapy of the preferred drug(s) on the AHCCCS Drug List and/or the AHCCCS Behavioral Health Drug List, as appropriate.

The AHCCCS P&T Committee makes recommendations to AHCCCS on the grandfathering status of each non-preferred drug for each therapeutic class reviewed by the committee. When the status of a non-preferred drug is changed and has been approved for grandfathering, the Division and AdSSs must grandfather members on these medications.
C. Prior Authorization

1. The AHCCCS Behavioral Health Drug List

The Division uses the AHCCCS Behavioral Health Drug List, which specifies the medications that require Prior-Authorization (PA). The Division and AdSSs must apply the same PA criteria as those specified on the AHCCCS website for medications listed on the AHCCCS Behavioral Health Drug List that require prior authorization prior to dispensing the medication. When a medication on the AHCCCS Behavioral Health Drug List is subject to PA but no PA criteria are specified, the Division and AdSSs may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice that include, but are not limited to, all of the following:

a. Food and Drug Administration (FDA) approved indications and limits
b. Published practice guidelines and treatment protocols
c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
d. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
e. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up To Date).

The Division and AdSSs are prohibited from adding prior authorization and/or step therapy requirements to medications listed on the AHCCCS Behavioral Health Drug List when the list does not specify these requirements.

For those behavioral health medications that are non-preferred drugs and not listed on the AHCCCS Behavioral Health Drug List, the Division and AdSSs must evaluate the submitted prior authorization request on an individual basis.

**All federally and state reimbursable drugs that are not listed on the AHCCCS Behavioral Health Drug List or AdSSs’ drug lists must be available through the prior authorization process.**

2. The AHCCCS Drug List

The Division and AdSSs administering the pharmacy benefit using the AHCCCS Drug List are responsible for establishing prior authorization criteria for medications which require prior authorization as identified on the AHCCCS Drug List with the exception of Smoking Cessation medications and Direct Acting Antiviral Hepatitis C medications. The Division and AdSSs must follow the criteria developed by AHCCCS for Smoking Cessation medications and for Direct Acting Antiviral Hepatitis C medications.
For all other medications subject to PA, the Division and AdSSs may elect to establish PA criteria based on clinical appropriateness, scientific evidence, and standards of practice, that include, but are not limited, to all of the following:

a. FDA approved indications and limits
b. Published practice guidelines and treatment protocols
c. Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
d. Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
e. Drug reference resources (e.g. Micromedex, Drug Facts and Comparisons, Up To Date).

In addition, for medications that are non-preferred drugs and not listed on the AHCCCS Drug List, the Divisions and AdSSs must evaluate the submitted prior authorization request on an individual basis.

The Division and AdSSs must not add prior authorization and/or step therapy requirements to medications listed on the AHCCCS Drug List when the list does not identify the medication as being subject to prior authorization or step therapy.

All federally and state reimbursable drugs that are not listed on the AHCCCS Drug List or contractors’ drug lists must be available through the prior authorization process.

A medication must not be denied solely due to the lack of a FDA indication. Off-label prescribing may be clinically appropriate as outlined above in C.2.b through e.

The Division and AdSSs must cover medically necessary federally and state reimbursable behavioral health medications for persons who are Title XIX, Title XXI, and for persons who are SMI, regardless of whether or not they are eligible for Title XIX. It is not a basis to deny coverage of a medically necessary medication when the member’s insurer, other than Medicare Part D, refuses to approve the request or appeal for a medication listed on the AHCCCS Behavioral Drug List.

D. Requests for Changes to the AHCCCS Drug

Requests for medication additions, deletions or other changes to the AHCCCS Drug Lists must be reviewed by the AHCCCS P&T Committee. Requests must be submitted no later than 60 days prior to the AHCCCS P&T Meeting to the AHCCCS Pharmacy Department email at: AHCCCSSPharmacyDept@azahcccs.gov
The request must include all of the following information:

a. Name of medication requested (brand name and generic name)
b. Dosage forms, strengths and corresponding costs of the medication requested
c. Average daily dosage
d. FDA indication and accepted off-label use
e. Advantages or disadvantages of the medication over currently available products on the AHCCCS Drug List
f. Adverse Drug Events reported with the medication
g. Specific monitoring requirements and costs associated with these requirements
h. A detailed clinical summary.

E. Quantity Limits/Step Therapy

For all preferred drugs on the AHCCCS Drug List and the AHCCCS Behavioral Health Drug List, the contractor must adopt the quantity limits and step therapy requirements exactly as presented in the AHCCCS Drug List and the AHCCCS Behavioral Health Drug List.

Step Therapy programs apply coverage rules at the point of service when a claim is adjudicated. If a claim is submitted for a second-line drug, which is a medication that is not the first drug normally used to treat a condition, the claim will reject. A message is transmitted to the pharmacy stating that the first-line drug treatment must be tried before coverage of the second-line drug can be authorized unless there is a clinical justification for not using the first line drug.

The Division and AdSSs are not required to provide a Notice of Adverse Benefit Determination when the prescribing clinician is in agreement with the change to the first-line drug. A prior authorization may be submitted for the second-line drug when the prescribing clinician is not in agreement with the transition request to the first-line drug. The Division and AdSSs must issue a Notice of Adverse Benefit Determination in accordance with Division Policy for Service Authorizations when a prior authorization request is denied, or a previously approved authorization is terminated, suspended, or reduced.
F.  Generic and Biosimilar Drug Substitutions

1.  The Division and AdSSs must use a mandatory generic drug substitution policy that requires the use of a generic equivalent drug whenever one is available. The exceptions to this requirement are:
   a. A brand name drug may be covered when a generic equivalent is available when the contractor’s negotiated rate for the brand name drug is equal to or less than the cost of the generic drug.
   b. AHCCCS may require the Division and AdSSs to provide coverage of a brand name drug when the cost of the generic drug has an overall negative financial impact to the state. The overall financial impact to the state includes consideration of the federal and supplemental rebates.

2. Prescribing clinicians must clinically justify the use of a brand-name drug over the use of its generic equivalent through the prior authorization process.

3. Generic and biosimilar substitutions must adhere to Arizona State Board of Pharmacy rules and regulations.

4. The Division and AdSSs must not transition to a biosimilar drug until AHCCCS has determined that the biosimilar drug is overall more cost-effective to the state than the continued use of the brand name drug.

G. Behavioral Health Medication Coverage

1. Behavioral Health Medications Prescribed by the Primary Care Provider (PCP) for the Treatment of Anxiety, Depression and Attention Deficit Hyperactivity Disorder (ADHD)

   The Division and AdSSs must provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat depression (including postpartum depression), anxiety and ADHD; this includes the monitoring and adjustments of behavioral health medications.

2. Behavioral Health Medication Coverage for AHCCCS Members Transitioning from a Behavioral Health Medical Professional (BHMP) to a PCP.

   Members transitioning from a BHMP to a PCP for their behavioral health medication management must be continued on the medication(s) prescribed by the BHMP until they transition to their PCP. The Division and AdSS must coordinate the care and ensure that the member has a sufficient supply of behavioral health medications to last through the date of the member’s first appointment with their PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services from the TRBHA.
H. Over-The-Counter Medication

The Division and AdSSs may cover an over-the-counter medication under the pharmacy benefit when it is prescribed in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and more cost effective than the covered prescription medication.

I. Prescription Drug Coverage Limitations

1. A new prescription or refill prescription in excess of a 30-day supply or a 100-unit dose is not covered, unless any of the following apply:
   a. The medication is prescribed for a chronic illness and the prescription is limited to no more than a 100-day supply or 100-unit dose, whichever is greater.
   b. The member will be out of the provider’s service area for an extended period of time and the prescription is limited to the extended time period, not to exceed 100 days or 100-unit dose, whichever is greater.
   c. The medication is prescribed for contraception and the prescription is limited to no more than a 100-day supply.

2. Prescription drugs for covered transplantation services will be provided in accordance with AHCCCS transplantation policies.

J. Prior Authorization (PA) Requirements for Long-Acting Opioid Medications

PA is required for all prescriptions for long-acting opioid medications. The prescriber must obtain PA for all prescriptions for long-acting opioid medications from the Division.

K. 5-Day Supply Limit of Prescription Opioid Medications-Contractor Requirements

1. Members under 18 years of age
   a. Except as otherwise specified in Section K(1)(b), Conditions and Care Exclusion from the 5-day Supply Limitation of this policy, a prescriber must limit the initial and refill prescriptions for any short-acting opioid medication for a member under 18 years of age to no more than a 5-day supply.

   An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member’s Pharmacy Benefit Management (PBM) prescription profile.
b. Conditions and Care Exclusion from the 5-day Supply Limitation

i. The initial and refill prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Children on opioid wean at time of hospital discharge
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures
- Chronic conditions for which the provider has received PA approval from the Division.

ii. The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for post-surgical procedures. However, initial prescriptions for short-acting opioid medications for post-surgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post-surgical procedures are limited to no more than a 5-day supply.

2. Members 18 years of age and older

a. Except as otherwise specified in Section K(2)(b), Conditions and Care Exclusion from the 5-day Supply Limitation of this policy, a prescriber must limit the initial prescription for any short-acting opioid medication for a member 18 years of age and older to no more than a 5-day supply.

An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member’s Pharmacy Benefit Management (PBM) prescription profile.
b. Conditions and Care Exclusion from the 5-day Initial Supply Limitation

The **initial** prescription 5-day supply limitation for short-acting opioid medications *does not* apply to prescriptions for the following conditions and care instances:

i. Active oncology diagnosis

ii. Hospice care

iii. End-of-life care (other than hospice)

iv. Palliative care

v. Skilled nursing facility care

vi. Traumatic injury, excluding post-surgical procedures

vii. Post-surgical procedures. Initial prescriptions for short-acting opioid medications for post-surgical procedures are limited to a supply of no more than 14 days.

L. AHCCCS Pharmacy Benefit Exclusions

The following are excluded from the pharmacy benefit:

1. Medication prescribed for the treatment of a sexual or erectile dysfunction, unless:
   a. The medication is prescribed to treat a condition other than a sexual or erectile dysfunction
   
   b. The Food and Drug Administration has approved the medication for the specific condition.

2. Medications that are personally dispensed by a physician, dentist, or other provider except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.

3. Drugs classified as Drug Efficacy Study Implementation (DESI) drugs by the Food and Drug Administration

4. Outpatient medications for members under the Federal Emergency Services Program

5. Medical Marijuana (refer to Division Medical Policy Manual, Policy 320-M in this manual)

6. Drugs eligible for coverage under Medicare Part D for AHCCCS members eligible for Medicare whether or not the member obtains Medicare Part D coverage
7. Experimental medications

8. Automatically refilled prescriptions.

Pharmacies are prohibited from auto-filling prescription medications.

M. Return of and Credit for Unused Medications

The Division and AdSSs must require the return of unused medications to the outpatient pharmacy from Nursing Facilities (NFs) upon the discontinuance of prescriptions due to the transfer, discharge, or death of a member. A payment/credit reversal must be issued for unused prescription medications by the outpatient pharmacy to the AHCCCS Administration or the appropriate AHCCCS contractor. The pharmacy may charge a reasonable restocking fee as agreed upon with the AHCCCS Administration and its contractors. The return of unused prescription medication must be in accordance with federal and state laws. A.A.C. R4-23-409 allows for this type of return and the redistribution of medications under certain circumstances. Documentation must be maintained and must include the quantity of medication dispensed and used by the member. A credit must be issued to the AHCCCS Administration, if the member is enrolled in the American Indian Health Plan/TRBHA/Fee-For-Service (AIHP/FFS) Program, or to the member’s contractor for members who are not FFS when the unused medication is returned to the pharmacy for redistribution.

N. Discarded Physician-Administered Medications

Discarded federally and state reimbursable physician-administered medications must not be billed to the Division or its contractors. A.A.C. R9-22-209(C) provides that pharmaceutical services are covered only if they are prescribed. The unused portion of a physician administered drug is not covered because it is not medically necessary or prescribed.

A.R.S. §36-2918(A)(1) prohibits a person from making a claim for an item or service that the person knows or has reason to know was not provided as claimed.

A.R.S. §36-2918(A)(3)(b) prohibits a person from submitting a claim for items and services that substantially exceed the needs of the patient.

O. Prior Authorization Criteria for Smoking Cessation Aids


P. Prior Authorization Criteria for Direct Acting Antiviral Treatment for Hepatitis C

See Division Medical Policy Manual, Policy320-N.

Q. Vaccines and Emergency Medications Administered by Pharmacists to Persons Age 18 Years and Older

Vaccines and emergency medication are covered, without a prescription order when administered by a pharmacist who is currently licensed and certified by the Arizona
State Board of Pharmacy consistent with the limitations of this policy and state law A.R.S. § 32-1974.

1. For purposes of this section “Emergency Medication” means emergency epinephrine and diphenhydramine. “Vaccines” are limited to pneumococcal and influenza vaccines.

2. The pharmacy providing the vaccine must be an AHCCCS-registered provider. Indian Health Service and 638 facilities may bill the outpatient all-inclusive rate for pharmacist vaccine administration as noted in Section L of this policy.

3. Contractors retain the discretion to determine the coverage of vaccine administration by pharmacists and coverage is limited to the Division and AdSS’s network pharmacies.

R. 340B Reimbursement

A.A.C. R9-22-710 (C) describes the reimbursement methodology to be used by AHCCCS and its contractors for Federally Qualified Health Center (FQHC) and FQHC Look-Alike Pharmacies for 340B drugs as well as reimbursement for Contract Pharmacies that have entered into a 340B drug purchasing arrangement with any 340B entity. The Rule also specifies reimbursement for FQHC and FQHC Look-Alike Pharmacies for drugs, which are not part of the 340B Drug Pricing program. This rule is located on the AHCCCS Website.

S. Pharmaceutical Rebates

The contractor, including the contractor’s PBM, is prohibited from negotiating any rebates with drug manufacturers for preferred or other pharmaceutical products when AHCCCS has a supplemental rebate contract for the product(s). A listing of products covered under supplemental rebate agreements will be available on the AHCCCS website under the Pharmacy Information section. If the contractor or its PBM has an existing rebate agreement with a manufacturer, all outpatient drug claims, including provider-administered drugs for which AHCCCS is obtaining supplemental rebates, must be exempt from such rebate agreements.

T. Informed Consent

Informed consent must be obtained from the member and/or legal guardian for each psychotropic medication prescribed. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for medication are contained within this policy manual. 310-V-Attachment A is recommended as a tool to document informed consent for psychotropic medications.
310-DD COVERED TRANSPLANTS AND RELATED IMMUNOSUPPRESSANT MEDICATIONS

EFFECTIVE DATE: October 1, 2019


This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy.

Federal law 42 U.S.C. 1396b (i) and 42 CFR 441.35 describe general requirements for Title XIX coverage of transplants. For adults, organ transplant services are not mandatory covered services under Title XIX, and each state has the discretion to choose whether or not transplants will be available to members. The AHCCCS Administration, as the single state agency, has the authority under federal law to determine which transplant procedures, if any, will be reimbursed as covered services.

In contrast to transplant coverage for persons age 21 years and older, the Early and Periodic Screening Diagnostic and Treatment (EPSDT) Program for individuals under age 21 covers all non-experimental transplants necessary to correct or ameliorate defects, illnesses and physical conditions. Transplant members under age 21 eligible ALTCS Program are covered when medically necessary irrespective of whether or not the particular non-experimental transplant is specified as covered in the AHCCCS State Plan.

The Division covers the specific medically necessary transplantation services and related immunosuppressant medications as described in this policy.

The solid organ and tissue transplant services described in this policy, including the relevant standards of coverage, are referenced in the AHCCCS State Plan. The AHCCCS State Plan is the document approved by the federal government which outlines the eligibility requirements and covered services for the AHCCCS program.

Transplants must be medically necessary, cost effective, federally reimbursable, and state reimbursable. Arizona State laws and regulations specifically address transplant services and related topics, as follows:

A. Specific non-experimental transplants approved for Title XIX reimbursement are covered services (A.R.S. §36-2907).

B. Services which are experimental, or which are provided primarily for the purpose of research are excluded from coverage (A.A.C. R9-22-202).

C. Medically necessary is defined as those covered services “provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse health conditions, or their progression, or prolong life” (A.A.C. R9-22-101).

D. Experimental services are as described in R9-22-203.
E. Standard of care is defined as “a medical procedure or process that is accepted as treatment for a specific illness, injury or medical condition through custom, peer review or consensus by the professional medical community” (A.A.C. R9-22- 101).

F. The AHCCCS Administration consulted with transplant experts to identify criteria for transplant coverage consistent with the current body of medical literature, including United Network for Organ Sharing (UNOS) clinical standards for solid organ transplant procedures, the Foundation for the Accreditation of Cellular Therapy (FACT) and peer-reviewed articles in medical journals published in the United States.

G. For persons ages 21 years and older, transplantation coverage is limited to the specific transplant types set forth in this policy. All other transplant types for persons ages 21 years and older are excluded from AHCCCS reimbursement. This policy includes criteria, indications and relative contraindications and absolute contraindications for each covered transplant type. Unless a contraindication is explicitly described as an absolute contraindication, the contraindication is a relative contraindication. However, these may change as a result of advances in medical treatment and technological innovation. The presence of an absolute contraindication precludes authorization for a transplant.

H. The AdSS must consult current authoritative medical sources to determine whether a transplant covered under this policy is medically necessary, cost-effective, non-experimental, and not primarily for purposes of research. The AdSS must provide the medical justification for the decision that is made. The AdSS has access to and may consult with the transplantation management entity (AHCCCS consultant) under contract with AHCCCS. Although the AdSS is encouraged to consult with the AHCCCS consultant for guidance in those cases requiring such medical determinations, the AdSS is not required to do so. AdSSs not using the AHCCCS consultant must obtain their own expert opinion.

Definitions

A. **Absolute Contraindication** – A condition or circumstance that if present precludes authorization of a transplant regardless of any other considerations.

B. **Close Proximity** - means within the geographic service area.

C. **Emergent Fulminant Hepatic/Liver Failure** - Liver failure that occurs suddenly in a previously healthy person. The most common causes are acute hepatitis, acetaminophen overdose, and liver damage from prescription drugs.

D. **Experimental service** – Refer to AHCCCS Rule R9-22-203. This rule provides, in part: Experimental services are not covered. A service is not experimental if:

1. It is generally and widely accepted as a standard of care in the practice of medicine in the United States and is a safe and effective treatment for the condition for which it is intended or used.

2. The service does not meet the standard in (1), but the service has been demonstrated to be safe and effective for the condition for which it is
intended or used based on the weight of the evidence in peer-reviewed articles in medical journals published in the United States.

3. The service does not meet the standard in (2) because the condition for which the service is intended or used is rare, but the service has been demonstrated to be safe and effective for the condition for which it is intended or used based on the weight of opinions from specialists who provide the service or related services.

E. Hematopoietic Stem Cell Transplants (HSCT) - The transplantation of blood stem cells derived from the bone marrow or peripheral blood, including cord blood. Conditioning therapy includes either myeloablative or non-myeloablative induction with or without Total Body Irradiation (TBI).

F. Relative Contraindications – A condition or circumstance that must be considered on a case-by-case basis to determine if a transplant will be authorized.

Description of Policy

This policy sets forth criteria, including indications and contraindications, for determining whether transplant services are medically necessary, cost effective, non-experimental, and not primarily for purposes of research. Contraindications are conditions which may significantly adversely impact the outcome of the transplant. They are not regarded as an absolute bar to transplantation. Contraindications must be evaluated along with all other relevant factors to determine whether the transplant service is medically necessary, non-experimental, and not primarily for purposes of research in each particular case.

The AdSS must consult with the Division’s Medical Director prior to denying the authorization for transplant of the heart, heart/lung, and liver.

Transplant Services and Settings

Transplant services are covered only when performed in specific settings:

A. Solid organ transplantation services must be provided in a CMS certified and UNOS approved transplant center which meets the Medicare conditions for participation and special requirements for transplant centers delineated in 42 CFR Part 482.

B. Hematopoietic stem cell transplant services must be provided in a facility that has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation. The facility must also satisfy the Medicare conditions of participation and any additional federal requirements for transplant facilities.

Transplantation related services and immunosuppressant drugs are not covered services for individuals in the Federal Emergency Services (FES) Program, pursuant to 42 U.S.C. 1396b(v)(3) and A.A.C. R9-22-206. Persons who qualify for transplant services, but who are later determined ineligible under A.R.S. 36-2907.10 due to excess income may qualify for extended eligibility (refer to AHCCCS Medical Policy 310-DD, Attachment A, Extended Eligibility Process/Procedure for Covered Solid Organ and Tissue Transplants).
Assessment for Transplant Consideration

The first step for transplant consideration is the initial assessment by the member’s Primary Care Provider (PCP) and/or the specialist treating the condition necessitating the transplant. In determining whether the member is appropriate for referral for transplant consideration, the PCP/specialist must determine that all of the following conditions are satisfied:

A. The member will be able to attain an increased quality of life and chance for long-term survival as a result of the transplant.

B. There are no significant impairments or conditions that would negatively impact the transplant surgery, supportive medical services, or inpatient and outpatient post-transplantation management of the member.

C. There are strong clinical indications that the member can survive the transplantation procedure and related medical therapy (e.g., chemotherapy, immunosuppressive therapy).

D. There is sufficient social support to ensure the member’s compliance with treatment recommendations such as, but not limited to, immunosuppressive therapy, other medication regimens and pre- and post-transplantation physician visits. For a pediatric/adolescent member, there is adequate evidence that the member and parent/guardian will adhere to the rigorous therapy, daily monitoring and re-evaluation schedule after transplant.

E. The member has been adequately screened for potential co-morbid conditions that may impact the success of the transplant. When the member’s medical condition is such that the evaluation must proceed immediately, the screenings may be provided by the PCP concurrent with the transplant evaluation.

F. The member’s condition has failed to improve with all other conventional medical/surgical therapies. The likelihood of survival with transplantation, considering the member’s diagnosis, age and comorbidities, is greater than the expected survival rate with conventional therapies. This information must be documented and submitted to the Division or the AdSS at the time of request for evaluation.

AHCCCS Covered Solid Organ and Hematopoietic Stem Cell Transplants

The Division covers solid organ and hematopoietic stem cell transplants covered services when medically necessary, cost effective, non-experimental, and not primarily for purposes of research. Live donor/kidney transplants are covered for pediatric and adult members.

Live donor transplants may be considered on a case-by-case basis for solid organs other than kidney when medically appropriate and cost effective. However, if a live donor transplant is approved for a non-kidney transplant, any costs related to the donor must not be separately reimbursed by AHCCCS or the Division, and no additional payment for the donor must be made unless the donor is AHCCCS eligible. Payment by AHCCCS and the Division for both the transplant recipient and the donor associated with non-kidney transplant services is limited to payment for the transplant and transplant-related services.
component during the 60-day post-transplant timeframe. Refer to the terms of the transplant contract for detailed information about coverage and payment for transplants and transplant-related services. For any additional charges, the living donor must accept the terms of financial responsibility for the charges associated with the transplant in excess of any payments under the transplant contract. Detailed criteria regarding specific transplants are found under the heading “Solid Organ and Related Devices: Specific Indications and Contraindications/Limitations.”

The following transplants are covered subject to the terms of this policy:

<table>
<thead>
<tr>
<th>Transplant Type</th>
<th>Covered For ALTCS Members * (Under Age 21)</th>
<th>Covered For Adult Members Eligible For ALTCS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Solid Organs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lung (single and double)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Heart/Lung</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Liver</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Kidney (cadaveric and live donor)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Simultaneous Liver/Kidney (SLK)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Simultaneous Pancreas/Kidney (SPK)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pancreas After Kidney (PAK)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pancreas Only</td>
<td>X</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Visceral Transplantation</td>
<td>X</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Intestine alone</td>
<td>X</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Intestine with pancreas</td>
<td>X</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Intestine with liver</td>
<td>X</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Intestine, liver, pancreas en bloc</td>
<td>X</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Partial pancreas (including islet cell transplants)</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Hematopoietic Stem Cell Transplants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allogeneic Related</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Allogeneic Un-related</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Autologous</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tandem Hematopoietic Stem Cell Transplant (HSCT)</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

*All other medically necessary, non-experimental transplants for members under the age of 21 are covered.

Other transplants and devices included in this policy are:

A. Circulatory Assist Device (CAD) is a covered service when used as a bridge to
transplantation and other specific criteria are met. Refer to “Solid Organ Transplants and Related Devices: Specific Indications and Contraindications/Limitations” within this policy section for more details.

B. Bone grafts and corneal transplants are covered services.

Coverage of transplantation services includes the following, as required by the specific type of transplant:

A. For the transplant candidate:

1. Donor search, human Leukocyte Antigens (HLA) typing, and harvest as necessary for stem cell transplants

2. Pre-transplant evaluation (inpatient or outpatient), which includes, but is not limited to:
   a. Physical examination
   b. Psychological and social service evaluations
   c. Laboratory studies
   d. X-ray and diagnostic imaging
   e. Biopsies

3. Pre-transplant dental evaluation and treatment of oral infection as described in Division Medical Policy 310-D, Exception for Transplant and Cancer Cases. Other dental services, including, but not limited to, restorative and cosmetic dentistry, will not be covered

4. Medically necessary post-transplant care (inpatient and outpatient), which may include, but is not limited to:
   a. Laboratory studies
   b. X-rays and diagnostic imaging
   c. Biopsies
   d. Home health
   e. Skilled Nursing Facility placement
   f. All related medications, including immunosuppressants

   Note: The Division is the secondary payer of immunosuppressant medications if the member is also a Medicare beneficiary and is eligible to receive the immunosuppressant medications under Medicare Part B. Drugs covered under Medicare Part D are not covered for Division members eligible for Medicare whether or
not the member receives Medicare Part D coverage. Refer to Division Medical Policy 310-V, Prescription Medication/Pharmacy Services.

5. Transportation, room, and board for the transplant candidate and, if needed, one adult care giver as identified by the transplant facility, to and from medical treatment during the time it is necessary for the member to remain in close proximity to the transplant center. This includes the evaluation, ongoing testing, transplantation, and post-transplant care by the transplant center.

B. For the donor:

Services are covered only when provided in the United States and are limited to the following:

a. Evaluation and testing for suitability
b. Kidney donor procurement or stem cell procurement, processing and storage.
c. Transportation, room and board to determine if the donor is a match or to donate either stem cells or organs under the transplant recipient's benefit.

Refer to the contract for detailed information regarding coverage and payment for transplants and transplant-related services. Transplants and transplant related services are limited to coverage through day 60 post-transplant surgery for non-kidney transplants or, in the case of kidney transplants, through day ten post kidney transplant. Complications for the transplant recipient or donor arising from the transplant surgery during the 60/10 post-transplant timeframe are considered transplant related and covered under the scope of the follow up care component(s).

Payment for the 60/10 follow-up care component represents payment for services for both the recipient and the donor, and no additional reimbursement must be made except as specified below for complications extending beyond the 60/10 timeframe.

Complications extending beyond day 60/10 are covered for the recipient if the recipient is AHCCCS eligible and the services are medically necessary and covered. Complications for the donor beyond day 60/10 are covered only if the donor is AHCCCS eligible at the time the complication arises and the services are medically necessary and covered.

Contraindications for All Transplants

Contraindications to solid organ and hematopoietic stem cell transplantation include, but are not limited to:

A. History of non-compliance or psychiatric condition(s) such that there is an inability to comply with post-transplant protocol

B. HIV positive status and viral load – members whose HIV status makes them ineligible for coverage of transplantation have the potential to seek transplant in one
of the National Institute of Health’s approved sites. These transplants are subject to the section of this described in the section of this policy entitled “Medically Necessary Services for Members who receive Transplants that are Not Covered.”

C. For solid organ transplants, active malignancy or prior metastatic malignancy within the past five years, other than localized cutaneous basal cell or squamous cell cancers, is an absolute contraindication. The five-year time frame for malignancy does not apply to liver transplants for hepatocellular carcinoma. For stem cell transplants, active or prior metastatic solid tumors malignancy within the past five years, other than localized cutaneous basal cell or squamous cell cancer, is a contraindication.

D. The failure of more than two organs. This does not include instances where the failure of one organ is secondary to the failure of another organ.

E. Presence of active uncontrolled infection or systemic infection (sepsis) at the time of transplant is an absolute contraindication.

F. Active substance abuse or history of substance abuse in the last six months (if there is an urgent need, evaluation may be allowed on a case-by-case basis).

G. Lack of a psychosocial support system, which, based on the member’s condition and general health, would place the success of the transplant at risk.

H. Non-adherence with previous or current treatment protocols that has resulted in the failure of a previously transplanted organ is a contraindication to re-transplantation.

**General Medical Conditions That Must Be Considered**

The general medical conditions that must be evaluated prior to transplant to determine whether a particular transplant is medically necessary, cost effective, non-experimental, and not primarily for purposes of research include, but are not limited to:

A. When a transplant consultation is requested, the AdSS will approve a drug and alcohol screen to be done at the requesting transplant center for all members 21 years of age and older.

B. For members with a history of substance abuse within the past three years, the member must provide a certificate of completion of a 12-month substance abuse program which has been approved by the Administration prior to determination for the transplant evaluation. For members with a history of substance abuse greater than three years from the date of the transplant consultation request, attendance in an approved substance abuse program may be waived. Members with a history of substance abuse within the past three-year timeframe must have a total of three consecutive negative random screens prior to the evaluation. In addition, the member will be monitored with random and repeated alcohol and drug screenings during the assessment process up to the time of the transplant. At the time of transplant evaluation, members with a history of substance abuse within the prior three-year timeframe must sign an agreement which states they will enroll in a post-transplant substance abuse program that will continue for a
continuous 12-month timeframe.

C. It is within the AdSS’s discretion to require a psychosocial assessment be completed prior to referral for transplant evaluation.

D. Any history of post-transplant substance abuse will exclude a member from further transplant procedures.

**Solid Organ Transplants and Related Devices: Specific Indications And Contraindications/Limitations**

**Heart Indications**

Prior to listing heart transplant, all other medical and/or surgical alternatives for correction and/or management of the underlying heart conditions(s) must either have been optimized or ruled out as a viable treatment option(s).

Criteria for medical necessity of heart transplantation include, but are not limited to, the following indications:

A. Left ventricular systolic dysfunction of any etiology

B. Valvular disease with left systolic dysfunction, unable to be surgically corrected

C. Congenital cardiac disease that has failed prior correction

D. Sarcoidosis

E. Drug-induced myocardial destruction due to prescription medication

F. Ischemic cardiomyopathy with a New York Heart Association Class III or IV cardiac disease when surgical or medical therapy is not likely to be effective and estimated survival is less than six to 12 months without a transplant.

G. Hypertrophic cardiomyopathy

H. Uncontrollable life-threatening arrhythmias

I. Refractory angina unresponsive to maximal medical and/or surgical therapy.

**Contraindications**

In addition to the contraindications noted in “Contraindication for All Transplants” section of this policy, the following are contraindications to heart transplantation:

A. Severe Pulmonary hypertension - inability to achieve Pulmonary Vascular Resistance (PVR) of <2.5 Wood units and/or a 15 mm Hg transpulmonary gradient on maximal medical therapy including vasodilators or inotropic medications; these patients may instead be candidates for heart-lung transplantation

B. Acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of one or more vital end-organs
C. Recent (within past six months) intracranial vascular disease or prior stroke with severe deficits

D. Severe peripheral vascular disease unable to be corrected surgically

E. Chronic obstructive pulmonary disease or chronic bronchitis

F. Recent and/or unresolved pulmonary infarction or pulmonary embolus

G. The need for or prior transplantation of another organ such as lung, liver, kidney or hematopoietic transplants

H. Autoimmune diseases or collagen vascular diseases are relative contraindications depending on the disease, severity, and predicted lifespan

I. Insulin-dependent diabetes mellitus with end-organ disease (e.g., peripheral vascular/arterial disease, retinopathy, neuropathy, or nephropathy)

J. Active peptic ulcer disease

K. Chronic inflammatory bowel disease

L. Hepatic insufficiency

M. Amyloidosis

N. Age over 70

O. HIV positive

P. Morbid obesity with Body Mass Index (BMI) of 35 kg/m².

**Circulatory Assistive Device (CAD) Formerly Known As Ventricular Assist Devices (VAD) And Total Artificial Hearts (TAH)**

The Division covers Circulatory Assist Devices (CADs) that support heart function as a bridge to heart transplant only, for eligible members when medically necessary, cost effective, non-experimental, not primarily for purposes of research, and when the device is used in accordance with the Food and Drug Administration (FDA) approved labeling instructions.

For purposes of this policy, Circulatory Assist Devices are defined as VADS and Total Artificial Hearts (TAH). TAH may be used in lieu of bi-VAD when clinically appropriate and cost effective.

AHCCCS-contracted transplant center surgeons use their skill and judgment to select the appropriate assist device, based on all of the following:

A. Degree and presentation of cardiac insufficiency

B. Size of recipient
C. Device capability.

**CAD Criteria**

Medical necessity for CADs as a bridge to transplant is based on the following criteria:

**Adult Member**

The potential adult recipient must meet **all** of the following:

A. Is actively listed for cardiac transplantation

   Note: If a member is on the inactive transplant list due to a temporary medical complication (e.g., Status 7) and undergoes placement of a VAD or Total Heart, separate payment for those devices is only made if the patient returns to active status and is medically able to undergo a transplant should an organ become available. Medical records must indicate resolution of the temporary medical condition and show Active status for transplant with UNOS. If the patient never returns to active status, the device is not paid for separately, but payment continues to be made for medical management of the patient, and

B. Is experiencing end stage heart failure with progressive failure to respond to medical management and meets the definition of cardiogenic shock according to the New York Heart Association (NYHA) functional classification system.

**Pediatric Member**

The potential pediatric recipient must meet **all** of the following:

A. Is actively listed for cardiac transplantation

   Note: If a member is on the inactive transplant list due to a temporary medical complication (e.g., Status 7) and undergoes placement of a VAD or Total Heart, separate payment for those devices is only made if the patient returns to active status and is medically able to undergo a transplant should an organ become available. Medical records must indicate resolution of the temporary medical condition and show active status for transplant with UNOS. If the patient never returns to active status, the device is not paid for separately, but payment continues to be made for medical management of the patient.

B. Age restrictions established by the FDA for the particular device used

C. Is in New York Heart Association class III or IV end-stage heart failure

D. Is refractory to medical therapy.
**Contraindications**

Contraindications to successful CAD placement and subsequent recovery include, but are not limited to:

A. Severe lung disease, except as appropriate for heart-lung transplantation (refer to the sections pertaining to lung and heart-lung transplantation in this policy)

B. Malignant disease

C. Stroke or refractory hypertension

D. Chronic pulmonary embolism or recent pulmonary infarction, except as appropriate for heart-lung transplantation (refer to the sections pertaining to lung and heart-lung transplantation in this policy)

E. Active infection

F. Irreversible disease of a major organ system, or

G. Critical psychosocial conditions, behaviors or problems in adherence to a disciplined medical regimen which preclude a positive transplant outcome.

**Lung Indications**

Criteria for medical necessity for lung transplantation include, but are not limited to, the following indications:

A. Alpha-1 antitrypsin deficiency

B. Primary pulmonary hypertension

C. Pulmonary fibrosis, idiopathic pulmonary fibrosis

D. Bilateral bronchiectasis

E. Cystic fibrosis (both lungs to be transplanted)

F. Bronchopulmonary dysplasia

G. Eisenmenger's syndrome

H. Sarcoidosis lung involvement

I. Scleroderma

J. Lymphangiomyomatosis

K. Eosinophilic granuloma

L. Pulmonary hypertension due to cardiac disease

M. Idiopathic fibrosing alveolitis.
**Absolute Contraindications**

In addition to the contraindications noted in “Contraindications for All Transplants” section of this policy, absolute contraindications to lung transplantation, include, but are not limited to:

A. Primary or metastatic malignancies of the lung
B. Colonization with highly resistant or highly virulent microorganisms
C. Untreatable, advanced dysfunction of any other organ (except the heart when a heart/lung transplant may be indicated
D. Non-curable extra-pulmonary chronic infection
E. Inadequate biventricular cardiac function, significant coronary artery disease, or inadequate left ventricular function (these are not absolute contraindications if combined with a heart transplant)
F. System-wide involvement of cystic fibrosis
G. End Stage Renal Disease (ESRD)
H. Active tuberculosis.

**Relative Contraindications**

In addition to the absolute contraindications noted above, relative contraindications to lung transplantation, include, but are not limited to:

A. Acute respiratory insufficiency or failure requiring mechanical ventilation except adults with cystic fibrosis, where mechanical ventilation has not been shown to affect transplant survival
B. Abscess of lung and mediastinum
C. Significant chest wall and/or spinal deformity; prior thoracic surgery or other basis for pleural adhesions
D. Current significant acute illness that is likely to contribute to a poor outcome if the member receives a lung transplant
E. Chronic, incurable pulmonary infection in candidates for single lung transplantation
F. Continued cigarette smoking or failure to have abstained for a period of 12 months or longer.
G. Chronic cortisone therapy with more than 20 mg prednisone daily or recent therapeutic use of systemic steroids.
H. Severely limited functional status with low potential for rehabilitation
I. HIV positive

J. Active infection with Hepatitis B or C with a detectable viral load

K. Diabetes with end-organ dysfunction (e.g., peripheral vascular/arterial disease, retinopathy, neuropathy, or nephropathy)

L. Osteoporosis with vertebral collapse compression fractures

M. Age over 65

N. Hepatic insufficiency

O. Morbid obesity with 30 kg/m².

**Heart and Lung Indications**

Criteria for medical necessity for heart/lung transplantation include, but are not limited to, the following indications:

A. Irreversible primary pulmonary hypertension with congestive heart failure

B. Non-specific pulmonary fibrosis

C. Eisenmenger’s complex with irreversible pulmonary hypertension and heart failure

D. Cystic fibrosis with severe heart failure

E. Emphysema with severe heart failure

F. Chronic Obstructive Pulmonary Disease (COPD) with severe heart failure.

**Contraindications**

Refer to the individual heart and lung sections in this policy for contraindications.

**Liver**

Timing of referral:

Prior to referral to a transplant center for evaluation, the AdSS must calculate the adult member’s Model for End stage Liver Disease (MELD) score. An adult member must have a MELD score greater than 10 to meet criteria for referral.

The AdSS must calculate the pediatric member’s Pediatric End stage Liver Disease (PELD) score prior to transplant evaluation. The PELD score automatically assigns additional points for a child.

**Indications for Adult and Pediatric Liver Transplants**

Criteria for medical necessity for liver transplantation in adults and pediatric liver transplants (except as otherwise indicated) include, but are not limited to, the following indications:
A. Fulminant hepatic failure – This is an emergent basis for transplant (viral [A, B and Non-A-Non-B], toxins, drugs, Wilson’s Disease, Idiopathic)

B. Primary/secondary biliary cirrhosis

C. Primary sclerosing cholangitis

D. Cryptogenic or autoimmune cirrhosis

E. Chronic active hepatitis due to Hepatitis B, C or delta hepatitis

F. Alcoholic liver disease after a period of abstinence of six months or more

G. Alpha-1 antitrypsin deficiency (non-acquired)

H. Wilson’s Disease

I. Primary hemochromatosis

J. Protoporphyria

K. Familial Intrahepatic Cholestasis (Byler’s disease)

L. Trauma

M. Drug- or toxin-induced liver disease (including but not limited to iatrogenic origin)

N. Extrahepatic biliary atresia, intrahepatic bile duct paucity (Alagille syndrome), and obstructive biliary disease

O. Budd-Chiari syndrome

P. Biliary dysplasia

Q. Metabolic liver disorders

R. Cholangiocarcinoma (for adults: when a transplant center applies for a MELD exception for unresectable cholangiocarcinoma based on underlying liver disease or due to technical considerations, mass < 3 cm. and with intrahepatic and extrahepatic metastases excluded)

S. Hepatocellular Carcinoma (HCC) when all of the following conditions are met:

1. The member is not a candidate for subtotal liver resection

2. The member has a single tumor less than or equal to 5 cm in diameter or up to 3 lesions each smaller than 3 cm

3. There is no macrovascular involvement or identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs or bones, and

4. This is not a recurrence of previous resected or treated HCC.
T. Re-transplantation when any of the following occurs:
   1. Chronic rejection with documented adherence to the post-transplant protocols
   2. Biliary stricture
   3. Hepatic artery thrombosis
   4. Graft thrombosis
   5. Sickle cell hepatopathy
   6. Hepatic veno-occlusive disease
   7. Reinfection with the Hepatitis C virus following a liver transplant is an absolute contraindication to re-transplantation.

Additional Indications Limited to Pediatric Transplants

Criteria for medical necessity for liver transplantation limited to the pediatric population include, but are not limited to, the following indications:

A. Intractable cholestasis, intrahepatic (idiopathic neonatal hepatitis)
B. Portal hypertension
C. Multiple episodes of ascending cholangitis
D. Failure of synthetic function
E. Failure to thrive, malnutrition
F. Intractable ascites
G. Encephalopathy
H. Caroli’s with Congestive Heart Failure (CHF)
I. Cystic fibrosis
J. Metabolic defects for which liver transplantation will reverse life threatening illness and prevent irreversible Central Nervous System (CNS) damage; the following may be underlying diagnoses/disorders that lead to pediatric liver transplantation:
   1. Urea cycle defects
   2. Selected organic acidemias
   3. Crigler-Najjar Syndrome
   4. Familial hypercholesterolemia
5. Neonatal iron storage disease
6. Hyperoxaluria Type I
7. Hemophilia A and B
8. Tyrosinemia
9. Glycogen storage disease (I, III, IV)
10. Glycogen debrancher deficiency 1B
11. Disorders of bile acid metabolism
12. Lipid storage disease, and
13. Protein C Deficiency
K. Malignancy including but not limited to:
   1. Hepatoblastoma
   2. Hepatocellular carcinoma
   3. Hemangioendothelioma
   4. Sarcomas, and
   5. Neuroendocrine tumors when the tumor does not extend beyond the margins of the liver.

**Contraindications Limited to Adults**

In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to liver transplantation in adults, include, but are not limited to:

A. Malignancies, other than Hepatocellular Carcinoma (HCC) with the criteria previously stated in this section

B. Acute severe hemodynamic compromise at the time of transplant if accompanied by compromise or failure of one or more vital organs

C. The need for prior transplantation of another organ such as lung, kidney, heart or blood or marrow if this represents a co-existence of significant disease

D. Insulin-dependent diabetes mellitus with end-organ disease

E. Gross vascular invasion of hepatocellular carcinoma

F. Systemic diseases that will result in member death regardless of liver transplant

G. Morbid obesity with BMI >35 kg/m².
Contraindications Limited to Pediatric Liver Transplants

In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to liver transplantation in the pediatric population include, but are not limited to:

A. Persistent viremia
B. Active sepsis
C. Severe cardio-pulmonary comorbidities
D. Severe neurological disorder
E. Gross vascular invasion of hepatocellular carcinoma
F. Malignancy extending beyond the margins of the liver with exception of neuroendocrine tumors metastatic into the liver
G. Systemic diseases that will result in member death despite liver transplant.

Kidney Indications

Criteria for medical necessity for live donor or cadaveric kidney transplantation includes, but is not limited to, and or all of the following indications:

A. All dialysis or advanced chronic kidney disease patients are transplant candidates until deemed unsuitable for transplant. Transplant is usually indicated when Glomerular Filtration Rate (GFR) falls below 20 ml/min,
B. When the onset of dialysis is expected in the next six months (pre-emptive transplant).
C. Symptomatic uremia at GFR above 20 ml/min.

Indications Limited to the Pediatric Population

For pediatric kidney transplants, additional criteria for transplantation include, but are not limited to:

A. Wilm’s tumor (non-metastatic)
B. Oxalosis (may also require a liver-kidney transplant and will be considered on a case-by-case basis)

Contraindications

In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to kidney transplantation include, but are not limited to any of the following:

A. Potential complications from immunosuppressive regimens that are unacceptable to
the member (the benefits of remaining on dialysis outweigh the risks of transplantation)

B. Structural problems, or abnormalities with the lower urinary tract, which interfere with normal renal function of the transplanted kidney

C. Severe cardiomyopathy or ischemic heart disease that is not correctable

D. Cardiac ejection fraction <30%

E. Hepatic cirrhosis

F. Diffuse, pronounced vascular disease that is not correctable

G. Active peptic ulcer disease

H. Any chronic medical condition besides chronic kidney dysfunction where life expectancy is less than two years

I. Morbid Obesity with BMI > 35 kg/m².

**Living Kidney Donor Exclusion Criteria**

A. To qualify as a living kidney donor, the donor must be at least 18 but not more than 65 years of age and must be able to give informed consent.

B. In addition, the donor will not be considered if he/she has any of the following:

1. Hypertension (>140/90 or requires medication)
2. Diabetes or abnormal glucose intolerance test
3. Proteinuria >250 mg/24 hours
4. Recent or recurrent kidney stones
5. Donors with a history of familial kidney disease such as Alport Syndrome, polycystic kidney disease, and nephrotic syndrome must be assessed for risk
6. Abnormal glomerular filtration rate, creatinine clearance <80 mL/min
7. Microscopic hematuria
8. Structural abnormalities in donor kidney
9. History of prior malignancy other than cutaneous squamous or basal cell cancer
10. Significant co-morbid medical conditions (e.g., malignancy, COPD)
11. Obesity (with BMI >35 kg/m²)
12. History of thrombosis or thromboembolism
13. Psychiatric contraindications including active substance abuse.

**Simultaneous Liver/Kidney (SLK)**

Timing of referral:

A. Prior to referral to a transplant center for evaluation, the AdSS must calculate the adult member’s Model for End stage Liver Disease (MELD) score. An adult member must have a MELD score greater than 10 to meet criteria for referral.

B. The Contractor must calculate the pediatric member’s Pediatric End stage Liver Disease (PELD) score prior to transplant evaluation. The PELD score automatically assigns additional points for a child.

**Indications for Simultaneous Liver/Kidney Transplants**

Refer to the individual liver and kidney sections in this policy for indications and general medical considerations.

**Contraindications for Simultaneous Liver/Kidney Transplants**

Refer to the individual liver and kidney sections in this policy for contraindications and general medical considerations.

**Simultaneous Pancreas/Kidney (SPK)**

Indications for Simultaneous Pancreas/Kidney (SPK) Transplantation

Criteria for medical necessity for simultaneous pancreas/kidney transplantation include, but are not limited to, the following indications:

A. Insulin-dependent diabetes mellitus with impending renal failure, and

B. The member is an acceptable candidate for pancreas transplantation

**Contraindications**

In addition to the general contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to SPK include, but are not limited to, any of the following:

A. Uncorrectable cardiovascular or peripheral vascular disease

B. Cardiac ejection fraction < 30%

C. Peripheral vascular disease that is not correctable

D. Active substance abuse

E. End-organ disease, in other than pancreas or kidney, secondary to insulin-dependent diabetes mellitus
F. Morbid obesity with BMI >30 kg/m².

**Pancreas After Kidney (PAK)**

For members under age 21 eligible for the ALTCS Program, covered services are limited to total pancreas only after kidney transplant. Partial pancreas and islet cell transplantation are not covered for both members under 21 and member’s age 21 years and older.

**Indications for Pancreas After Kidney Transplantation**

Criteria for medical necessity of pancreas after kidney transplantation include, but are not limited to:

A. Achievement of adequate renal function post kidney transplantation
B. Extreme labile Type I diabetes that has not responded to conventional therapy including an insulin pump.

**Contraindications**

In addition to the general contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to pancreas after kidney transplantation include, but are not limited to:

A. Uncorrectable cardiovascular or peripheral vascular disease
B. Cardiac ejection fraction < 30%
C. Peripheral vascular disease that is not correctable
D. Active substance abuse
E. End-organ disease, in other than pancreas or kidney, secondary to insulin-dependent diabetes mellitus
F. Morbid obesity with BMI >30 kg/m².

**Pancreas Only**

Pancreas-only transplants are limited to members under age 21 eligible for the ALTCS Programs when the member meets the criteria below.

A. Documented pancreas organ failure
B. Documented medically uncontrollable labile insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require frequent (three or more emergency room visits or hospital admissions in a three-month period) hospitalization
C. Hospitalizations related to complications due to frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring hypoglycemic attacks, and
D. Management by an endocrinologist for a minimum of 12 months with the most medically recognized advanced insulin formulations and delivery systems, including insulin pump therapy if appropriate.

Note: For individuals age 21 and older, AHCCCS covers pancreas after kidney and simultaneous pancreas/kidney transplants. Pancreas-only transplants are not a covered benefit for adults unless the member has previously had a Pancreas After Kidney transplant or Simultaneous Pancreas/Kidney transplant and the pancreas is failing.

**Visceral Transplants**

A. Visceral transplantation is limited to members who are under 21 years of age and meet the medical eligibility criteria.

B. Cadaveric en bloc visceral transplants involving pancreas/liver/small bowel are covered when clinically indicated.

**Indications For Members Under Age 21 Eligible For TheALTCS Program**

Criteria for visceral transplantation alone, and combined small bowel/liver/pancreas transplantation in any combination include, but are not limited to the following conditions:

A. Small bowel syndrome resulting from inadequate intestinal propulsion due to neuromuscular impairment

B. Small bowel syndrome resulting from post-surgical conditions due to resections for any of the following:
   1. Intestinal cysts
   2. Mesenteric cysts
   3. Tumors involving small bowel
   4. Crohn’s disease
   5. Mesenteric thrombosis
   6. Volvulus.

C. Short-gut syndromes in which there is liver function impairment (usually secondary to Total Parenteral Nutrition [TPN])

D. Impending or overt liver or pancreas failure due to TPN-induced liver injury, with clinical manifestations including elevated serum bilirubin and/or liver enzymes, splenomegaly, thrombocytopenia, gastroesophageal varices, coagulopathy, stomal bleeding or hepatic fibrosis/cirrhosis

E. Thrombosis of two or more major central venous channels (jugular, subclavian or femoral veins)
F. Two or more episodes per year of systemic sepsis secondary to line infection, which require hospitalization, indicating failure of TPN therapy

G. Frequent episodes of severe dehydration despite intravenous fluid supplement in addition to TPN

H. Gastrochisis.

Contraindications for Members Under Age 21 Eligible for the ALTCS Program

In addition to the general contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to visceral transplantation include, but are not limited to, the following conditions:

A. Insufficient vascular patency

B. Life-threatening and non-correctable illness not related to the digestive system such as:
   1. Profound neurological disability
   2. Chronic cardio-pulmonary disease.

Hematopoietic Stem Cell Transplants (HSCT)

Hematopoietic Stem Cell Transplant (HSCT) is the transplantation of blood stem cells derived from the bone marrow or blood, including cord blood. Conditioning therapy includes either myeloablative or non-myeloablative induction with or without Total Body Irradiation (TBI).

Medical necessity for Cord Blood Transplantation (CBT) in adults will be determined on a case-by-case basis. For any pediatric CBT, a single cord blood unit will be considered standard treatment.

Autologous HSCT

Criteria for medical necessity for autologous HSCT include, but are not limited to, any of the following indications:

A. Adults
   1. Acute Myelogenous Leukemia (AML) in remission
   2. Chronic Myelogenous Leukemia (CML) in remission
   3. Relapsed Hodgkin Lymphoma that is chemosensitive
   4. Mantle cell lymphoma that is chemosensitive
   5. Germ cell tumors (tandem)
   6. Multiple myeloma (tandem)
7. Amyloidosis in patients with adequate organ function
8. Waldenstrom’s macroglobulinemia
9. Non-Hodgkin lymphoma subtypes where peer-reviewed data has confirmed safety and efficacy of the proposed transplant procedure.

B. Pediatric
1. Neuroblastoma (tandem appropriate if done per a clinical trial)
2. Medulloblastoma
3. Brain tumors, other than medulloblastoma, including central nervous system germ cell tumors, Peripheral Neuro-Ectodermal Tumor (PNET), atypical Teratoid/Rhabdoid Tumor (AT/RT), oligodendroglioma, and pineoblastoma, where peer-reviewed data on safety and efficacy for the proposed transplant procedure have been successfully demonstrated Relapsed chemo-sensitive Hodgkin lymphoma
4. Relapsed chemo-sensitive Non-Hodgkin lymphoma
5. Other pediatric solid tumors (Wilm’s tumor, Ewings sarcoma, etc.) where peer-reviewed data on safety and efficacy for the proposed transplant have been successfully demonstrated.

Whether a specific disease meets the criteria for autologous HSCT is determined by current guidelines as published by specialty societies such as the American Society for Blood and Marrow Transplantation (ASBMT) and the Children’s Oncology Group (COG).

Contraindications

In addition to the general contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to Autologous HSCT include, but are not limited to, the any of the following conditions:

A. Evidence of cirrhosis or significant liver dysfunction, since this can be a factor for development of Sinusoidal Obstruction Syndrome (SOS) formerly called Veno-Occlusive Disease (VOD)

B. Uncontrolled, progressive or active systemic infection at the time of transplant is an absolute contraindication. Prior infection, or infection where there is relative control with a post-transplant plan of control, is not an absolute contraindication and must be considered on a case-by-case basis

C. Prior malignancy, other than disease being treated by transplant, within the last five years. These must be considered on a case-by-case basis

D. Cystic fibrosis (absolute) and other multi-system disease not correctable by hematopoietic stem cell transplantation
E. End-organ damage of either heart or lungs

F. Parenchymal brain disease that raises the risk of cerebrovascular hemorrhage

G. Prior allogeneic hematopoietic stem cell transplant is a relative contraindication depending on disease responsiveness, disease control, patient’s performance status, and presence of other co-morbidities. These must be considered on a case-by-case basis.

**Allogeneic HSCT**

Criteria for medical necessity for Allogeneic HSCT include, but are not limited to, the following indications:

A. Adults

1. Acute Myelogenous Leukemia
   a. Primary indication failure or slow to induce or refractory disease
   b. In first complete remission, if patient at moderate risk for relapse per standard criteria and a match, related donor is available
   c. In first complete remission, if patient at high-risk for relapse per standard criteria and has either a match, related donor or a well-matched unrelated donor available
   d. In second complete remission

2. Acute Lymphogenous Leukemia, in remission

3. Chronic Myelogenous Leukemia
   a. Unresponsive to tyrosine kinase inhibitor control with three prior lines of therapy
   b. Intolerance to tyrosine kinase inhibitors or has severe side effects
   c. Accelerated phase or blast crisis

4. Relapsed or progressive Hodgkin lymphoma that is chemosensitive

5. Relapsed or progressive large cell Non-Hodgkin lymphoma that is chemosensitive

6. Chemosensitive low-grade or follicular Non-Hodgkin lymphoma when clinical evidence indicates transformation to more aggressive subtype (Richter transformation)

7. Relapsed or progressive Non-Hodgkin lymphoma that is chemosensitive and there is peer-reviewed data demonstrating both safety and efficacy for the particular NHL subtype involved
8. Myelodysplastic Syndrome with acceptable donor (either a matched, related
donor or well, matched, unrelated donor)

9. Fanconi Anemia

10. Other Hematological Disorders for which peer-reviewed data on safety and
efficacy for proposed transplant have been successfully demonstrated
including, but not limited to:
   a. Sickle cell disease
   b. Severe congenital anemia
   c. Thalassemia.

B. Pediatric
   1. Acute Myelogenous Leukemia
   2. Juvenile Myelomonocytic Leukemia, at any stage, with any donor type
   3. Chronic Myelogenous Leukemia
      a. Unresponsive to tyrosine kinase inhibitor control (usually three prior
         lines of therapy
      b. Intolerance to tyrosine Kinase inhibitors,
      c. Accelerated phase or blast crisis
   4. Acute Lymphogenous Leukemia
      a. In first complete remission, if high-risk for relapse; or primary
         indication failures who subsequently achieve a first complete remission
      b. T-cell Acute Lymphogenous Leukemia in first complete remission with
         early marrow relapse (<six months)
      c. In the second complete remission, if early relapse (less than 36
         months remission)
   5. Relapsed or progressive Hodgkin Lymphoma that is chemosensitive
   6. Relapsed or progressive Non-Hodgkin Lymphoma that is chemosensitive, and
      there is peer-reviewed data demonstrating safety and efficiency of the
      proposed procedure for the particular Non-Hodgkin Lymphoma subtype
      involved
   7. Inborn errors of Metabolism in patients who have not yet suffered either
      significant or irreversible end-organ damage

Example Indications:
• Hurler syndrome
• Sly syndrome (MPSVII)
• D-Mannosidosis
• X-linked Adrenoleukodystrophy
• Aspartylglucosaminuria
• Wolman disease
• Late infantile metachromatic leukodystrophy
• Krabbe disease

8. Primary lethal immune deficiencies and hemophagocytic lymphohistiocytosis such as:
   a. Wiskott-Aldrich Syndrome,
   b. Severe combined immune deficiencies (SCID), and

9. Fanconi Anemia

10. Other Hematological Disorders for which peer-reviewed data on safety and efficacy for the proposed transplant have been successfully demonstrated, including but not limited to:
    a. Sickle cell disease,
    b. Severe congenital anemia
    c. Thalassemia.

Contraindications

In addition to the contraindications noted in the “Contraindications for All Transplants” section of this policy, contraindications to allogeneic HSCT include, but are not limited to, the following conditions:

A. Evidence of cirrhosis or sever liver dysfunction
B. Cystic fibrosis is an absolute contraindication
C. Uncontrolled, progressive or active systemic infection at the time of transplant is an absolute contraindication
D. End-organ damage of either heart or lungs
E. Parenchymal brain disease that poses a risk for cerebrovascular hemorrhage
F. Prior hematopoietic stem cell transplant is a relative contraindication depending on
disease responsiveness, disease control, patient’s performance status, and presence of other co-morbidities. These must be considered on a case-by-case basis.

**Out-Of-Network Coverage**

The AdSSs must provide out-of-network coverage for solid organ or hematopoietic stem cell transplants for those members who have current medical requirements that cannot be met by an appropriate in-network transplant center. These medical requirements must be manifested as requiring either a specific level of technical expertise or program coverage that is not currently provided by an AHCCCS contracted facilities. A request for out-of-network coverage will not be approved if the member has already received a medical denial from an AHCCCS contracted transplant center. The use of out-of-network transplant centers is determined by the review of quality and outcome data, as published by center’s accreditation organization, and the center’s cost containment standards.

When a member completes a Division approved transplantation at an out-of-network facility, the necessary follow-up services will be covered through an AHCCCS contracted in-network facility, if one is available. These services include, but are not limited to, travel, lodging, meals, medical testing and post-operative evaluation and apply to any transplant performed under AHCCCS coverage, another third-party payer or through self-pay.

**Multiple Site Listing For Solid Organ/Hematopoietic Transplantation**

If a member seeks to be evaluated for solid organ, or hematopoietic stem cell transplantation and is "listed" with more than the primary AHCCCS contracted transplant center, the Division will only pay for one center’s evaluation services.

If a member becomes listed by a facility other than the primary AHCCCS contracted transplant center, the Division will not provide coverage for any costs in excess of the state-contracted rate for the specific transplant procedure.

In addition, reimbursement will be available only to FACT accredited or UNOS approved facilities. Facilities must be CMS certified transplant centers and must meet the Medicare conditions of participation and the special requirements for transplant centers set forth in 42 CFR Part 482.

If a member chooses to make his/her own arrangements for travel, lodging and/or meals, the member must notify the AdSS of the arrangements they have made. In addition, the member, in such circumstances, is responsible for securing and sending appropriate medical records to the appropriate transplant case manager.

**Non-transplant Medically Necessary Services Covered by AHCCCS for Members Who Receive Non-covered Transplants**

If a member receives a transplant that is not covered by the Division, medically necessary, non-experimental services commence following discharge from the acute care hospitalization for the transplant.

A. Covered services include, but are not limited to:

   a. Transitional living arrangements appropriately ordered for post-transplant
members when the member does not live in close proximity to the center

b. Essential laboratory and radiology procedures
c. Medically necessary post-transplant therapies
d. Immunosuppressant medications
e. Medically necessary transportation.

B. Covered services do not include:

a. Evaluations and treatments to prepare for transplant candidacy
b. The actual transplant procedure and accompanying hospitalization
c. Organ or tissue procurement.

Division reimbursement of the AdSS for medically necessary services following non-covered organ transplantation is in accordance with the regular reinsurance guidelines found in the AHCCCS Reinsurance Processing Manual as adopted by the Division. Division-covered transplantation and its related medically necessary services are reimbursed in accordance with the transplant reinsurance guidelines found in the Reinsurance Processing Manual, with the exception of kidney transplants, cornea transplants and bone grafts. These services are covered as part of regular capitation payments and any related services may be covered in accordance with the regular reinsurance guidelines.

**Transplantation Management**

The AHCCCS Administration has entered into a contract with a transplantation management entity (consultant) to review developments, outcomes and respective changes in technology, and assist in the development and revision of this policy. The consultant will be available, as necessary, to provide expertise regarding clinical issues arising from transplant requests.

Although the AdSS is encouraged to consult with the transplantation management entity (AHCCCS consultant) under contract with AHCCCS for guidance in making medical determinations regarding transplants. The AdSS is not required to use the AHCCCS consultant in reaching its medical determination. The AdSS may obtain its own expert opinion. A written medical justification for the AdSS’s decision is required in each case.

AHCCCS, in partnership with the consultant, is available to assist with questions and issues concerning specific diagnoses and medical conditions that are covered for transplantation.

Consultation may include, but is not limited to:

A. Telephone access to the Consultant Medical Director. Access will be arranged by the DHCM Medical Management Unit

B. Regular updates on changes in experimental status of selected transplants and advances in technology and devices
C. Analysis of transplantation and related technology developments with enough information, including cost projections, to assist AHCCCS in revising this policy as necessary

D. Assistance in recommendation of approved/appropriate transplant facilities, as necessary, for out-of-network coverage.
310-FF MONITORING CONTROLLED AND NON-CONTROLLED MEDICATION UTILIZATION

EFFECTIVE DATE: October 1, 2019
REFERENCES: Section F3, Contractor Chart of Deliverables
DELIVERABLES: Pharmacy and/or Prescriber - Member Assignment/Restrictions Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The AdSS must engage in activities to monitor controlled and non-controlled medication use. The policy also sets forth minimum requirements to ensure members receive clinically appropriate prescriptions. These requirements are also referred to as interventions.

Definitions

A. **Controlled Substance** - Drugs and other substances that are defined as controlled substances under the Controlled Substance Act (CSA).

B. **CSPMP** - Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program.

C. **Drug Diversion** - Redirection of prescription drugs for illicit purposes.

D. **Exclusive Pharmacy** - Individual pharmacy, which is chosen by the member or assigned by the AdSS to provide all medically necessary federally reimbursable pharmaceuticals to the member.

Minimum Monitoring Requirements

A. The AdSS is required to monitor controlled and non-controlled medications on an ongoing basis. Monitoring must include, at a minimum, the evaluation of prescription use by members, prescribing patterns by clinicians and dispensing by pharmacies. Drug use data must be used to identify and screen high-risk members and providers who may facilitate drug diversion. The monitoring requirements are to determine potential misuse of the drugs used in the following therapeutic classes:

1. Atypical Antipsychotics,
2. Benzodiazepines,
3. Hypnotics,
4. Muscle Relaxants,
5. Opioids, and

B. The AdSS must use the following resources, when available, for their monitoring activities:

1. Prescription claims data,
2. CSPMP,
3. Indian Health Service (IHS) and Tribal 638 pharmacy data, and
4. Other pertinent data.

C. The AdSS must evaluate the prescription claims data, at a minimum, quarterly, to identify:
   1. Medications filled prior to the calculated days-supply,
   2. Number of prescribing clinicians,
   3. Number of different pharmacies used by the member, and
   4. Other potential indicators of medication misuse.

**Minimum Intervention Requirements**

The AdSS must implement the following interventions to ensure members receive the appropriate medication, dosage, quantity, and frequency:

A. Provider education in accordance to AMPM Policy 310-V.
B. Point-of-Sale (POS) safety edits and quantity limits.
C. Care/case management.
D. Referral to, or coordination of care with, a behavioral health service provider(s) or other appropriate specialist.
E. Assignment of members who meet any of the evaluation parameters in Table 1 to an exclusive pharmacy, in accordance with 42 CFR 431.54, for a minimum 12-month period except for the following members. The AdSS may assign members who meet these parameters to a single prescriber in addition to the assignment to an exclusive pharmacy. Members with one or more of the following conditions must not be subject to the intervention requirements described in subsections A through D:
   a. Treatment for an active oncology diagnosis,
   b. Receiving hospice care, or
   c. Residing in a skilled nursing facility or intermediate care facility.
Table 1 Program Evaluation Criteria

<table>
<thead>
<tr>
<th>EVALUATION PARAMETER</th>
<th>MINIMUM CRITERIA FOR INITIATING INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OVERUTILIZATION</td>
<td>Member used the following in a three-month time period:</td>
</tr>
<tr>
<td></td>
<td>&gt; Four prescribers; and</td>
</tr>
<tr>
<td></td>
<td>&gt; Four different abuse potential drugs; and</td>
</tr>
<tr>
<td></td>
<td>&gt; Four Pharmacies. OR</td>
</tr>
<tr>
<td></td>
<td>Member has received 12 or more prescriptions of the medications listed in Minimum Monitoring Requirements in the past 3 months.</td>
</tr>
<tr>
<td>FRAUD</td>
<td>Member has presented a forged or altered prescription to the pharmacy.</td>
</tr>
</tbody>
</table>

F. A member who is assigned to an exclusive pharmacy and/or an exclusive prescriber for 12 months must be provided a written notice detailing the factual and legal based for the restriction. This restriction must be treated as an “action” pursuant to A.A.C. R9-43-202 and A.A.C. R9-34-302. The written notice must inform the member of the opportunity to file an appeal and the timeframes and process for doing so as described in A.A.C. Title 9, Chapter 34, Articles 2 and 3. Neither the Division nor the AdSS shall implement the restriction before providing the member notice and opportunity for a hearing. If the member has filed an appeal, no restriction shall be imposed until:

1. Director’s Decision has affirmed the restriction,
2. The member has voluntarily withdrawn the appeal or request for hearing, or
3. The member fails to file an appeal or request for hearing in a timely manner.

G. At the end of the designated time period, the AdSS must review the member’s prescription and other utilization data to determine whether the intervention will be continued or discontinued. The AdSS must notify the member in writing of the decision to continue or discontinue the assignment of the pharmacy and/or provider. If the decision is to continue the assignment, the AdSS is required to include instructions for the appeals/fair hearing process in the notification letter to the member.

H. The intervention of assigning an exclusive pharmacy and/or provider does not apply to emergency services furnished to the member. The AdSS must ensure that the member has reasonable access to services covered by the Division of Developmental Disabilities.
Disabilities (Division), taking into account the geographic location and reasonable travel time. The AdSS must provide specific instructions to the member, the assigned exclusive pharmacy and/or exclusive provider, and their Pharmacy Benefit Manager (PBM), on how to address the following:

1. **Emergencies** defined as medical services provided for the treatment of an emergency medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
   a. Placing the member’s health in serious jeopardy,
   b. Serious impairment to bodily functions, or
   c. Serious dysfunction of any bodily organ or part,

2. The medication is out-of-stock at the exclusive pharmacy, or

3. The exclusive pharmacy is closed.

**Reporting Requirements**

A. Identified cases of member deaths due to medication poisoning/overdose or toxic substances must be referred to the Division’s Quality Management staff for research and review.

B. The AdSS must report all suspected fraud, waste, and abuse, to the appropriate entity, and copy the Division as specified in Section F3, Contractor Chart of Deliverables.

C. The AdSS must report to the Division, as specified in the Section F3, Contractor Chart of Deliverables, the number of members on that day that are assigned to an exclusive pharmacy and/or single prescriber, due to excessive use of prescriptive medications (narcotics and non-narcotics).

D. The AdSS are also required to report to the Division as specified in the Section F3, Contractor Chart of Deliverables, when the AdSS have additional changes and implements additional interventions and more restrictive parameters as noted in this policy.

E. The Division will work with all appropriate entities regarding the implementation of the interventions outlines above on an as-needed basis.
310-GG NUTRITIONAL THERAPY, METABOLIC FOODS, AND TOTAL PARENTAL NUTRITION

EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM, Chapter 310-GG, Attachment A - AHCCCS Certificate of Medical Necessity for Commercial oral Nutritional Supplements, for Members 21 Years of Age and Older – Initial or Ongoing Requests

Purpose

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This Policy establishes requirements regarding nutritional assessments, nutritional therapy, including metabolic foods, commercial oral supplements, and total parental nutrition for members 21 years of age and older.

Definitions:

A. **Commercial Oral Supplemental Nutrition** - Nourishment available without a prescription that serves as sole caloric intake or additional caloric intake to.

B. **Enteral Nutrition** - Liquid nourishment provided directly to the digestive tract of a member who cannot ingest an appropriate number of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by J-tube, G-tube or N/G tube.

C. **Metabolic Medical Food Formulas or Medical Foods** - Nutrition and specialized diets used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder. In order to avoid toxic effects, the treatment of the associated metabolic disorder depends on dietary restriction of foods containing the substances that cannot be metabolized by the member.

D. **Total Paternal Nutritional (TPN) Therapy** - Nourishment provided through the venous system to members with severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength appropriate for the individual’s general condition. Nutrients are provided through an indwelling catheter.

Policy

A nutritional assessment is required for a member who has been identified as having a health status which may improve or be maintained with nutrition intervention such as nutritional therapy.

Refer to AdSS Medical Policy 430 for requirements specific to nutritional assessments and nutritional therapy for all members 20 years of age and under.

AHCCCS covers the nutritional assessment as determined medically necessary and as a part of health risk assessment and screening services provided by the member’s Primary Care Provider (PCP). Nutritional assessment services provided by a registered dietitian also are...
AHCCCS covers nutritional therapy on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member’s daily nutritional and caloric intake. AdSS follows Medicare requirements for the provision of TPN services.

**Prior Authorization**

Prior Authorization (PA) from the AdSS is required for commercial oral nutritional supplements, enteral nutrition, and parenteral nutrition unless:

A. The member is currently receiving nutrition through enteral or parenteral feedings for which PA has already been obtained.

B. For the first 30 days with members who require oral supplemental nutritional feedings on a temporary basis due to an emergent condition; i.e. post-hospitalization.

**Commercial Oral Nutritional Supplements**

Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member’s PCP or specialty provider, using the criteria specified in this Policy. The PCP or specialty provider must use the AHCCCS approved form (AMPM 310-GG Attachment A) to obtain authorization from the AdSS.

A. Specific criteria must be met with AMPM 310-GG Attachment A when assessing the medical necessity of providing commercial oral nutritional supplements. These criteria include the following:

1. The Member is currently underweight with a BMI of less than 18.5, presenting serious health consequences for the member, or has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment),

2. The Member is able to consume/eat no more than 25% of his/her nutritional requirements from typical food sources,

3. The Member has been evaluated and treated for medical conditions that may cause problems with weight gain and growth (e.g. feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems), and

4. The Member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. 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 Attachment C, along with supporting documentation demonstrating the risk posed to the member for the AdSS Medical Director’s consideration in approving the provider’s PA request.
B. Supporting documentation must also accompany AMPM 310-GG Attachment A. This documentation must demonstrate that the member meets all of the required criteria and includes:

1. Initial Requests:
   a. 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,
   b. Clinical notes or other supporting documentation dated no earlier than three months prior to date of the request, providing a detailed history and thorough physical assessment and demonstrating evidence of the member meeting all of the required criteria listed in AMPM 310-GG Attachment A. The physical assessment must include the member's current/past height, weight, and BMI,
   c. 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, as well as member adherence to the prescribed dietary plan/alternatives attempted.

2. Ongoing Requests:
   a. Subsequent submissions must include a clinical note or other supporting documentation dated no earlier than three months prior to the date of the request, that includes the members overall response to supplemental therapy and justification for continued supplement use. This shall include the member’s tolerance, recent hospitalizations, current height, weight, and BMI,
   b. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate, and
   c. Members receiving nutritional therapy must be physically assessed by the member's PCP, specialty provider, or registered dietitian at least annually.
   d. Initial and ongoing certificate of medical necessity is considered valid for a period of six month.

**Metabolic Medical Foods**

Metabolic medical foods are used to treat inherited metabolic disorders that are rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme. Metabolic formula or modified low protein foods are produced or manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons in the absence of a qualifying metabolic disorder.
A. Metabolic formulas and medical foods are covered within limitations specified in this Policy for members diagnosed with the following metabolic conditions: Phenylketonuria; Homocystinuria; Maple Syrup Urine Disease; Galactosemia (requires soy formula); Beta Keto-Thiolase Deficiency; Citrullinemia; Glutaric Acidemia Type I; Isovaleric Acidemia; Methylmalonic Acidemia; Propionic Acidemia; Argininosuccinic Acidemia; Tyrosinemia Type I; HMG CoA Lyase Deficiency; Very long chain acyl-CoA Dehydrogenase deficiency (VLCAD), and long Chain acyl-CoA dehydrogenase deficiency (LCHAD).

1. The AdSS is responsible for the initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist,

2. The AdSS is responsible for all medically necessary laboratory tests and other services related to the provision of medical formulas/foods for members diagnosed with an inherited metabolic disorder,

3. Metabolic formula or modified low protein foods shall be processed or formulated to be deficient in the nutrients(s) specific to the member’s metabolic condition; meet the member’s distinctive nutritional requirements; determined to be essential to sustain the member’s optimal growth within nationally recognized height/weight or BMI, and metabolic homeostasis; obtained under physician order; member’s medical and nutritional status shall be supervised by the member’s PCP, attending physician or appropriate specialist,

4. Modified low protein foods must be formulated to contain less than 1 gram of protein per unit or serving. For purposes of this policy, modified low protein foods do not include foods that are naturally low in protein,

5. Soy formula is covered only for members receiving Early and periodic Screening, Diagnosis and Treatment (EPSDT) services and only until members are able to eat solid lactose-free foods,

6. Foods that are available in the grocery store or health food store are not covered as a metabolic food, and

7. Education and training regarding proper sanitation and temperatures to avoid contamination of foods which are blended or specially prepared for the member is required, if the member/guardian/designated representative elects to prepare the member’s food.

Provider Requirements

A. When requesting initial or ongoing PA for supplemental nutrition, providers must provide the following:

1. A completed copy of AMPM 310-GG Attachment A to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed in this Policy

2. Documentation of ongoing monitoring conducted to assess member

310-GG Nutritional Therapy, Metabolic Foods, and Total Parenteral Nutrition
adherence/ tolerance to the prescribed nutritional supplement regimen and any necessary adjustments.

3. The AdSS must implement protocols for transitioning a member who is receiving nutritional therapy to or from another AdSS or Provider.
310-HH END OF LIFE CARE AND ADVANCE CARE PLANNING

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division's Administrative Services Subcontractors (AdSS). The Division provides oversight and monitoring of delegated duties.

This Policy establishes guidelines for the concept of End of Life (EOL) care and the provision of Advance Care Planning.

Definitions

A. **Advance Directive** - A document by which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

B. **Advance Care Planning** - Advance care planning is a part of the End of Life concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:

   1. Educate the member/guardian/designated representative(s) about the member’s illness and the health care options that are available to them.

   2. Develop a written plan of care that identifies the member’s choices for treatment.

   3. Share the member’s wishes with family, friends, and his or her physicians.

C. **Curative Care** - Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. An example is chemotherapy, which seeks to cure cancer patients.

D. **End-of-Life Care** - A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.

E. **Hospice Services** - A program of care and support for terminally ill members who meet the specified medical criteria/requirements.

F. **Practical Support** - Non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to: housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.

End of Life Care Concept

EOL care is member-centric care that includes Advance Care Planning, and the delivery of appropriate health care services and practical supports. The goals of End of Life care focuses on providing treatment, comfort, and quality of life for the duration of the member’s life. The EOL concept of care strives to ensure members achieve quality of life through the provision of services such as:
A. Physical and/or behavioral health medical treatment to:
   1. Treat the underlying illness and other comorbidities.
   2. Relieve pain.

B. Referrals to community resources for services such as, but not limited to:
   1. Pastoral/counseling services
   2. Legal services.

C. Practical supports are non-billable services provided by a family member, friend or volunteer to assist or perform functions such as, but not limited to:
   1. Housekeeping
   2. Personal Care
   3. Food preparation
   4. Shopping
   5. Pet care

Members aged 21 years and older who receive EOL care may continue to receive curative care until they choose to receive hospice care.

Members under the age of 21 may receive curative care concurrently with EOL care and hospice care.

**Advance Care Planning**

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

**AHCCCS Medical Manual Section 310 – Covered Services**

Advance Care Planning often results in the creation of an Advance Directive for the member. Refer to AMPM Policy 640 for provider requirements pertaining to Advance Directives.

The AdSS must ensure providers perform the following as part of the EOL concept of care when treating qualifying members:

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

B. Teach the member/guardian/designated representative about the member’s illness
and the health care options that are available to the member to enable them to make educated decisions.

C. Identify the member’s healthcare, social, psychological and spiritual needs.

D. Develop a written member centered plan of care that identifies the member’s choices for care and treatment, as well as life goals.

E. Share the member’s wishes with family, friends, and his or her physicians.

F. Complete Advance Directives.

G. Refer to community resources based on member’s needs.

H. Assist the member/guardian/designated representative in identifying practical supports to meet the member’s needs.

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

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

**Hospice Services**

Refer to Division Medical Policy 310-J.

**Training**

AdSS must ensure providers and their staff are educated in the concepts of EOL care, Advance Care Planning and Advance Directives.

**Network Adequacy**

AdSS must ensure an adequate network of providers who are trained to conduct Advance Care Planning. Refer to Administrative Services Subcontractors Operations Manual, Policy 415.
320-H MEDICAL FOODS

EFFECTIVE DATE: October 1, 2019

Description of Benefit
The Division covers medical foods, within the limitations specified in this Policy, for any member diagnosed with one of the following inherited metabolic conditions:

A. Phenylketonuria
B. Homocystinuria
C. Maple Syrup Urine Disease
D. Galactosemia (requires soy formula)
E. Beta Keto-Thiolase Deficiency
F. Citrullinemia
G. Glutaric Acidemia Type I
H. 3 Methylcrotonyl CoA Carboxylase Deficiency
I. Isovaleric Acidemia
J. Methylmalonic Acidemia
K. Propionic Acidemia
L. Arginosuccinic Acidemia
M. Tyrosinemia Type I
N. HMG CoA Lyase Deficiency
O. Cobalamin A, B, C Deficiencies

Definitions

A. Medical Foods - Metabolic formula or modified low-protein foods that are produced or manufactured specifically for persons with a qualifying metabolic disorder and that are not generally used by persons in the absence of a qualifying metabolic disorder. Soy formula is also included within the limitations set by this Policy when used by persons diagnosed with galactosemia.

B. Metabolic Nutritionist - A provider registered with the Arizona Health Care Cost Containment System (AHCCCS) who is a registered dietitian specializing in nutritional assessment and treatment of metabolic conditions.
Conditions, Limitations and Exclusions

A. The diagnosis of the member’s inherited metabolic condition is documented in the member’s medical record by the Primary Care Provider (PCP), attending physician or appropriate specialist. Documentation also includes test results used in establishing the diagnosis.

B. Metabolic formula and modified low-protein foods must be:
   1. Essential to sustain the member’s growth within nationally recognized height/weight or BMI (body mass index) levels, maintain health and support metabolic balance;
   2. Obtained only under physician order; and
   3. Supervised by the member’s PCP, attending physician or appropriate specialist for the medical and nutritional management of a member who has:
      a. Limited capacity to metabolize typical foods or certain nutrients contained in typical food; or
      b. Other specific nutrient requirements as established by medical evaluation.

C. Metabolic formulas ordered for a member must be processed for the specific dietary management of the member’s metabolic condition. The formula must meet the member’s distinctive nutritional requirements that are established through medical evaluations by the member’s PCP, attending physician or appropriate specialist, and/or the metabolic nutritionist.

D. Modified low-protein foods must be formulated to contain less than one gram of protein per unit or serving. For purposes of this Policy, modified low-protein foods do not include foods that are naturally low in protein.

E. Soy formula is covered only for members receiving Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, who are diagnosed with galactosemia, only until they are able to eat solid lactose-free foods.

F. The Division provides both necessary metabolic formula and modified low protein foods for members who have been diagnosed with one of the inherited metabolic disorders included in this Policy.

G. The AdSS is responsible for initial and follow-up consultations by a genetics physician and/or a metabolic nutritionist, lab tests and other services related to the provision of medical foods for enrolled members diagnosed with a metabolic disorder included in this Policy.

H. Medical foods must be ordered from a supplier of metabolic formula, modified low-protein foods or soy formula that is approved by the AdSS. Foods purchased through grocery or health food stores are not covered.
TELEHEALTH AND TELEMEDICINE

EFFECTIVE DATE: October 1, 2019
REFERENCES: AMPM Policy 431; Social Security Act, Section 1905(a)

The Division of Developmental Disabilities (Division) covers medically necessary consultative and/or treatment telemedicine services for all members eligible for AHCCCS, when these services are provided by an appropriate AHCCCS-registered provider.

Definitions

A. Asynchronous or "Store and Forward" - the transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

B. Consulting Provider - any AHCCCS-registered provider who is not located at the originating site who provides an expert opinion to assist in the diagnosis or treatment of a member.

C. Distant or Hub Site - the site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

D. Originating or Spoke Site - the location of the patient at the time the service being furnished via a telecommunications system occurs. Telepresenters may be needed to facilitate the delivery of this service.

E. Telecommunications Technology (which includes store and forward) - the transfer of medical data from one site to another through the use of a camera, electronic data collection system such as an Electrocardiogram (ECG), or other similar device, that records (stores) an image which is then sent (forwarded) via telecommunication to another site for consultation. Services delivered using telecommunications technology, but not requiring the member to be present during their implementation, are not considered telemedicine. For information about coverage of these services, see Section titled Use of Telecommunications in this policy.

F. Teledentistry - the acquisition and transmission of all necessary subjective and objective diagnostic data through interactive audio, video or data communications by an AHCCCS-registered dental provider to a distant dentist for triage, dental treatment planning, and referral.

1. Teledentistry includes the provision of preventive and other approved therapeutic services by the AHCCCS registered Affiliated Practice Dental Hygienist, who provides dental hygiene services under an affiliated practice relationship with a dentist.
Division of Developmental Disabilities
Administrative Services Subcontractors
Medical Policy Manual
Chapter 300
Medical Policy for Acute Services

2. Teledentistry does not replace the dental examination by the dentist; limited, periodic, and comprehensive examinations cannot be billed through the use of Teledentistry alone.

G. **Telehealth (or Telemonitoring)** - use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

1. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine, they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under section 1905(a) of the Social Security Act).

H. **Telemedicine** - the practice of health care delivery, diagnosis, consultation and treatment and the transfer of medical data between the originating and distant sites through real time interactive audio, video or data communications that occur in the physical presence of the member.

I. **Telepresenter** - a designated individual who is familiar with the member's case and has been asked to present the member's case at the time of telehealth service delivery if the member's originating site provider is not present. The telepresenter must be familiar, but not necessarily the medical expert, with the member's medical condition in order to present the case accurately.

**Use of Telemedicine**

The Division covers the following medically necessary services provided via telemedicine. These services must be provided in real-time visits, the cost of which would otherwise be reimbursed by the Division.

A. Cardiology
B. Dermatology
C. Endocrinology
D. Hematology/oncology
E. Infectious diseases
F. Neurology
G. Obstetrics/gynecology
H. Oncology/radiation
I. Ophthalmology

J. Orthopedics

K. Pain clinic

L. Pathology

M. Pediatrics and pediatric subspecialties

N. Radiology

O. Rheumatology

P. Surgery follow-up and consultations

Q. Behavioral Health

R. Diagnostic consultation and evaluation, including:
   1. Psychotropic medication adjustment and monitoring
   2. Individual and family counseling
   3. Case management

Use of Telecommunications

Services delivered using telecommunications are generally not covered by the Division as a telemedicine service. The exceptions to this are described below:

A. A provider in the role of telepresenter may be providing a separately billable service under their scope of practice such as performing an ECG or an x-ray. In this case, that separately billable service would be covered, but the specific act of tele-presenting would not be covered.

B. A consulting provider at the distant site may offer a service that does not require real time interaction with the member. Reimbursement for this type of consultation is limited to dermatology, radiology, ophthalmology, and pathology and is subject to review by the Division.

C. In the special circumstance of the onset of acute stroke symptoms within three hours of presentation, the Division and AHCCCS recognize the critical need for a neurology consultation in rural areas to aid in the determination of suitability for thrombolytic administration. Therefore, when a member presents within three hours of onset of stroke symptoms, the Division will reimburse the consulting neurologist if the consult is placed for assistance in determining appropriateness of thrombolytic therapy even when the patients’ condition is such that real-time video interaction cannot be achieved due to an effort to expedite care.
Use of Teledentistry Services

The Division covers teledentistry for members eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when provided by an AHCCCS-registered dental provider. Refer to Division Policy 431 for more information on “Oral Health Care for EPSDT Aged Members.”

Conditions, Limitations and Exclusions

A. Both the referring and consulting providers must be registered with AHCCCS.

B. A consulting service delivered via telemedicine by other than an Arizona-licensed provider must be provided by an AHCCCS-registered provider licensed to practice in the state or jurisdiction from which the consultation is provided. Consulting providers employed by an Indian Health Services (IHS), Tribal or Urban Indian Health Program, must be appropriately licensed based on IHS and 638 Tribal Facility requirements.

C. At the time of service delivery via real time telemedicine, the member’s health care provider may designate a trained telepresenter to present the case to the consulting provider if the member’s primary care provider or attending physician, or other medical professional who is familiar with the member’s medical condition, is not present. The telepresenter must be familiar with the member's medical condition in order to present the case accurately. Medical questions may be submitted to the referring provider when necessary but no payment is made for such questions.

D. Nonemergency transportation to and from the telemedicine originating site to receive a medically necessary consultation or treatment service is covered.
320-O  BEHAVIORAL HEALTH ASSESSMENTS AND TREATMENT/SERVICE PLANNING

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy describes the providing of for behavioral health assessment and treatment/service planning for members eligible for the Division.

Definitions
A. Behavioral Health Home - Contracted behavioral health provider that serves as an intake agency, provides or coordinates the provision of covered behavioral health services, and coordinates care with the primary care provider for adults and/or children with behavioral health needs.

B. Behavioral Health Professional (BHP) -
1. A person licensed under A.R.S. § 32-3251 et seq., who can:
   a. Independently engage in the practice of behavioral health as defined in A.R.S. § 32-3251 or
   b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101
2. A psychiatrist as defined in A.R.S. § 36-501
3. A psychologist as defined in A.R.S. § 32-2061
4. A physician
5. A behavior analyst as defined in A.R.S. § 32-2091
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse
7. A registered nurse.
C. **Behavioral Health Technician (BHT)** -

As specified in A.A.C. R9-10-101, a person who is not a BHP who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures. A BHT is a person who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. § 32-3251 et seq

2. Is provided with clinical oversight by a behavioral health professional.

D. **Specialty Provider** – A provider of a behavioral health service that is not available in the Behavioral Health Home.

E. **Treatment Plan** – A written description of covered health services and informal supports identified based on an assessment to assist the member in achieving an improved quality of life. This Plan must be incorporated into the Planning Document completed by the Support Coordinator.

**Overview**

The model for behavioral health assessment, treatment/service planning, and service delivery must be strength-based, member-centered, family-friendly, culturally and linguistically appropriate, and clinically supervised.

The model:

A. Is based on four components:

1. Input from the member/guardian/designated representative regarding his/her needs, strengths, and preferences

2. Input from other persons involved in the member’s care who have integral relationships with the member

3. Development of a therapeutic alliance between the member/guardian/designated representative and behavioral health provider that promotes an ongoing partnership built on mutual respect and equality

4. Clinical expertise/qualifications of person(s) conducting the assessment, treatment/service planning, and service delivery.

B. Incorporates the concept of a “team.”

For children, this team is the Child and Family Team (CFT) and for adults, this team is the Adult Recovery Team (ART). At a minimum, the functions of the CFT and ART include:

1. Ongoing engagement of the member/guardian/designated representative,
family, assigned Support Coordinator and others who are significant in meeting the behavioral health needs of the member, including their active participation in the decision-making process and involvement in treatment. The member’s Support Coordinator must participate in all CFT and ART meetings.

2. An assessment process that:
   a. Elicits information on the strengths and needs of the member and his/her family
   b. Identifies the need for further or specialty evaluations
   c. Supports the development and updating of the treatment/service plan(s) which effectively meets the member's/family's needs and results in improved health outcomes.

3. Continuous evaluation of treatment effectiveness through the CFT or ART process, the ongoing assessment of the member, and input from the member/guardian/designated representative and Support Coordinator resulting in change to the treatment plan(s), as necessary.

4. Provision of all covered services as identified on the treatment/service plan(s), including assistance in accessing community resources as appropriate.

5. For children, services are provided consistent with the Arizona Vision - 12 Principles as outlined in Division Medical Policy Manual, Policy 430. For adults, services are provided consistent with the Adult Service Delivery System - 9 Guiding Principles.

6. Ongoing collaboration with other people and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g. primary care providers, specialty service providers, school, child welfare, Division of Developmental Disabilities (DDD), justice system and others). This must include sharing of clinical information as appropriate.

7. Ensure continuity of care by assisting members who are transitioning to a different treatment program, changing behavioral health providers and/or transferring to another service delivery system (e.g. out-of-area, out-of-state, or to a different AdSS). For more details, see Administrative Services Subcontractors Operations Manual Policy 402 and Division Medical Policy Manual, Policy 520.

**Assessment and Service Planning**

A. General Requirements :

1. Behavioral health assessments and treatment planning must comply with the Rules in A.A.C. R9-10 and A.A.C. R9-21, as applicable.
2. Behavioral health providers, including specialty providers, may engage in assessment and treatment planning activities to support timely access to medically necessary behavioral health services.

3. If the assessment is completed by the BHT, the requirements of A.A.C. R9-10-1011(B)(3) must be met.

4. At a minimum, the member/guardian/designated representative and a BHP must be included in the assessment process and development of the treatment/service plan.

5. The assessment and service plan must be included in the clinical record in accordance with Division Medical Policy Manual, Policy 940.

6. The service plan must be based on the current assessment and identify the specific services and supports to be provided.

7. The behavioral health provider must document whether or not the member/guardian/designated representative agrees with the service plan.

8. The member/guardian/designated representative must be provided with a copy of his/her service plan within seven calendar days of completion of the service plan and/or upon request.

9. Serious Mental Illness (SMI) Determination must be completed for members who request an SMI determination in accordance with AdSS Medical Policy Manual, Policy 320-P.

10. For members determined SMI:
   a. Assessment and treatment/service planning must be conducted in accordance with A.A.C. R9-21-301 et seq. and A.A.C. R9-21-401 et seq.
   b. Special Assistance assessment must be completed in accordance with Division Medical Policy Manual Policy 320-R.
   c. The completed treatment/service plan must be signed by the member/guardian/designated representative in accordance with A.A.C. R9-21-308.
   d. For appeal requirements, see A.A.C. R9-21-401 et seq. and Administrative Services Subcontractors Operations Manual Policy 444.

B. Additional Requirements:

1. The Behavioral Health Home must maintain the comprehensive assessment and conduct periodic assessment updates to meet the changing behavioral health needs for members who continue to receive behavioral health services.
2. Assessments must be updated at a minimum of once annually,

3. Assessments and treatment/service plans must be completed by BHPs or BHTs under the clinical oversight of a BHP that meets credentialing and training requirements outlined in Division Medical Policy Manual, Policy 950,

4. The Behavioral Health Home must maintain the treatment/service plan and conduct periodic treatment/service plan updates to meet the changing behavioral health needs for members who continue to receive behavioral health services,

5. Other qualified BHPs, including specialty providers not part of the behavioral health home, may engage in assessment and treatment/service planning activities to support timely access to medically necessary behavioral health services. These providers must provide completed assessment and treatment/service plan documentation to the Behavioral Health Home for inclusion in the comprehensive Behavioral Health Home clinical record. The AdSS may incorporate additional requirements, such as Behavioral Health Home referral expectations, as long as they do not prevent timely access to covered behavioral health services.

6. The Behavioral Health Home must coordinate with the member’s health plan, PCP, specialty providers, the designated Support Coordinator, and others involved in the care or treatment of the member (e.g. DCS, Probation), as applicable, regarding assessment and treatment/service planning see Division Medical Policy Manual, Policy 540.

7. Special Circumstances

   a. Children Age 0 to 5 – Developmental screening must be conducted by the Behavioral Health Home for children age 0-5 with a referral for further evaluation when developmental concerns are identified.

   b. Children Age 6 to 18 - The Child and Adolescent Service Intensity Instrument (CASII) must be completed by the Behavioral Health Home during the initial assessment and updated at least once annually.

   c. Children Age 6 to 18 - with CASII Score of four or Higher: Strength, Needs and Culture Discovery Document must be completed by the Behavioral Health Home.

   d. Children Age 11 to 18 - Standardized substance use screen and referral for further evaluation when screened positive must be completed by the Behavioral Health Home.
320-P   SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATION

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division of Developmental Disabilities’ (Division) Administrative Services Subcontractors (AdSS). The Division contracts with the AdSS and delegates the responsibilities of implementing this policy. The Division provides oversight and monitoring of delegated duties.

Policy Overview

A critical component of the AHCCCS delivery system is the effective and efficient identification of individuals who have behavioral health needs due to the severity of their behavioral health disorder. One such group is individuals determined to have a serious mental illness (SMI). Without receipt of the appropriate care, these individuals are at high risk for further deterioration of their physical and mental condition, increased hospitalizations, and potential homelessness and incarceration. To ensure that individuals who may have an SMI are promptly identified and evaluated, AHCCCS has established a standardized process for the referral, evaluation and determination of SMI eligibility as set forth in this Policy. The Division has adopted Exhibits from AHCCCS AMPM Policy 320-P for use by the AdSS.

Definitions

Assessment: The ongoing collection and analysis of an individual’s medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the individual’s service plan is designed to meet the individual’s (and family’s) current needs and long term goals.

Evaluation: The process of analyzing current and past treatment information, including assessment, treatment, other medical records and documentation, for purpose of determining an individual’s eligibility for SMI services.

Day: Computation of Time as defined in A.A.C. R9-21-103.

Determining Entity: The AHCCCS designee authorized to make the determination of SMI eligibility.

Serious Mental Illness: A designation as defined in A.R.S. §36-550 and determined in an individual 18 years of age or older.

Seriously Mentally Ill (SMI): Individuals who, as a result of a mental disorder as defined in A.R.S. 36-501, exhibit emotional or behavioral functioning that is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these individuals’ mental disability is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

SMI Determination: A determination as to whether or not an individual meets the diagnostic
and functional criteria established for the purpose of determining an individual’s eligibility for SMI services.

**SMI Decertification:** The process that results in a modification to a member’s medical record by changing the behavioral health category designation from SMI to General Mental Health.

**A. General Requirements**

1. All individuals must be evaluated for SMI eligibility by a qualified clinician, as defined in A.A.C. R9-21-101(B), and have an SMI Determination made by the Determining Entity if:
   a. The individual makes such a request;
   b. A guardian/legal representative, who is authorized pursuant to A.R.S. 14-5312, makes a request on behalf of the individual;
   c. An Arizona Superior Court issues an order instructing that an individual is to undergo an SMI Evaluation/determination; or
   d. A member is at least the age of 17.5. (Refer to AHCCCS Transition to Adulthood Practice Tool 8.0.)

2. The SMI eligibility evaluation record must contain all documentation considered during the review, including but not limited to, current and/or historical treatment records. The record may be maintained in either hardcopy or electronic format. The AdSS shall develop and make available to providers any requirements or guidance on SMI eligibility evaluation record location and/or maintenance.

3. Computation of time is as follows:
   a. Day Zero: The day the initial assessment is completed by a qualified clinician, regardless of time of the assessment;
   b. Day One: The next business day after the initial assessment is completed. The individual or organization completing the initial assessment must provide it to the Determining Entity as soon as practicable, but no later than 11:59 pm on Day One;
   c. Day Three: The third business day after the initial assessment is completed. The Determining Entity shall have at least two business days to complete the final SMI Determination, but the final SMI Determination must be completed no later than Day Three; and
   d. Determination Due Date: Day Three, three business days after Day Zero, excluding weekends and holidays, and is the date that the determination decision must be rendered. This date may be amended if an extension is approved in accordance with this policy.
B. **Process for Completion of Initial SMI Evaluation**

1. Upon receipt of a request, referral, or identification of the need for an SMI Determination, the AdSS will schedule an appointment for an initial meeting with the individual and a qualified clinician. This shall occur no later than seven business days after receiving the request or referral.

2. For referrals seeking an SMI eligibility determination for individuals admitted to a hospital for psychiatric reasons the entity scheduling the evaluation shall ensure that documented efforts are made to schedule a face-to-face SMI assessment with the member while hospitalized.

3. During the initial SMI evaluation meeting with the individual and qualified clinician, the clinician must:
   a. Make a clinical judgement as to whether the individual is competent enough to participate in an Evaluation;
   b. Obtain written consent to conduct the assessment from the individual or, if applicable, the individual’s guardian, unless the individual is under court-ordered evaluation as part of court-ordered treatment proceedings;
   c. Provide the individual and, if applicable, the individual’s guardian, the information required in A.A.C. R9-21-301(D)(2), a client rights brochure, and the appeal notice required by A.A.C. R9-21-401(B);
   d. Obtain authorization for the release of information, if applicable, (see AMPM Policy 550) for any documentation that would assist in the determination of the individual’s eligibility for SMI services;
   e. Conduct an assessment if one has not been completed within the last six months;
   f. Complete the SMI Determination Form (see AMPM 320-P Attachment A; and
   g. Upon completion of the initial SMI evaluation, submit all information to the Determining Entity within one business day.

C. **Criteria for SMI Eligibility**

1. The final determination of SMI requires both a qualifying SMI diagnosis and functional impairment because of the qualifying diagnosis (see AMPM 320-P Attachment B for qualifying diagnoses).

2. To meet the functional criteria for SMI status, an individual must have, as a result of a qualifying SMI diagnosis, dysfunction in at least one of the four domains described below for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months:
   a. Inability to live in an independent or family setting without
supervision. Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food and clothing must be provided or arranged for by others. Unable to attend to the majority of basic needs of hygiene, grooming, nutrition, medical and dental care. Unwilling to seek prenatal care or necessary medical/dental care for serious medical or dental conditions. Refuses treatment for life threatening illnesses because of behavioral health disorder;

b. A risk of serious harm to self or others. Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others’ bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others in the individual’s care. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan. Affective disruption causes significant damage to the individual’s education, livelihood, career, or personal relationships;

c. Dysfunction in role performance. Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities.

d. Risk of Deterioration. If an individual does not meet any one of the above functional criteria, and is expected to deteriorate to such a level without treatment, SMI eligibility may be established based on any of the following criteria:

i. A qualifying diagnosis with probable chronic, relapsing and remitting course;

ii. Co-morbidities (e.g., developmental/intellectual disability, substance use disorder, personality disorders);

iii. Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors (e.g., life-threatening or debilitating medical illnesses, victimization); or

iv. Other (e.g., past psychiatric history, gains in functioning have not solidified or are a result of current compliance only, court-committed, care is complicated and requires multiple providers).

3. The following reasons are not sufficient alone for denial of SMI eligibility:

a. An inability to obtain existing records or information; or
b. Lack of a face-to-face psychiatric or psychological evaluation.

D. **Process for Completion of Final SMI Determination**

1. The AdSS shall develop policies and procedures that describe the providers’ requirements for submitting the Evaluation Packet and providing additional clinical information in order for the Determining Entity to make the final SMI eligibility determination.

2. If the Determining Entity requires additional information to make a final SMI eligibility determination, the AdSS shall ensure that evaluating agencies respond to the Determining Entity within three business days of the request for information.

3. The licensed psychiatrist, psychologist or nurse practitioner designated by the Determining Entity will make a final determination as to whether the individual meets the eligibility requirements for SMI status based on:
   a. A face-to-face assessment or reviewing a face-to-face assessment by a qualified clinician; and
   b. 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.

4. The following shall occur if the designated reviewing psychiatrist, psychologist or nurse practitioner has not conducted a face-to-face assessment and has a disagreement with the current evaluating or treating qualified behavioral health professional or behavioral health technician that cannot be resolved by oral or written communication:
   a. Disagreement regarding diagnosis: Determination that the individual does not meet eligibility requirements for SMI status must be based on a face-to-face diagnostic evaluation conducted by a designated psychiatrist, psychologist or nurse practitioner. The resolution of (specific reasons for) the disagreement must be documented in the individual’s comprehensive clinical record.
   b. Disagreement regarding functional impairment: Determination that the individual does not meet eligibility requirements must be documented by the psychiatrist, psychologist or nurse practitioner in the individual’s comprehensive clinical record to include the specific reasons for the disagreement and will include a clinical review with the qualified clinician.

5. If there is sufficient information to determine SMI eligibility, the individual shall be provided written notice of the SMI eligibility determination within three business days of the initial meeting with the qualified clinician in accordance with this Policy.
E. **Issues Preventing Timely Completion of SMI Eligibility Determination**

**Extending Completion of SMI Eligibility Time Period**

1. The time to initiate or complete the SMI eligibility determination may be extended no more than 20 calendar days if the individual agrees to the extension and:

   a. There is substantial difficulty scheduling a meeting in which all necessary participants can attend;
   b. The individual fails to keep an appointment for assessment, evaluation or any other necessary meeting;
   c. The individual is capable of, but temporarily refuses to cooperate in the preparation of the completion of an assessment or evaluation;
   d. The individual or the individual’s guardian and/or designated representative requests an extension of time;
   e. Additional documentation has been requested but not received; or
   f. There is insufficient functional or diagnostic information to determine SMI eligibility within the required time periods.

**NOTE:** Insufficient diagnostic information shall be understood to mean that the information available to the reviewer is suggestive of two or more equally likely working diagnoses, only one of which qualifies as SMI, and an additional piece of existing historical information or a face-to-face psychiatric evaluation is likely to support one diagnosis more than the other(s).

2. The Determining Entity must:

   a. Document the reasons for the delay in the individual’s eligibility determination record when there is an administrative or other emergency that will delay the determination of an SMI status, and
   b. Not use the delay as a waiting period before determining an SMI status or as a reason for determining that the individual does not meet the criteria for SMI eligibility (because the determination was not made within the time standards).

3. In situations in which the extension is due to insufficient information:

   a. The Determining Entity shall request and obtain the additional documentation needed (e.g., current and/or past medical records) and/or perform or obtain any necessary psychiatric or psychological evaluations;
   b. The designated reviewing psychiatrist, psychologist or nurse practitioner must communicate with the individual’s current treating clinician, if any, prior to the determination of an SMI, if there is insufficient information to determine the individual’s level of functioning; and
c. SMI eligibility must be determined within three days of obtaining sufficient information, but no later than the end date of the extension.

4. If the evaluation or information cannot be obtained within the required time period because of the need for a period of observation or abstinence from substance use in order to establish a qualifying mental health diagnosis, the individual shall be notified by the Determining Entity that the determination may, with the agreement of the individual, be extended for up to 90 calendar days for an Extended Evaluation Period. This is a 90-day period of abstinence from drug and/or alcohol use in order to help the reviewing psychologist make an informed decision regarding SMI eligibility.

This extension may be considered a technical re-application to ensure compliance with the intent of A.A.C. R9-21-303; however, the individual does not need to actually reapply. Alternatively, the determination process may be suspended and a new application initiated upon receipt of necessary information.

5. If the individual refuses to grant an extension, SMI eligibility must be determined based on the available information. If SMI eligibility is denied, the individual will be notified of his/her appeal rights and the option to reapply in accordance with this Policy.

F. Notification of SMI Eligibility Determination

1. If the individual is determined SMI, the SMI status must be reported to the individual or legal guardian, by the Determining Entity, in writing, including notice of the individual’s right to appeal the decision.

2. If the eligibility determination results in a denial of SMI status, the Determining Entity must provide written notice of the decision and include:
   a. The reason for denial of SMI eligibility,
   b. The right to appeal, and
   c. The statement that individuals who are ALTCS eligible will continue to receive needed ALTCS covered services. In such cases, the individual’s behavioral health category assignment must be assigned based on criteria in the AHCCCS Technical Interface Guidelines.

G. Re-enrollment or Transfer

1. If the individual’s status is SMI at disenrollment or transition to another AdSS or acute contractor, the individual's status shall continue as SMI.

2. An individual shall retain his/her SMI status unless a determination is made by a Determining Entity that the individual no longer meets criteria.

H. Review of SMI Eligibility

1. The AdSS must indicate in policies and procedures made available to their providers the process for reviewing an SMI eligibility determination.
2. The AdSS may seek a review of an individual’s SMI eligibility from the Determining Entity:
   a. As part of an instituted, periodic review of all individuals determined to have an SMI;
   b. When there has been a clinical assessment that supports that the individual no longer meets the functional and/or diagnostic criteria; or
   c. As requested by a member, who has been determined to meet SMI eligibility criteria, or his/her legally authorized representative.

3. A review of the determination may not be requested by the AdSS or their contracted behavioral health providers within six months from the date an individual has been determined SMI eligible.

I. SMI Decertification

There are two established methods for removing an SMI designation, one clinical and the other an administrative option, as follows:

1. A member who has an SMI designation or an individual from the member’s clinical team may request an SMI Clinical Decertification from the AHCCCS designee that conducts SMI Determinations. An SMI Clinical Decertification is a determination that a member who has an SMI designation no longer meets SMI criteria. If, as a result of a review, the individual is determined to no longer meet the diagnostic and/or functional requirements for SMI status:
   a. The Determining Entity must ensure that written notice of the determination and the right to appeal is provided to the affected individual with an effective date of 30 calendar days after the date the written notice is issued, and
   b. The AdSS must ensure that services are continued if an appeal is timely filed, and that services are appropriately transitioned as part of the discharge planning process.

2. A member who has an SMI designation may request an SMI Administrative Decertification from AHCCCS, DHCM, and Clinical Resolution Unit if the member has not received behavioral health services for a period of two or more years.
   a. Upon receipt of a request for Administrative Decertification, the AdSS shall direct the member to contact AHCCCS, DHCM, Customer Service, and
   b. AHCCCS will evaluate the member’s request and review data sources to determine the last date the member received a behavioral health service. AHCCCS will inform the member of changes that may result with the removal of the member’s SMI designation. Based upon review, the following will occur:
i. If the member has not received a behavioral health service within the previous two years, the member will be provided with AMPM 320-P Attachment C. This form must be completed by the member and returned to AHCCCS; or

ii. If the review finds that the member has received behavioral health services within the prior two-year period, the member will be notified that he/she may seek Decertification of his/her SMI status through the Clinical Decertification process.
GENERAL AND INFORMED CONSENT

EFFECTIVE DATE: October 1, 2019

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(c); AMPM Policy 310-V; AMPM 310-V, Attachment A; AMPM Exhibit 320-Q, Attachments A and B

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). Each member of the Division of Developmental Disabilities (Division) has the right to participate in decisions regarding his or her behavioral health care, including the right to refuse treatment. It is important for members seeking behavioral health services to agree to those services, be made aware of the service options and alternatives available to them, and to be aware of the specific risks and benefits associated with these services.

Definitions

General Consent - a one-time agreement to receive certain services, including but not limited to behavioral health services, that is usually obtained from a member during the intake process at the initial appointment and is always obtained prior to the provision of any behavioral health services. General consent must be obtained from the member/responsible person.

Informed Consent - permission granted in the knowledge of the possible consequences; typically consent that is given by a patient to a doctor for treatment with full knowledge of the possible risks and benefits. Informed consent is required to be obtained from a member/responsible person prior to the provision of the following services and procedures:

A. Complementary and Alternative Medicine (CAM)
B. Psychotropic medications
C. Electro-Convulsive Therapy (ECT)
D. Use of telemedicine
E. Application for a voluntary evaluation
F. Research
G. Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness)
H. Procedures or services with known substantial risks or side effects.

Overview

The Division and AHCCCS recognizes two primary types of consent for behavioral health services: general consent and informed consent.

Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in A.A.C. R9-21-206.01(c), must present the facts necessary for a
member/responsible person to make an informed decision regarding whether to agree to the specific treatment and/or procedures. Documentation that the required information was given and that the member/responsible person agrees or does not agree to the specific treatment, and the member’s/responsible person’s signature when required, must be included in the comprehensive clinical record.

In addition to general and informed consent for treatment, state statute (A.R.S. § 15-104) requires written consent from a child’s parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school based prevention program.

The intent of this section is to describe the requirements for reviewing and obtaining general, and informed consent, for members receiving services within the behavioral health system, as well as consent for any behavioral health survey or evaluation in connection with an AHCCCS school-based prevention program.

**General Requirements**

A. Any member, aged 18 years and older, in need of behavioral health services, must give voluntary general consent to treatment, demonstrated by the member’s or legal guardian’s signature on a general consent form, before receiving behavioral health services.

B. For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. § 8-514.05[C]) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative’s signature on a general consent form prior to the delivery of behavioral health services.

C. Any member aged 18 years and older or the member’s legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency, after being fully informed of the consequences, benefits and risks of treatment, has the right not to consent to receive behavioral health services.

D. Any member aged 18 years and older or the member’s legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency has the right to refuse medications unless specifically required by a court order or in an emergency situation.

E. 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 must obtain consent, as applicable, in accordance with A.R.S. § 36-501 et seq.

F. All evidence of informed consent and general consent to treatment must be documented in the comprehensive clinical record per Policy 940 of this Policy Manual.

G. The Administrative Services Subcontractor (AdSS) must develop and make available to providers policies and procedures that include any additional information or forms.

H. A foster parent, group home staff, foster home staff, relative, or other person or
agency in whose care a child is currently placed may give consent for:

1. Evaluation and treatment for emergency conditions that are not life threatening, and

2. Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. § 8-514.05(C)).

I. To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS), whomever is available to do so immediately upon request (A.R.S. § 8-514.05(C)).

J. Foster or kinship caregivers can consent to evaluation and treatment for routine medical and dental treatment and procedures, including behavioral health services. Examples of behavioral health services for which foster or kinship caregivers can consent include:

1. Assessment and service planning
2. Counseling and therapy
3. Rehabilitation services
4. Medical Services
5. Psychiatric evaluation
6. Psychotropic medication
7. Laboratory services
8. Support Services
9. Case Management
10. Personal Care Services
11. Family Support
12. Peer Support
13. Respite
14. Sign Language or Oral Interpretive Services
15. Transportation
16. Crisis Intervention Services
17. Behavioral Health Day Programs.

K. A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed must not consent to:

1. General anesthesia
2. Surgery
3. Testing for the presence of the human immunodeficiency virus
4. Blood transfusions
5. Abortions.

L. Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires DCS consultation and agreement.

M. If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS caseworker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

**General Consent**

Administrative functions associated with a member’s enrollment do not require consent, but before any services are provided, general consent must be obtained.

The AdSS must develop and make available to providers any form used to obtain general consent to treatment.

**Informed Consent**

A. In all cases where informed consent is required by this policy, informed consent must include at a minimum:

1. 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
2. Information about the member’s diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment
3. The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding
4. The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects

5. The ability of any consent given to be withheld or withdrawn in writing or orally at any time (when this occurs, the provider must document the member’s choice in the medical record)

6. The potential consequences of revoking the informed consent to treatment

7. A description of any clinical indications that might require suspension or termination of the proposed treatment.

B. Documenting Informed Consent

1. Members, or if applicable, the member’s parent, guardian or custodian, must give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.

2. When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established.

   If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the responsible person, refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner must document in the member’s record that:

   a. The information was given
   b. The member refused to sign an acknowledgment
   c. The member gives informed consent to use psychotropic medication or telemedicine.

C. When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

1. Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court

2. Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience.

   It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.
D. Psychotropic Medications, Complementary and Alternative Treatment and Telemedicine

1. Unless treatments and procedures are court ordered, providers must obtain written informed consent, and if written consent is not obtainable, providers must obtain oral informed consent. If oral informed consent is obtained instead of written consent from the member, parent or legal guardian, it must be documented in the medical record. Informed consent is required prior to:

   a. Initiation of any psychotropic medication or initiation of Complementary and Alternative Treatment (CAM) (see Division Medical Policy Manual Policy 310-V)

      The use of Informed Consent/Assent for Psychotropic Medication Treatment Form (AMPM 310-V Attachment A) is recommended as a tool to review and document informed consent for psychotropic medications.

   b. Delivery of behavioral health services through telemedicine.

2. Written informed consent must be obtained from the member, parent or legal guardian, unless treatments and procedures are under court order, prior to:

   a. Provision of Electro-Convulsive Therapy (ECT)

      ECT includes research activities, voluntary evaluation, and procedures or services with known substantial risks or side effects.

   b. Involvement of the member in research activities

   c. Provision of a voluntary evaluation for a member

      The use of Application for Voluntary Evaluation (AMPM 320-Q, Attachment A) is required for members determined to have a Serious Mental Illness and is recommended as a tool to review and document informed consent for voluntary evaluation of all other populations.

   d. Delivery of any other procedure or service with known substantial risks or side effects.

E. Written informed consent must be obtained from the member, legal guardian, or an appropriate court, prior to the member's admission to any medical detoxification program, inpatient facility, or residential program, operated by a behavioral health provider.

F. If informed consent is revoked, treatment must be promptly discontinued, except when abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.
G. Informed Consent for Telemedicine

1. Before a health care provider delivers health care via telemedicine, verbal or written informed consent from the member or legally authorized health care decision maker must be obtained. Refer to this Policy Manual, Policy 320-I.

2. Information regarding informed consent may be provided by the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience. When providing information regarding informed consent, it must be communicated in a manner that the member and/or legal guardian can adequately understand.

3. Exceptions to this consent requirement include:
   a. If the telemedicine interaction does not take place in the physical presence of the member
   b. In an emergency situation in which the member or the member’s legally authorized health care decision maker is unable to give informed consent
   c. The transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.

Special Requirements for Children

A. In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization, state-supported institution, or any person employed by any of these entities, may procure, solicit to perform, arrange for the performance of, or perform, mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

B. Non-Emergency Situations

1. When the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child’s legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:
   a. Lawfully authorized legal guardian
   b. Foster parent, group home staff or other person with whom the DCS has placed the child, or
c. Government agency authorized by the court.

2. If someone other than the child’s parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child’s comprehensive clinical record:

<table>
<thead>
<tr>
<th>INDIVIDUAL/ENTITY</th>
<th>DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal guardian</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>Relatives</td>
<td>Copy of power of attorney document</td>
</tr>
<tr>
<td>Other person/agency</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>DCS Placements (for children removed from the home by DCS), such as:</td>
<td>None required (see note)</td>
</tr>
<tr>
<td>Foster parents</td>
<td></td>
</tr>
<tr>
<td>Group home staff</td>
<td></td>
</tr>
<tr>
<td>Foster home staff</td>
<td></td>
</tr>
<tr>
<td>Relatives</td>
<td></td>
</tr>
<tr>
<td>Other person/agency in whose care DCS has placed the child</td>
<td></td>
</tr>
</tbody>
</table>

Note: If behavioral health providers doubt whether the person bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the person by DCS indicating that the person is an authorized DCS placement. If the person does not have this documentation, the provider may also contact the child’s DCS caseworker to verify the person’s identity.

3. For any child who has been removed from the home by DCS, the foster parent, group home staff, foster home staff, relative or other person or agency in whose care the child is currently placed may give consent for the following behavioral health services:

a. Evaluation and treatment for emergency conditions that are not life threatening, and

b. Routine medical and dental treatment and procedures, including early periodic screening, diagnosis and treatment services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (including behavioral health services and psychotropic medications).
4. Any minor who has entered into a lawful contract of marriage, whether or not that marriage has been dissolved subsequently, any emancipated youth or any homeless minor may provide general and, when applicable, informed consent to treatment without parental consent (A.R.S. § 44-132).

C. Emergency Situations

1. In emergencies involving a child in need of immediate hospitalization or medical attention, general and, when applicable, informed consent to treatment is not required.

2. Any child, 12 years of age or older, who is determined upon diagnosis of a licensed physician, to be under the influence of a dangerous drug or narcotic, not including alcohol, may be considered an emergency situation and can receive behavioral health care as needed for the treatment of the condition without general and, when applicable, informed consent to treatment.

Special Requirements for Children

At times, involuntary treatment can be necessary to protect safety and meet needs when a member, due to mental disorder, is unwilling or un-able to consent to necessary treatment. In this case, a court order may serve as the legal basis to proceed with treatment. However, capacity to give informed consent is situational, not global, as a member may be willing and able to give informed consent for aspects of treatment even when not able to give general consent. Members should be assessed for capacity to give informed consent for specific treatment, and such consent should be obtained if the member is willing and able, even though the member remains under court order.

Consent for Behavioral Health Survey or Evaluation for School-Based Prevention Programs

A. Written consent must be obtained from a child’s parent or legal guardian for any behavioral health survey, analysis, or evaluation conducted in reference to a school-based prevention program administered by AHCCCS.

B. Substance Abuse Prevention Program and Evaluation Consent (AMPM 320-Q, Attachment B) must be used to gain parental consent for evaluation of school based prevention programs. Providers may use an alternative consent form only with the prior written approval of the Division and AHCCCS. The consent must satisfy all of the following requirements:

1. Contain language that clearly explains the nature of the screening program and when and where the screening will take place

2. Be signed by the child’s parent or legal guardian

3. Provide notice that a copy of the actual survey, analysis, or evaluation questions to be asked of the student is available for inspection upon request by the parent or legal guardian.
C. Completion of Substance Abuse Prevention Program and Evaluation Consent (AMPM 320-Q, Attachment B) applies solely to consent for a survey, analysis, or evaluation only, and does not constitute consent for participation in the program itself.
**320-R SPECIAL ASSISTANCE FOR MEMBERS WITH SERIOUS MENTAL ILLNESS**

**EFFECTIVE DATE:** October 1, 2019

**REFERENCES:** AMPM Policy 1040; AMPM 320-R Attachment A; A.R.S. §§ 14-5304, 36-107, 36-501, 36-504, 36-509, 36-517.01, 41-3803, and 41-3804; 9 A.A.C 21

**DELIVERABLES:** Members Determined to Have SMI Receiving Special Assistance

This policy applies to the Division Administrative Services Subcontractor (AdSS). The Division’s AdSS must identify and report, to the Division, persons determined to have a Serious Mental Illness (SMI) and meet the criteria for Special Assistance.

If the person’s Special Assistance needs appear to be met by an involved family member, friend, designated representative, or guardian:

A. The AdSS, or a behavioral health provider, must still submit a notification to the Division.

B. The AdSS, must ensure that the person designated to provide Special Assistance is involved at key stages.

**Purpose**

The purpose of this policy is to establish uniform guidelines for:

A. Identifying persons determined to have a Serious Mental Illness (SMI) who are in need of Special Assistance

B. Ensuring that persons in need of Special Assistance have their Special Assistance needs met

C. Maintaining and disseminating required reports on persons in need of Special Assistance.

The AdSS must ensure that all subcontracted providers adhere to the requirements of this policy.

**General Requirements**

A. Criteria to deem a person to be in need of Special Assistance are as follows:

1. A person determined to have a Serious Mental Illness (SMI) is in need of Special Assistance if he/she is also unable to do any of the following:
   
   a. Communicate preferences for services.
   
   b. Participate effectively in Planning Meetings, or Inpatient Treatment Discharge Planning (ITDP).
   
   c. Participate effectively in the appeal, grievance or investigation processes.
d. The member’s limitations described in a.-c. above must also be due to any of the following:
   
i. Cognitive ability/intellectual capacity (i.e., cognitive impairment, borderline intellectual functioning, or diminished intellectual capacity)
   
ii. Language barrier (an inability to communicate, other than a need for an interpreter/translator)
   
iii. Medical condition (including, but not limited to traumatic brain injury, dementia, or severe psychiatric symptoms).

2. A person who is subject to general guardianship has been found to be incapacitated under A.R.S. § 14-5304, and therefore automatically satisfies the criteria for Special Assistance.

B. For a person determined to have an SMI, the existence of any of the following circumstances should prompt the AdSS to more closely review whether the person is in need of Special Assistance:

1. Developmental disability involving cognitive ability
2. Residence in a 24 hour setting
3. Limited guardianship, or the AdSS is recommending and/or pursuing the establishment of a limited guardianship
4. Existence of a serious medical condition that affects his/her intellectual and/or cognitive functioning (such as, dementia or traumatic brain injury).

C. Any of the following people may deem a person to be in need of Special Assistance:

1. A qualified clinician providing treatment for the person
2. A Support Coordinator
3. A clinical team of the AdSS
4. The Division/Division Planning Team
5. A program director of an AdSS-subcontracted provider (including the Arizona State Hospital [AzSH])
6. The Deputy Director of AHCCCS or designee
7. A hearing officer assigned to an appeal involving a person determined to have an SMI.
D. When to Screen for Special Assistance

The AdSS, and their subcontracted providers must, on an ongoing basis, screen whether persons determined to have an SMI are in need of Special Assistance in accordance with the criteria set out in the General Requirements section of this policy. Minimally, this must occur at the following stages:

1. Assessment and annual updates
2. Development of, or update to, the Behavioral Health Individual Service Plan (ISP)
3. Upon admission to a psychiatric inpatient facility
4. Development of, or update to, an Inpatient Treatment and Discharge Plan (ITDP)
5. Initiation of the grievance or investigation processes
6. Filing of an appeal
7. Existence of a condition that may be a basis for a grievance, investigation or an appeal.

Documentation

A. The AdSS, and their subcontracted providers must document in the clinical record each time a staff member screens a person for Special Assistance, indicating the factors reviewed and the conclusion. If the conclusion is that the person is in need of Special Assistance, they must notify the Division, using AHCCCS Medical Policy Manual (AMPM) 320-R Attachment A, Notification of Member in Need of Special Assistance, as adopted by the Division, in accordance with the procedures below.

B. Before submitting AMPM 320-R Attachment A, the AdSS, and their subcontracted providers must check if the person is already identified as in need of Special Assistance. A notation of Special Assistance designation and a completed AMPM 320-R Attachment A should already exist in the clinical record. However, if it is unclear, subcontracted providers must review data or contact the AdSS to inquire about current status.

C. The AdSS are required to maintain a database on persons in need of Special Assistance and share data with providers on a regular basis (at a minimum quarterly).

Requirements to Notify the Division

A. If a person is not correctly identified as Special Assistance, the AdSS, and their subcontracted providers, must submit Part A of AMPM 320-R Attachment A to the Division within five working days of identifying a person in need of Special Assistance. If the person has a Special Assistance need requiring immediate assistance, the notification form must be submitted immediately with a notation
indicating the urgency. The AdSS and their subcontracted providers should inform the person of the notification and explain the benefits of having another person involved who can provide Special Assistance, if able.

B. If the person is under a guardianship or one is in process, the documentation of such must also be submitted to the Division. However, if the documentation is not available at the time of submission of the AMPM 320-R Attachment A notification, the form should be submitted within the required timeframes, followed by submittal of the guardianship documentation.

C. The Division reviews the notification form to ensure that it contains sufficient information detailing the criteria and responds to the AdSS and their subcontracted providers by completing Part B of AMPM 320-R Attachment A within five working days of receipt of the form. If the necessary information is not provided on the form, the Division contacts the staff member submitting the notification for clarification. If the notification is urgent, the Division will respond as soon as possible, but generally within one working day of receipt of the notification.

D. The notification process is not complete until the Division completes Part B of the form and sends it back to the AdSS and its subcontracted providers. The AdSS and their subcontracted providers should follow up if no contact is made or if Part B is not received within five working days.

E. The Division designates which agency/person will provide Special Assistance when processing AMPM 320-R Attachment A. When the agency/person providing Special Assistance changes, the Division processes an “updated Part B” to document the change.

F. If the person or agency currently identified as providing Special Assistance is no longer actively involved, the Division must notify Division of Healthcare Care Advocacy & Advancement (DHCAA). If a DHCAA advocate is also assigned, notification to the advocate is sufficient.

**Persons No Longer in Need of Special Assistance**

A. The AdSS or their subcontracted providers must notify the Division within 10 days of an event or determination that a person in need of Special Assistance no longer meets criteria by completing Part C of the original notification form (with Parts A and B completed when first identified), noting:

1. The reason(s) why Special Assistance is no longer required
2. The effective date
3. The name, title, phone number and e-mail address of the staff person completing the form
4. The date the form is completed.
B. The following are instances that should prompt the AdSS or their subcontracted providers to submit a Part C:

1. The original basis for the person meeting Special Assistance criteria is no longer applicable and the person does not otherwise meet criteria.

   The AdSS or their subcontracted provider must first discuss the determination with the person or agency providing Special Assistance to obtain any relevant input, and this includes when a person is determined to no longer be a person with an SMI (proper notice and appeal rights must be provided and the period to appeal must have expired).

2. The person passes away.

3. The person’s episode of care is ended with the AdSS (on-Title XIX persons with an SMI will also be disenrolled) and the person is not transferred to another AdSS.

C. The AdSS or their subcontracted providers must first perform all required re-engagement efforts, which includes contacting the person providing Special Assistance, per AMPM Policy 1040, Outreach, Engagement, Re-engagement and Closure for Behavioral Health. Proper notice and appeal rights must be provided and the period to appeal must have expired prior to submission of Part C.

   Note: Submission of a Part C is not needed when a person transfers to another AdSS, as the Special Assistance designation follows the person.

D. Upon receipt of Part C of the AMPM 320-R Attachment A, the Division reviews content to confirm accuracy and completeness and returns it to the agency that submitted it, copying the AdSS or their subcontractors.

**Requirement of the Division, its AdSSs, Subcontractors to Help Ensure the Provision of Special Assistance**

A. The AdSS or their subcontracted providers must maintain open communication with the person (e.g., guardian, family member, friend, advocate) assigned to meet the person’s Special Assistance needs. Minimally, this involves providing timely notification to the person providing Special Assistance to ensure involvement in the following:

1. Behavioral Health ISP planning and review, which occurs in any instance when the person makes a decision regarding service options and/or denial/modification/termination of services (service options include not only a specific service but also potential changes to provider, site, and physician and case manager assignment).

2. Behavioral Health ISP development and updates, which must be in accordance with 320-O, Service Planning, Assessments, and Discharge Planning in this Policy Manual.

3. ITDP planning, which occurs any time a person is admitted to a psychiatric...
inpatient facility and involvement throughout the stay and discharge.

4. Appeal process, which occurs in circumstances that may warrant the filing of an appeal, so all Notices Adverse Benefit Determination (NOA) or Notices of Decision (NOD) issued to the person/guardian must also be copied to the person designated to meet Special Assistance needs; and

5. Investigation or Grievance, which occurs when an investigation/grievance is filed and circumstances when initiating a request for an investigation/grievance may be warranted.

B. If such procedures are delayed in order to ensure the participation of the person providing Special Assistance, the AdSS, subcontracted providers must document the reason for the delay, in the clinical record or in the investigation, grievance or appeal file. If an emergency service is needed the AdSS, and/or their subcontracted providers must, ensure that the person receives the needed services in the interim and promptly notify the agency/person providing Special Assistance.

C. The AdSS must timely provide relevant details and a copy of the original AMPM 320-R Attachment A (both Parts A and B) to the receiving entity when a person in need of Special Assistance is

1. Admitted to an inpatient facility
2. Admitted to a residential treatment setting
3. Transferred to a different AdSS.

D. The AdSS must periodically review whether the person’s needs are being met by the person or agency designated to meet the person’s Special Assistance needs. If a concern arises, they should first address it with the person or agency providing Special Assistance. If the issue is not promptly resolved, they must take further action to address the issue, which may include contacting the Division for assistance.

AdSS Reporting Requirements

A. The AdSS must maintain a copy of completed AMPM 320-R Attachment A, Parts A, B and updated if any.

B. The AdSS must maintain a database on persons in need of Special Assistance to ensure compliance with this policy and the reporting requirements described in this section. This cannot be delegated to providers.

- The AdSS must, by the 10th calendar day of each month, provide the Division Compliance Unit with a comprehensive report listing of all persons in need of Special Assistance who are active as of the end of the previous month
- Any Part C notifications, during the previous month, that a person no longer needs Special Assistance
- Any persons transferred, to the AdSS during the previous month, who were
Special Assistance in the previous contractor or Tribal Regional Behavioral Health Authority (TRBHA)

- Any person in need of Special Assistance who was transferred from the AdSS to another AdSS.

The monthly reports must contain the following information:

1. CIS Number
2. Name
3. Date of Birth
4. Guardian (yes or no)
5. Current address
6. Current phone number
7. Type of residence
8. Whether currently at AzSH and unit name
9. AzSH Identification Number
10. Name of Provider
11. Name/location of Provider site
12. Name of Case Manager
13. Name of Clinical Supervisor
14. Title XIX (AHCCCS) enrollment status (yes or no)
15. Effective Date (date Part B was completed)
16. Person/relationship or agency meeting Special Assistance needs
17. Name, address and phone number of person meeting the Special Assistance needs
18. If applicable, the Date of Discharge from AzSH
19. If applicable, the Date of the Removal (when Part C of the notification was sent to the Division) or the event and event date that prompted the removal
20. If applicable, information on any updated Part B (indicating change in person meeting needs), and
21. If applicable, the Date of the transfer including the name of the receiving contractor.
C. By the 25th day of the month following the end of a quarter, the Division provides AdSS with a comprehensive report for the previous quarter.

D. The AdSS, in response to the Division’s quarterly report, must:
   1. Update the AdSS database with data updates contained in the quarterly report for persons assigned to an advocate.
   2. Submit an updated report to the Division by the 10th day of the next month. The report must identify any changes, in client information, for persons not assigned to an Advocate, that occurred during the previous quarter.

   Examples include change in Title XIX enrollment, changes in the person’s residence, case management provider or case manager assignment, etc. The AdSS and the Division must work together to rectify any data discrepancies in a timely manner to ensure that the data maintained is accurate.

E. The Division, using data it maintains on all persons in need of Special Assistance, must provide a list of persons in each region to each Independent Oversight Committee (IOC) by the 25th calendar day of each month. The Division customarily provides a courtesy copy of the report.

F. By the 10th calendar day of each month, AdSS must provide the Division with a comprehensive report listing of persons in need of Special Assistance that were receiving services at AzSH during the previous month. The Division provides the final report to the DDD IOC and a copy to the AdSS by the 25th of the month.

G. AdSS must share Special Assistance data with its subcontracted providers that provide case management to persons determined to have an SMI and verify that a process exists at each case management provider to ensure this data is accessible by front-line provider staff (at a minimum quarterly). AdSS must also establish a process with such providers to obtain quarterly updates on persons currently identified as Special Assistance to support the AdSS quarterly data updates process with the Division.

Confidentiality Requirements

A. The AdSS and subcontracted providers must grant access to clinical records of persons in need of Special Assistance in accordance with federal and state confidentiality laws (see Division Medical Policy Manual 550).

B. DDD IOCs and their members must safeguard the monthly list that contains the names of those persons in need Special Assistance regarding any Protected Health Information (PHI). IOCs must inform AHCCCS annually in writing of how it will maintain the confidentiality of the Special Assistance lists. If IOCs request additional information that contains PHI that is not included in the monthly report.
Other Procedures

A. The AdSS must maintain a copy of the completed AMPM 320-R Attachment A, (Parts A and B and updated B, if any) in the person’s comprehensive clinical record. If a person was identified as no longer needing Special Assistance and a Part C of the notification form was completed, the AdSS and subcontracted providers must maintain a copy of the form in the comprehensive clinical record.

B. The AdSS must clearly document in the clinical record (i.e., on the assessment, ISP, ITDP, face sheet) and case management/client tracking system if a person is identified as in need of Special Assistance, the person assigned currently to provide Special Assistance, the relationship, contact information including phone number and mailing address.

C. The DDD IOCs must make regular visits to the residential environments of persons in need of Special Assistance to determine whether the services meet their needs and their satisfaction with the residential environment.

D. The AdSS must implement quality management measures to ensure the subcontracted providers implement the requirements of this policy. Audit tools and procedures must be shared with the Division prior to use to ensure they address:
   1. Screening requirements
   2. Documentation requirements
   3. Provisions of Special Assistance requirements.

E. The AdSS must ensure that all applicable staff are trained regarding the requirements of Special Assistance (see Division Medical Policy Manual, Policy 1060).
320-S  APPLIED BEHAVIOR ANALYSIS

EFFECTIVE DATE: 10/01/2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This Policy establishes requirements for Applied Behavior Analysis (ABA) service delivery, and treatment.

Definitions

A. **Applied Behavior Analysis (ABA)** - The design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvements in human behavior. It includes the empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis. ABA interventions are based on scientific research and the direct observation and measurement of behavior and the environment. Behavior analysts utilize contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to help people develop new behaviors, increase or decrease existing behaviors, and emit behaviors under specific environmental conditions.

B. **Behavior Analysis Trainee** - A BCaBA®, or a matriculated graduate student or trainee whose activities are part of a defined ABA program of study, practicum, intensive practicum, or supervised independent fieldwork. The practice under this role requires direct and ongoing supervision consistent with the standards set by a nationally recognized behavior analyst certification board as determined by the Arizona Board of Psychologist Examiners, and in accordance with A.R.S. §32-2091.08.

C. **Behavior Analyst Certification Board, Inc.® (BACB®)** - A nonprofit 501(c)(3) corporation established to meet professional credentialing requirements for behavior analysts, governments, and consumers of behavior analysis services.

D. **Behavioral Health Technician** - An individual who meets qualifications to be a Behavioral Health Technician (BHT) as specified in 9 A.A.AC. 10, R9-10-101.

E. **Board Certified Behavior Analyst (BCBA)** - A Graduate level independent practitioner certified in behavior analysis by the Behavior Analyst Certification Board®.

F. **Board Certified Assistant Behavior Analyst® (BCABA®)** - A bachelor’s prepared individual who meets the professional credentialing requirements of the Behavior Analyst Certification Board®. BCaBA® may not practice independently and shall be supervised by someone certified at the Board Certified Behavior Analyst® (BCBA®) or Board Certified Behavior Analyst-Doctoral (BCBA-D®) level.

G. **Board Certified Behavior Analyst, Doctoral (BCBA-DTM)** - A Board Certified Behavior Analyst® who has completed Doctoral training in behavior analysis.

H. **Licensed Behavior Analyst (LBA)** - A Board Certified Behavior Analyst® (BCBA®) or Board Certified Behavior Analyst-Doctoral™ (BCBA-D™) who has successfully completed all applicable requirements imposed by the state of Arizona to practice ABA (see A.R.S. §32-2091). LBAs are designated as behavioral health professionals under 9 A.A.C. 10, R9-10-101.

I. **Registered Behavior Technician™ (RBT®)** - A paraprofessional who has obtained certification as a Registered Behavior Technician™ (RBT®) through the Behavior Analyst
Certification Board®, and who is responsible for the direct implementation of behavior analytic services under the direction and supervision of a BCBA®, BCBA-D™, BCaBA®, or Behavior Analysis Trainee

**Program Description**

Applied Behavior Analysis (ABA) services are an AHCCCS covered benefit for individuals with Autism Spectrum Disorder (ASD) and other diagnoses as justified by medical necessity. ABA services are designed to accomplish one or more of the following: increase functional skills, increase adaptive skills (including social skills), teach new behaviors, increase independence and/or reduce or eliminate behaviors that interfere with behavioral or physical health.

ABA services are medically necessary when there are specific and objectively-defined target behaviors impacting the member’s development, communication, or ability to access or participate in their environment or community. ABA interventions will be focused on building the member’s adaptive skills and reducing maladaptive behaviors, improving functioning, and preventing deterioration.

ABA services are prescribed or recommended in specific dosages, frequency, intensity, and duration by a qualified Behavioral Health Professional as the result of an assessment of the member, the intensity of the behavioral targets, and complexity and range of treatment goals.

Refer to the Behavioral Health Services Billing Matrix and Medical Coding Resources on the AHCCCS website for more information regarding required coding information, including covered settings.

**Provider Qualifications**

ABA services are directed and overseen by Licensed Behavior Analysts (LBAs) and supported, where applicable, by BCaBA®s, Behavior Analysis Trainees, and/or Behavior Technicians.

A. The below services may be provided LBAs:

1. Assessments to determine the relationship between a member’s behaviors and environmental events or context.
2. Development of a written behavior plan, including skill development, behavior reduction, and maintenance.

B. The below services may be provided by LBAs, BCaBA®s, Behavior Analysis Trainees, and/or Behavior Technicians:

1. Evaluation and revision of the behavior plan as needed to meet the individual’s needs.
2. Assisting caregivers or others to carry out the behavior plan.
3. Observing the implementation of the behavior plan to monitor fidelity.
4. Observing the member’s behavior to determine efficacy of the behavior plan.
5. Providing on-site assistance in behavior reduction or skill acquisition.
### PROVIDERS OF ABA SERVICES

<table>
<thead>
<tr>
<th>PROVIDERS OF ABA SERVICES</th>
<th>PROVIDER IS RESPONSIBLE FOR SUPERVISING:</th>
<th>PROVIDER IS SUPERVISED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LBA</td>
<td>BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians</td>
<td>N/A</td>
</tr>
<tr>
<td>BCaBA®</td>
<td>Behavior Technician</td>
<td>LBA</td>
</tr>
<tr>
<td>Behavior Analysis Trainee</td>
<td>Behavior Technician</td>
<td>LBA</td>
</tr>
<tr>
<td>Behavior Technician</td>
<td>N/A</td>
<td>LBA, and/or BCaBA®, Behavior Analysis Trainee</td>
</tr>
</tbody>
</table>

C. The LBA is responsible for training BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians to implement assessment and intervention protocols with members. The LBA is responsible for all aspects of clinical direction, supervision, and provider-level case management.

D. The LBA is responsible for ensuring that the extent, kind, and quality of the ABA services the BCaBA®, Behavior Analysis Trainee, and Behavior Technician performs are consistent with his or her training and experience.

E. The LBA is responsible for the BCaBA®, Behavior Analysis Trainee, and Behavior Technician compliance with this Policy and Arizona state rules and regulations including those provisions set forth in A.R.S. §32-2091.

### ABA Assessments

ABA services are based upon assessment(s) that include Standardized and/or Non-standardized instruments through both direct and indirect methods.

A. Standardized instruments and procedures include, but are not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all members (e.g. Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).

B. Non-standardized instruments and procedures include, but are not limited to, curriculum-referenced assessments, stimulus preference assessment procedures, and other procedures for assessing behaviors and associated environmental events that are specific to the individual member and their behaviors.

C. Re-assessments for members who are in ABA treatment is conducted at minimum every six months.

### ABA Treatment Planning

ABA services are rendered according to an individualized ABA Treatment Plan will:
A. Be developed by a LBA, based upon an assessment completed of the member and their behaviors as described above.

B. Be person-centered and individualized to the member’s specific needs.

C. Specify the setting(s) in which services will be delivered.

D. Identify the modality by which the service will be delivered (whether in person or via telehealth, or in group or individual setting, or combination thereof).

E. Identify the baseline levels of target behaviors.

F. Specify long- and short-term objectives that are defined in observable, measurable, and behavioral terms.

G. Specify the criteria that will be used to determine treatment progress and achievement of objectives.

H. Include assessment and treatment protocols for addressing each of the target behaviors.

I. Clearly identify the schedule of services planned and roles and responsibilities for service delivery.

J. Include frequent review of data on target behaviors.

K. Include adjustments of the treatment plan and/or protocols by the LBA as needed based upon the review of data, including recommendations for treatment intensity and duration based upon the member’s response to treatment.

L. Include training, supervision, and evaluation of procedural fidelity for BCaBA®s, Behavior Analysis Trainees, and Behavior Technicians implementing treatment protocols.

M. Include training and support to enable parents and/or other caregivers, if applicable, to participate in treatment planning and treatment plan implementation.

N. Include care coordination activities involving the member’s team in order to assist in the generalization and maintenance of treatment targets. This may include Child and Family Team (CFT) or Adult Recovery Team (ART), Health Care Decision Maker, the Primary Care Provider (PCP), school, medical specialists, behavioral health prescribers, DCS, and/or other state-funded programs, and others as applicable.

O. Result in progress reports at minimum, every six months. Progress reports includes, but are not limited to, the following components:

1. Member Identification

2. Background Information (family dynamics, school placement, cultural considerations, prenatal and/or developmental history, medical history, sensory, dietary and adaptive needs, sleep patterns, and medications).

3. Assessment Findings (communication, social, motor, and self-help skills, maladaptive behaviors, and primary caregiver concerns).

4. Outcomes (measurable objectives, progress towards goals, clinical
recommendations, treatment dosage, family role and family outcomes, and nature of family participation).

5. Care Coordination (transition statement and individualized discharge criteria).

P. Be consistent with applicable professional standards and guidelines relating to the practice of ABA as well as Arizona Medicaid laws and regulations and Arizona state behavior analyst licensure laws and regulations (A.R.S. §32-2091).

**Discontinuation of Services**

Discontinuation of ABA services occurs based upon any of the following:

A. The member, or member’s primary caregivers, are not engaging in treatment or have declined treatment recommendations after successive attempts to resolve.

B. The member has achieved a stable level of functioning, and further treatment is not expected to produce significant improvement in functioning.

C. Caregivers are able to independently provide effective interventions without ongoing ABA services.

D. Less intensive or more cost effective services are sufficient to meet the member’s needs.
320-U PRE-PETITION SCREENING, COURT-ORDERED EVALUATION, AND COURT-ORDERED TREATMENT

EFFECTIVE DATE: October 1, 2019

This Policy establishes guidelines, as applicable, for the provision and coordination of behavioral health services regarding the pre-petition screening, court ordered evaluation, and court ordered treatment process.

Definitions

A. Court-Ordered Evaluation (COE) - A professional multidisciplinary analysis based on data describing the person's identity, biography and medical, psychological and social conditions with all evaluation requirements defined in A.R.S. § 36-501.

B. Court-Ordered Treatment (COT) - In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533, an individual in Arizona can be ordered by the court to undergo mental health treatment if found to fit one of the following categories due to a mental disorder:

1. A Danger to Self (DTS),
2. A Danger to Others (DTO),
3. Gravely Disabled (GD), or
4. Persistently or Acutely Disabled (PAD).

C. Evaluation Agency - A health care agency licensed by the Arizona Department of Health Services (ADHS) that has been approved pursuant to A.R.S. Chapter 5 Title 36 providing those services required of such agency as delineated in the A.R.S. Chapter 5 Title 36 (A.R.S. § 36-501).

D. Mental Disorder - A substantial disorder of the individual's emotional processes, thought, cognition, or memory as defined in A.R.S. §36-501.

E. Pre-Petition Screening - The review of each application requesting court ordered evaluation, including an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed individual. The purpose of the interview with the proposed member is to assess the problem, explain the application, and, when indicated, attempt to persuade the proposed member to receive, on a voluntary basis, evaluation or other services.

F. Screening Agency - A health care agency licensed by ADHS and that provides those services required of such agency pursuant to A.R.S. Chapter 5 Title 36 (A.R.S. § 36-501).

G. Voluntary Evaluation - An inpatient or outpatient evaluation service that is provided after a determination that a person will voluntarily receive an evaluation and is unlikely to present a danger to self or others until the voluntary evaluation
is completed. A voluntary evaluation is invoked after the filing of a pre-petition screening but before the filing of a court ordered evaluation and requires the informed consent of the person. Additionally, the person must be able to manifest capacity to give informed consent pursuant to A.R.S. § 36-518.

Policy

This Policy outlines the processes and responsibilities applicable when it is necessary to initiate COE/COT proceedings detailed in A.R.S. §§ 36-501 et seq. This process is used to ensure the safety of an individual, or the safety of others when, due to an individual’s Mental Disorder, that individual is unable or unwilling to participate in treatment. AdSS responsibilities may vary for Pre-Petition Screening and COE based on contractual arrangements between the Division, AHCCCS, AdSS, and the counties. AdSS must ensure providers responsible for the COE/COT process adhere to requirements of this Policy.

When necessary, in accordance with A.A.C. R9-21-101 and A.R.S. § 36-520, any responsible person may submit an application, as specified in Attachment A (Application for Involuntary Evaluation), when another individual is alleged to be, as a result of a Mental Disorder:

- Danger to Self (DTS).
- Danger to Others (DTO).
- Persistently or Acutely Disabled (PAD), or
- Gravely Disabled (GD).

If the individual who is the subject of a court-ordered commitment proceeding is subject to the jurisdiction of a tribal nation, rather than the state, the laws of that tribal nation will govern the commitment process. Information about the tribal court process and the procedures under state law for recognizing and enforcing a tribal court order are found in this Policy.

Pre-Petition Screening includes an examination of the individual’s mental status and/or other relevant circumstances by a designated Screening Agency. Upon review of the application, examination of the individual and review of other pertinent information, a licensed Screening Agency’s medical director or designee will determine if the individual meets criteria for DTS, DTO, PAD, or GD as a result of a mental disorder.

If the pre-petition application screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file an application, as specified in Attachment B (Application for Emergency Admission for Evaluation), for a COE. Based on the immediate safety of the individual or others, an emergency admission for evaluation may be necessary. The Screening Agency, upon receipt of the application must determine the need for continued evaluation and immediately act as prescribed, not to exceed 48 hours of the filing of the application excluding weekends and holidays as specified in A.R.S. § 36-520.

Based on the COE, the Evaluating Agency may petition for COT on behalf of the
individual. The subsequent hearing is the determination as to whether the individual will be court ordered to treatment as specified in A.R.S. § 36-539. COT may include a combination of inpatient and outpatient treatment. Inpatient treatment days are limited contingent on the individual’s designation as DTS, DTO, PAD, or GD. Individuals identified as:

- DTS may be ordered up to 90 inpatient days per year.
- DTO and PAD may be ordered up to 180 inpatient days per year, and
- GD may be ordered up to 365 inpatient days per year.

If the court orders a combination of inpatient and outpatient treatment, a mental health agency will be identified by the court to supervise the individual’s outpatient treatment. Before the court can order a mental health agency to supervise the individual’s outpatient treatment, the agency medical director must agree and accept responsibility by submitting a written treatment plan to the court.

At every stage of the Pre-Petition Screening, COE and COT process, an individual who manifests the capacity to give informed consent pursuant to A.R.S. § 36-518 will be provided an opportunity to change the status to voluntary. Under voluntary status, the individual will voluntarily receive an evaluation and is unlikely to present as DTO/DTS during the time pending the voluntary evaluation.

Entities responsible for COE must ensure the use of the following forms prescribed in 9 A.A.C. 21, Article 5 for individuals determined to have a Serious Mental Illness (SMI) and may also use these forms for all other populations:

- AMPM Policy 320-U, Attachment A, Application for Involuntary Evaluation
- AMPM Policy 320-U, Attachment B, Application for Emergency Admission for Evaluation
- AMPM Policy 320-U, Attachment C, Petition for Court Ordered Evaluation
- AMPM Policy 320-U, Attachment D, Petition for Court Ordered Treatment
- AMPM Policy 320-U, Attachment E, Affidavit, Addendum No. 1 and Addendum No. 2
- AMPM Policy 320-U, Attachment F - Flow Chart Recognition of Tribal Court Order Process

Although the AdSS may not be contracted for providing Pre-Petition Screening services, emergency/crisis petition filing, and COE services in all counties, the AdSS must provide policies and procedures for providers outlining these processes.

For FFS members not residing on a reservation, the FFS provider (mental health agency) must follow all legal authorities in the State and county of the FFS member’s place of
residence or the county in which treatment was ordered because of a behavioral health crisis occurring off tribal land.

FFS members residing on a reservation are subject to the tribe’s laws and tribal court jurisdiction. FFS providers (mental health agencies) must ensure clinical coordination with the appropriate entities including but not limited to American Indian tribes, TRBHAs, and tribal courts. Refer to this policy for more information regarding Tribal Court Orders.

A. Licensing Requirements

Behavioral health providers who are licensed by the ADHS/Division of Public Health Licensing as a COE or COT agency must adhere to ADHS licensing requirements.

B. Pre-Petition Screening

1. Unless otherwise indicated in an Intergovernmental Agreement (IGA) with a county, Arizona counties are responsible for managing, providing, and paying for Pre-Petition Screening and COEs and are required to coordinate provision of behavioral health services with the member’s AdSS or FFS program, responsible for the provision of behavioral health services. For additional information, visit the AHCCCS website, https://www.azahcccs.gov.

   During the Pre-Petition Screening, the designated Screening Agency must offer assistance, if needed, to the applicant in the preparation of the application for involuntary COE (see Attachment A, Application for Involuntary Evaluation). Any behavioral health provider that receives an application for COE (Attachment A, Application for Involuntary Evaluation) must immediately refer the application for Pre-Petition Screening and petitioning for COE to the AdSS-designated Pre-Petition Screening agency or county facility.

2. The AdSS must develop policies that outline its role and responsibility related to the treatment of individuals who are unable or unwilling to consent to treatment. The policy must conform to the processes provided in A.R.S. §§ 36-501 et seq, and at a minimum address:
   a. Involuntary evaluation,
   b. Petitioning process,
   c. COE/COT process, including tracking the status of Court orders,
   d. Execution of Court orders, and
   e. Judicial Review.

C. Responsibility for Providing Pre-Petition Screening
When the AdSS is responsible through an IGA with a county for Pre-Petition Screening and petitioning for COE, the AdSS must refer the applicant to a subcontracted Pre-Petition Screening Agency.

The Pre-Petition Screening Agency must follow these procedures:

1. Provide Pre-Petition Screening within 48 hours excluding weekends and holidays.
2. Prepare a report of opinions and conclusions. If Pre-Petition Screening was not possible, the Screening Agency must report reasons why the screening was not possible, including opinions and conclusions of staff members who attempted to conduct the Pre-Petition Screening.
3. Ensure the agency’s medical director or designee review of the report if the report indicates that there is no reasonable cause to support the allegations for COE by the applicant.
4. Prepare a petition for COE (Attachment C, Petition for Court Ordered Evaluation) and file the petition if the Screening Agency determines that due to a Mental Disorder, there is reasonable cause to believe that the individual meets the criteria set forth in §36-521(D).
5. Ensure completion of Attachment B (Application for Emergency Admission for Evaluation), and take all reasonable steps to procure hospitalization on an emergency basis, if it determines that there is reasonable cause to believe that the individual, without immediate hospitalization, is likely to harm themselves or others.
6. Contact the county attorney prior to filing a petition if it alleges that an individual is DTO.

D. Emergent/Crisis Petition Filing Process for Contractors Contracted as Evaluating Agencies

When it is determined that there is reasonable cause to believe that the individual being screened is in a condition that without immediate hospitalization is likely to harm themselves or others, an emergent application must be filed. The petition must be filed at the appropriate agency as determined by the AdSS. Pursuant to A.R.S. §36-501 et seq., when considering the emergent petition process, the following apply:

1. Only applications indicating DTS and/or DTO can be filed on an emergent basis.
2. The applicant must have knowledge of the behavior(s) displayed by the individual that is a danger to self or others consistent with requirements identified in A.R.S. §36-524.
3. The applicant must complete Attachment B (Application for Emergency Admission for Evaluation).
4. The applicant and all witnesses identified in the application as direct observers of the dangerous behavior/s may be called to testify in court if the application results in a petition for COE.

5. Immediately Upon receipt of an Attachment B (Application for Emergency Admission for Evaluation) and all corroborating documentation necessary to successfully complete a determination, the admitting physician will determine if enough evidence exists for an emergency admission for evaluation. If there is enough evidence to support the emergency admission for evaluation, the appropriate facility is not currently operating at or above its allowable member capacity, and the individual does not require medical care, then, facility staff will immediately coordinate with local law enforcement for the detention of the individual and transportation to the appropriate facility.

6. If the individual requires a medical facility, or if appropriate placement cannot be arranged within the 48 hour timeframe identified above relating to Attachment B (Application for Emergency Admission for Evaluation), the Medical Director of the AdSS will be consulted to arrange for a review of the case.

7. Attachment B (Application for Emergency Admission for Evaluation) may be discussed by telephone with the facility admitting physician, the referring physician, and a peace officer to facilitate transportation of the individual to be evaluated.

8. An individual proposed for emergency admission for evaluation may be apprehended and transported to the facility under the authority of law enforcement using Attachment B (Application for Emergency Admission for Evaluation), in accordance with A.R.S. §§ 36-524(D) and 36-525(A), which outlines criteria for a peace officer to apprehend and transport an individual based upon either a telephonic or written application for emergency admission.

9. An emergency admission for evaluation begins at the time the individual is detained involuntarily by the admitting physician who determines if there is reasonable cause to believe that the individual, as a result of a Mental Disorder, is a DTS or DTO and that during the time necessary to complete pre-screening procedures the individual is likely, without immediate hospitalization, to suffer harm or cause harm to others.

10. During the emergency admission period of up to 23 hours the following occurs:
   a. The individual’s ability to consent to voluntary treatment is assessed,
   b. The individual must be offered and receive treatment to which the individual may consent; otherwise, the only treatment administered involuntarily will be for the safety of the individual or others, i.e.
seclusion/restraint or pharmacological restraint in accordance with A.R.S. § 36-513, and

c. When applicable, the psychiatrist will complete the Voluntary Evaluation within 24 hours of determination that the individual no longer requires an involuntary evaluation.

E. Court-Ordered Evaluation

1. If, after review of the petition for evaluation, the individual is reasonably believed to be DTS, DTO, PAD, GD as a result of a Mental Disorder, the court can issue an order directing the individual to submit to an evaluation at a designated time and place. The order must specify whether the evaluation will take place on an inpatient or an outpatient basis.

   a. The court may also order that, if the individual does not or cannot submit, the individual be taken into custody by a peace officer and delivered to an Evaluation Agency. For further requirements surrounding COEs on an inpatient basis, refer to A.R.S. § 36-529.

2. If the Pre-Petition Screening indicates that the individual may be DTS, DTO, PAD, or GD, the Screening Agency will file a petition for COE. When, through an IGA with a county, AdSS are contracted to provide COE, they must adhere to the following requirements when conducting COEs:

   a. An individual who is reasonably believed to be DTO, DTS, PAD, or GD as a result of a Mental Disorder must have a petition for COE prepared, signed and filed by the Medical Director of the agency or designee,

   b. An individual admitted to an Evaluation Agency must receive an evaluation as soon as possible, and receive care and treatment as required by their condition for the full period they are hospitalized,

   c. A clinical record must be kept for each individual that details all medical and psychiatric evaluations and all care and treatment received by the individual,

   d. An individual being evaluated on an inpatient basis must be released within 72 hours if further evaluation is not appropriate, unless the individual makes application for further care and treatment on a voluntary basis, or unless an application for COT has been filed, and

   e. On a daily basis at minimum, an evaluation must be conducted throughout the COE process for the purposes of determining if an individual desires to be switched to a voluntary status, or qualifies for discharge.

3. For information on individuals being released from COE, and on COE dispositions, refer to A.R.S. § 36-531.
4. For FFS members undergoing COE, the FFS provider (Evaluation Agency) is responsible for all aspects of care coordination with the appropriate entities, including but not limited to the Screening Agency conducting the Pre-Petition Screening if applicable, treatment agency if applicable, and AHCCCS DFSM.

F. Voluntary Evaluation

1. AdSS must require behavioral health providers that receive an application for Voluntary Evaluation to immediately refer the individual to a facility responsible for Voluntary Evaluations. The Voluntary Evaluation may be on an inpatient or outpatient basis. Voluntary Evaluation may be carried out only if chosen by the individual during the course of a Pre-Petition Screening after an application for evaluation has been made.

2. When an individual consents to Voluntary Evaluation, the evaluating agency must follow these procedures:
   a. Obtain the individual’s informed consent prior to the evaluation (Attachment G, Application for Voluntary Evaluation),
   b. Provide an evaluation at a scheduled time and place within five business days of the notice that the individual will voluntarily receive an evaluation, and
   c. For inpatient Voluntary Evaluations, complete evaluations in less than 72 hours of receiving notice that the individual will voluntarily receive an evaluation.

3. The AdSS must require behavioral health providers that conduct Voluntary Evaluation services to include the following in the comprehensive clinical record (see Division’s Medical Policy Manual Policy 940):
   a. A copy of the application for Voluntary Evaluation, Attachment G (Application for Voluntary Evaluation),
   b. A completed informed consent form (see Division Medical Policy Manual Policy 320-Q), and
   c. A written statement of the individual’s present medical condition.

G. Court-Ordered Treatment Following Civil Proceedings

Based on the COE, the evaluating agency may petition for COT. As specified in A.R.S. §§ 36-501 et seq, the AdSS must require behavioral health providers to follow these procedures:

1. Upon determination that a person is DTS, DTO, GD, or PAD, and if no alternatives to COT exist, the Medical Director of the agency that provided the COE must file a petition with the court for COT (see Attachment D, Petition for Court Ordered Treatment).
2. Any behavioral health provider filing a petition for COT must do so in consultation with the individual’s clinical team prior to filing the petition.

3. The petition must be accompanied by the affidavits of the two physicians who conducted the examinations during the evaluation period and by the affidavit of the applicant for the evaluation (Attachment E, Affidavit).

4. In cases of GD, a copy of the petition must be mailed to the public fiduciary in the county of the individual’s residence, or the county in which the individual was found before evaluation, and to any person nominated as guardian/legal representative. In addition, a copy of all petitions must be mailed to the superintendent of the Arizona State Hospital (AzSH).

5. For information regarding court options for treatment, release, discharge, annual reviews, or COT violations, refer to A.R.S. § 36-540 et seq. For requirements relating to Judicial Review, see A.R.S. §§ 36-546 and 36-546.01.
   a. For COT relating to DUI/Domestic Violence or other Criminal Offenses, refer to the Division Operations Manual Policy 423.

H. Individuals Who Are Title XIX/XXI Eligible and/or Determined to Have a Serious Mental Illness

When an individual referred for COT is Title XIX/XXI eligible and/or determined or suspected to have an SMI, AdSS must:

1. Conduct an evaluation to determine if the individual has an SMI in accordance with the Division Medical Policy Manual Policy 320-P, and conduct a behavioral health assessment to identify the individual’s service needs in conjunction with the individual’s clinical team, as specified in the Division Medical Policy Manual Policy 320-O.

2. Provide necessary COT and other covered behavioral health services in accordance with the individual’s needs, as determined by the individual’s clinical team, family members, other involved parties.

3. Perform, either directly or by contract, all treatment required by A.R.S. Title 36, Chapter 5, Article 5 and 9 A.A.C. 21, Article 5.

I. Court-Ordered Treatment for American Indian Tribal Members in Arizona

Arizona tribes are sovereign nations and tribal courts have jurisdiction over their members residing on reservation. Tribal court jurisdiction, however, does not extend to tribal members residing off the reservation or to state issued COE or COT due to a behavioral health crisis occurs off reservation.

Several Arizona tribes have adopted procedures in their tribal codes, which are similar to Arizona law for COE and COT, however, each tribe has its own laws that must be followed for the tribal court process.
Additional information on the history of the tribal court process, legal documents and forms, a diagram of payment structures, as well as contact information for the tribes, tribal liaisons, TRBHAs, and tribal court representatives can be found on the AHCCCS website under Tribal Court Procedures for Involuntary Commitment.

1. Tribal (COT) for American Indian tribal members in Arizona is initiated by the tribal behavioral health staff, the tribal prosecutor or other individuals as authorized under tribal laws. In accordance with tribal codes, tribal members who may be a danger to themselves or others and in need of treatment due to a Mental Disorder are evaluated and recommendations are provided to the tribal judge for a determination of whether tribal COT is necessary. Tribal court orders specify the type of treatment needed.

2. Since many tribes do not have treatment facilities on reservation to provide the treatment ordered by the tribal court, tribes may need to secure treatment off reservation for tribal members. To secure COT off reservation, the court order must be “recognized” or transferred to the jurisdiction of the state.

3. The process for establishing a tribal court order for treatment under the jurisdiction of the state is a process of recognition, or “enforcement” of the tribal court order (see A.R.S. § 12-136). Once this process occurs, the state recognized tribal court order is enforceable off reservation. The state recognition process is not a rehearing of the facts or findings of the tribal court. Treatment facilities must provide treatment as identified by the tribe and recognized by the state. Attachment F (Flow Chart Recognition of Tribal Court Order Process) is a flow chart demonstrating the communication between tribal and state entities in accordance with A.R.S. § 12-136.

4. AdSS and providers must comply with state recognized tribal court orders for Title XIX/XXI and Non-Title XIX individuals with an SMI determination. When tribal providers are also involved in the care and treatment of court ordered tribal members, AdSS and providers must involve tribal providers to ensure the coordination and continuity of care of the members for the duration of COT, and when members are transitioned to services on the reservation, as applicable. AdSS are encouraged to enter into agreements with tribes to address behavioral health needs and improve the coordination of care for tribal members.

5. The enforcement process must run concurrently with the tribal staff’s initiation of the tribal court ordered process in an effort to communicate and ensure clinical coordination with the appropriate AdSS. This clinical communication and coordination with the AdSS is necessary to assure continuity of care and to avoid delays in admission to an appropriate facility for treatment upon state/county court recognition of the tribal court order. The AzSH must be the last placement alternative considered and used in this process.
6. The Court must consider all available and appropriate alternatives for the treatment and care of the member. The Court must order the least restrictive treatment alternative available (A.R.S. § 36-540(B)). The AdSS is expected to partner with American Indian tribes, TRBHAs, and tribal courts in their geographic service areas to collaborate in finding appropriate treatment settings for American Indians in need of behavioral health services.

Due to the options American Indians have regarding their health care, including behavioral health services, AHCCCS eligible American Indians may be covered and/or coordinate behavioral health services through a TRBHA, AIHP, AdSS, Tribal ALTCS, IHS, or 638 tribal provider.

J. Reporting Requirements

In addition to any reporting requirements related to COE/COT otherwise identified in Contract, AdSS must submit Attachment H (COE deliverable) and Attachment I (COT deliverable) as specified in Contract.

For FFS members receiving COT, FFS providers responsible for the treatment must submit Attachment D, Petition for COT to the Division.

K. Reimbursement

1. Reimbursement for court ordered screening and evaluation services are the responsibility of the county pursuant to A.R.S. § 36-545. For additional information regarding behavioral health services refer to 9 A.A.C. 22.

2. Refer to the Division Operations Manual Policy 437 for clarification regarding financial responsibility for the provision of medically necessary behavioral health services rendered after the completion of a COE.

3. Title XIX/XXI funds must not be used to reimburse COE services.
   
a. For any Title XIX/XXI enrolled member who has been admitted to an Evaluation Agency under a petition for COE, the evaluation period is deemed to end upon the filing of a petition for COT by the Evaluation Agency. County payment responsibility ends that day, and transfers to the AdSS, who must pay for all Title XIX/XXI medically necessary services thereafter, including services associated with the period of time between the filing of the Petition for COT, and the hearing set for the purposes of a judicial determination for the need for COT, and

b. County responsibility for payment of medically necessary days also ends when the 72-hour COE period is exceeded, which does not include inpatient days falling on weekends or legal holidays or if the time of admission on the initial day of COE is after 5:00 pm.

4. For COEs that do not require an inpatient stay, any medically necessary physical health services provided to the individual must be the
responsibility of the AdSS of enrollment.
320-V BEHAVIORAL HEALTH RESIDENTIAL FACILITIES

EFFECTIVE DATE: October 1, 2019

This policy establishes requirements for the provision of care and services in a Behavioral Health Residential Facility (BHRF).

Definitions

A. Adult Recovery Team (ART) - A group of individuals who, following the nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, collaborate and are actively involved in an assessment of the member of the Division (member), service planning and service delivery.

At a minimum, the team consists of the member, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include members of the enrolled member's family, physical health, behavioral health or social service providers, representatives or other agencies serving the member, professionals representing various areas of expertise related to the member's needs, designated representatives or other persons identified by the enrolled member.

B. Behavioral Health Condition - Mental, Behavioral, or Neurodevelopmental Disorder (F01-F99) diagnosis defined by International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

C. Behavioral Health Residential Facility - As specified in A.A.C. R9-10-101, a health care institution that provides treatment to a member experiencing a behavioral health issue that limits the member's ability to be independent or causes the member to require treatment to maintain or enhance independence.

D. Behavioral Health Paraprofessional - As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and

2. Is provided supervision by a behavioral health professional.

E. Behavioral Health Professional (BHP) –

1. An individual licensed under A.R.S. Title 32, Chapter 33, whose scope of practice allows the individual to:

   a. Independently engage in the practice of behavioral health as defined
in A.R.S. § 32-3251, or

b. Except for a licensed substance abuse technician, engage in the practice of behavioral health as defined in A.R.S. § 32-3251 under direct supervision as defined in A.A.C. R4-6-101,

2. A psychiatrist as defined in A.R.S. § 36-501
3. A psychologist as defined in A.R.S. § 32-2061
4. A physician
5. A behavior analyst as defined in A.R.S. § 3-2091
6. A registered nurse practitioner licensed as an adult psychiatric and mental health nurse
7. A registered nurse.

F. Behavioral Health Technician (BHT) –

As specified in A.A.C. R9-10-101, an individual, who is not a behavioral health professional, who provides behavioral health services at, or for, a health care institution according to the health care institution’s policies and procedures, who:

1. If the behavioral health services were provided in a setting other than a licensed health care institution, would be required to be licensed as a behavioral professional under A.R.S. Title 32, Chapter 33; and
2. Is provided with clinical oversight by a behavioral health professional.

G. BHRF Staff - Any employee of the BHRF agency including but not limited to Administrators, Behavioral Health Paraprofessionals, Behavioral Health Professionals (BHP) and Behavioral Health Technicians.

H. Child and Family Team (CFT) - A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited by the child and family to participate. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, and community resource providers, representatives from churches, synagogues, or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope, and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand and Contract as necessary to be successful on behalf of the child.

I. Co-occurring - Coexistence of both a behavioral health and a substance use disorder.

J. Medication Assisted Treatment (MAT) - Use of medications in combination with
counseling and behavioral therapies for the treatment of substance use disorders.

K. **Natural Support** – Support provided by those individuals who know or are related to the member/family, but do not provide a paid service, such as a grandparent or neighbor who is connected to the member/family.

L. **Peer/Recovery Support Service** - Intentional partnerships, based on shared lived experiences, to provide social and personal support. This support is coupled with specific, skill-based training, coaching, or assistance to bring about social or personal change at the individual, family, or community level. These services can include a variety of individualized and personal goals, including living preferences, employment or educational goals and development of social networks and interests.

M. **Peer/Recovery Support Specialist** - Individual trained, credentialed, and qualified to provide peer/recovery support services within the AHCCCS Program.

N. **Service Plan** - A complete written description, of all covered health services and other informal supports, which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

O. **Treatment Plan** - Complete written description of all services to be provided by Behavioral Health Residential Facility. The Treatment Plan must be based on the intake assessments, outpatient Service Plan, and must include input from the CFT/ART. The Treatment Plan will be reviewed and updated at the BHRF with the member and CFT/ART at least once a month.

**Policy**

Care and services provided in a BHRF are based on a per diem rate (24-hour day), require prior and continued authorization, and do not include room and board.

AdSS must ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA upon intake to and discharge from the BHRF.

References to CFT/ARTs pertain to AdSS and not to Fee-For-Services (FFS) Programs or FFS populations. A CFT/ART is not required for FFS members to receive services.

A. **Criteria for Admission**

AdSS must have admission criteria for medical necessity that, at a minimum, include the below elements. AdSS must publish the criteria, subject to Division approval as specified in the Contract. BHRF providers providing services to FFS members must adhere to the below elements.

If a member has a diagnosed Behavioral Health Condition that reflects the symptoms and behaviors necessary for a request for residential treatment, the Behavioral Health Condition causing the significant functional and/or psychosocial impairment must be evidenced in the assessment by the following:

1. At least one area of significant risk of harm within the past three months as a
result of:

a. Suicidal/aggressive/self-harm/homicidal thoughts or behaviors without current plan or intent
b. Impulsivity with poor judgment/insight
c. Maladaptive physical or sexual behavior
d. Member’s inability to remain safe within his or her environment, despite environmental supports (i.e. Natural Supports)
e. Medication side effects due to toxicity or contraindications

2. At least one area of serious functional impairment as evidenced by:

a. Inability to complete developmentally appropriate self-care or self-regulation due to member’s Behavioral Health Condition(s)
b. Neglect or disruption of ability to attend to majority of basic needs, such as personal safety, hygiene, nutrition or medical care
c. Frequent inpatient psychiatric admissions or legal involvement due to lack of insight or judgment associated with psychotic or affective/mood symptoms or major psychiatric disorders
d. Inability to independently self-administer medically necessary psychotropic medications despite interventions such as education, regimen simplification, daily outpatient dispensing, and long-acting injectable medications
e. Impairments persisting in the absence of situational stressors that delay recovery from the presenting problem

3. A need for 24-hour behavioral health care and supervision to develop adequate and effective coping skills that will allow the member to live safely in the community

4. Anticipated stabilization cannot be achieved in a less restrictive setting

5. Evidence that appropriate treatment in a less restrictive environment has not been successful or is not available, therefore warranting a higher level of care

6. Member agrees to, and participates in, treatment. In the case of minors, family/guardian/designated representative also agrees to and participates as part of the treatment team.

B. Expected Treatment Outcomes

1. Treatment outcomes must align with all of the following:

a. The Arizona Vision-12 Principles for Children’s Behavioral Health
Service Delivery as directed in AMPM Policy 430

b. The 9 Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems as outlined in Contract

c. The member’s individualized basic physical, behavioral, and developmentally appropriate needs.

2. Treatment goals must be:

a. Specific to the member’s Behavioral Health Condition(s)

b. Measurable and achievable

c. Unable to be met in a less restrictive environment

d. Based on the member’s unique needs and tailored to the member and the family’s/guardian’s/designated representative’s choices where possible

e. Supportive of the member’s improved or sustained functioning and integration into the community.

C. Exclusionary Criteria

Admission to a BHRF must not be used as a substitute for the following:

1. An alternative to detention or incarceration

2. A means to ensure community safety in circumstances where a member is exhibiting primarily conduct disordered behavior without the presence of risk or functional impairment

3. A means of providing safe housing, shelter, supervision, or permanency placement

4. A behavioral health intervention when other less restrictive alternatives are available and meet the member’s treatment needs; including situations when the member/guardian/designated representative are unwilling to participate in the less restrictive alternative, or

5. An intervention for runaway behaviors unrelated to a Behavioral Health Condition.

D. Criteria for Continued Stay

AdSS must have medical necessity criteria for continued stay that, at a minimum, include the below elements. AdSS must publish those criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the below elements.
During Treatment Plan review BHRF staff, and as applicable the CFT/ART, must assess continued stay and update the Treatment Plan. Progress towards the treatment goals and continued display of risk and functional impairment must also be assessed.

Treatment interventions, frequency, crisis/safety planning, and targeted discharge must be adjusted accordingly to support the need for continued stay. The following criteria must be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a Behavioral Health Condition.

2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.

E. Discharge Readiness

AdSS must have medical necessity criteria for discharge that, at a minimum, include the below elements. AdSS must publish that criteria, subject to Division approval as specified in Contract. BHRF providers providing services to FFS members must adhere to the minimum discharge elements below.

Discharge readiness must be assessed by the BHRF staff and as applicable by the CFT/ART during each Treatment Plan review and update. The following criteria must be considered when determining discharge readiness:

1. Symptom or behavior relief is reduced as evidenced by completion of Treatment Plan goals.

2. Functional capacity is improved; essential functions such as eating or hydrating necessary to sustain life has significantly improved or is able to be cared for in a less restrictive level of care.

3. Member can participate in needed monitoring or a caregiver is available to provide monitoring in a less restrictive level of care.

4. Providers and supports are available to meet current behavioral and physical health needs at a less restrictive level of care.

F. Admission, Assessment, and Treatment Plan

AdSS must have a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with A.A.C. R9-10-707 and 708 and Contract requirements. BHRF Providers rendering services to Fee-For-Service members must follow the below outlined admission, assessment, and treatment planning requirements.

1. Except as provided in subsection R9-10-707(A)(9), a behavioral health assessment for a member is completed before treatment is initiated and within 48 hours of admission.
2. The CFT/ART/TRBHA, as applicable, is included in the development of the Treatment Plan within 48 hours of admission for members enrolled with the AdSS.

3. All BHRFs serving TRBHA members must coordinate care with the TRBHA throughout the admission, assessment, treatment, and discharge process.

4. The Treatment Plan connects back to the member’s comprehensive Service Plan for members enrolled with the AdSS.

5. A comprehensive discharge plan is created during the development of the initial Treatment Plan and is reviewed and/or updated at each review thereafter. The discharge plan must document the following:
   a. Clinical status for discharge
   b. Member/guardian/designated representative and, CFT/ART/TRBHA as applicable, understands follow-up treatment, crisis and safety plan, and
   c. Coordination of care and transition planning are in process (e.g. reconciliation of medications, applications for lower level of care submitted, follow-up appointments made).

6. The BHRF staff and the CFT/ART as applicable meet to review and modify the Treatment Plan at least once a month.

7. A Treatment Plan may be completed by a BHP, or by a BHT with oversight and signature by a BHP within 24 hours.

8. The provider has a system to document and report on timeliness of BHP signature/review when the Treatment Plan is completed by a BHT.

9. The provider has a process to actively engage family/guardians/designated representative in the treatment planning process as appropriate.

10. The provider’s clinical practices, as applicable to services offered and population served, must demonstrate adherence to best practices for treating the following specialized service needs, which include but are not limited to:
   a. Cognitive/intellectual disability
   b. Cognitive disability with comorbid Behavioral Health Condition(s)
   c. Older adults, and co-occurring disorders (substance use and Behavioral Health Condition(s), or
   d. Comorbid physical and Behavioral Health Condition(s).

11. Services deemed medically necessary through the assessment and/or CFT/ART/TRBHA as applicable, which are not offered at the BHRF, must be documented in the Service Plan and documentation must include a description of the need, identified goals and identified provider who will be meeting the
need. The following services must be made available and provided by the BHRF and cannot be billed separately unless otherwise noted below:

a. Counseling and Therapy (group or individual)

Group Behavioral Health Counseling and Therapy may not be billed on the same day as BHRF services unless specialized group behavioral health counseling and therapy have been identified in the Service Plan as a specific member need that cannot otherwise be met as required within the BHRF setting.

b. Skills Training and Development

i. Independent Living Skills (e.g., self-care, household management, budgeting, avoidance of exploitation/safety education and awareness)

ii. Community Reintegration Skill building (e.g., use of public transportation system, understanding community resources and how to use them)

iii. Social Communication Skills (e.g., conflict and anger management, same/opposite-sex friendships, development of social support networks, recreation)

c. Behavioral Health Prevention/Promotion Education and Medication Training and Support Services, including but not limited to:

i. Symptom management (e.g., including identification of early warning signs and crisis planning/use of crisis plan)

ii. Health and wellness education (e.g., benefits of routine medical check-ups, preventive care, communication with the PCP and other health practitioners)

iii. Medication education and self-administration skills

iv. Relapse prevention

v. Psychoeducation Services and Ongoing Support to Maintain Employment Work/Vocational skills, educational needs assessment and skill building

vi. Treatment for Substance Use Disorder (e.g., substance use counseling, groups)

vii. Personal Care Services (see additional licensing requirements in A.A.C. R9-10-702, R9-10-715, R9-10-814).

G. BHRF and Medication Assisted Treatment
AdSS and BHRF providers must have policies and procedures to ensure members on Medication Assisted Treatment (MAT) are not excluded from admission and are able to receive MAT to ensure compliance with Arizona Opioid Epidemic Act SB 1001, Laws 2018. First Special Session.

H. BHRF with Personal Care Services

BHRFs licensed to provide Personal Care Services must offer services in accordance with A.A.C R9-10-702 and A.A.C R9-10-715. AdSS and BHRF providers must ensure that all identified needs can be met in accordance with R9-10-814 (A)(C)(D) and (E).

The following are examples of services that may be provided:

A. Blood sugar monitoring, Accu-Check diabetic care
B. Administration of oxygen
C. Application and care of orthotic devices
D. Application and care of prosthetic devices
E. Application of bandages and medical supports, including high elastic stockings
F. ACE wraps, arm and leg braces, etc.
G. Application of topical medications
H. Assistance with ambulation
I. Assistance with correct use of cane/crutches
J. Bed baths
K. Care of hearing aids
L. Radial pulse monitoring
M. Respiration monitoring
N. Denture care and brushing teeth
O. Dressing member
P. Supervising self-feeding of members with swallowing deficiencies
Q. Hair care, including shampooing
R. Incontinence support, including assistance with bed pans/bedside commodes/ bathroom supports
S. Measuring and recording blood pressure
T. Non-sterile dressing change and wound care

U. Passive range of motion exercise

V. Use of pad lifts

W. Shaving

X. Shower assistance using shower chair

Y. Skin maintenance to prevent and treat bruises, injuries, pressure sores. Members with stage 3 or 4 pressure sore is not to be admitted to BHRF (A.A.C.R9-10-715(3)), and infections

Z. Use of chair lifts

AA. Skin and foot care

BB. Measuring and giving insulin, glucagon injection

CC. G-tube care

DD. Ostomy and surrounding skin care

EE. Catheter care
CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. Pregnancy Termination
2. Quality Management/Performance Improvement (QM/PI) Program Annual Plan
3. Sterilization Reporting
4. Stillbirth Supplement Request
5. AHCCCS Certificate of Necessity for Pregnancy Termination & AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination requests
6. Dental Plan and Evaluation
7. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and Adult Monitoring Report
8. EPSDT Plan and Evaluation
9. Maternity Care Plan and Evaluation
10. Number of Pregnant Women who are HIV/AIDS Positive.
410 - MATERNITY CARE SERVICES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.A.C. R9-16-111 through 113, A.R.S. § 14-5101; AMPM 400:410; AMPM Appendix F; AMPM Attachment 410-B, C, D, and E; AMPM Exhibit 400-2A; Section F3, Contractor Chart of Deliverables

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with Administrative Services Subcontractors (AdSS) and delegates the responsibility of implementation of this policy. All maternity services covered by the Division are provided by the AdSS.

Definitions

A. Certified Nurse Midwife (CFM) - An individual certified by the American College of Nursing Midwives (ACNM) on the basis of a national certification examination and licensed to practice in Arizona by the State Board of Nursing. CNMs practice independent management of care for pregnant women and newborns, providing antepartum, intrapartum, postpartum, gynecological, and newborn care, within a health care system that provides for medical consultation, collaborative management, or referral.

B. Free Standing Birthing Centers - Out-of-hospital, outpatient obstetrical facilities, licensed by the ADHS and certified by the Commission for the Accreditation of Free Standing Birthing Centers. These facilities are staffed by registered nurses to provide assistance with labor and delivery services. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities shall be affiliated with, and in close proximity to, an acute care hospital for the management of complications, should they arise.

C. High-Risk Pregnancy - Refers to a pregnancy in which the mother, fetus, or newborn is, or is anticipated to be, at increased risk for morbidity or mortality before or after delivery. High-risk is determined through the use of the Medical Insurance Company of Arizona (MICA) or American Congress of Obstetricians and Gynecologists (ACOG) standardized medical risk assessment tools.

D. Licensed Midwife - An individual licensed by the Arizona Department of Health Services (ADHS) to provide maternity care pursuant to A.R.S. Title 36, Chapter 6, Article 7 and A.A.C. Title 9, Chapter 16 (This provider type does not include certified nurse midwives licensed by the Board of Nursing as a nurse practitioner in midwifery or physician assistants licensed by the Arizona Medical Board).

E. Maternity Care - Includes identification of pregnancy, prenatal care, labor/delivery services, and postpartum care.

F. Maternity Care Coordination - Consists of the following maternity care related activities: determining the member's medical or social needs through a risk assessment evaluation; developing a plan of care designed to address those needs; coordinating referrals of the member to appropriate service providers and community
resources; monitoring referrals to ensure the services are received; and revising the plan of care, as appropriate

G. **Perinatal Services** - Medical services for the treatment and management of obstetrical patients and neonates (A.A.C. R9-10-201).

H. **Practitioner** - Refers to certified nurse practitioners in midwifery, physician's assistants, and other nurse practitioners. Physician's assistants and nurse practitioners are defined in A.R.S. Title 32, Chapters 25 and 15 respectively.

I. **Postpartum** - For the purposes of this Policy, postpartum is defined as the period beginning the day of parturition and ends the last day of the month in which the 57th day following parturition occurs.

J. **Postpartum Care** - The period beginning the day of parturition and ends the last day of the month in which the 57th day following parturition occurs.

K. **Preconception Counseling** - The provision of assistance and guidance aimed at identifying/reducing behavioral and social risks, through preventive and management interventions, in women of reproductive age who are capable of becoming pregnant, regardless of whether she is planning to conceive. This counseling focuses on the early detection and management of risk factors before pregnancy and includes efforts to influence behaviors that can affect a fetus prior to conception. The purpose of preconception counseling is to ensure that a woman is healthy prior to pregnancy.

Preconception counseling is considered included in the well-woman preventative care visit and does not include genetic testing.

L. **Prenatal care** - Prenatal care is the health care provided during pregnancy and is composed of three major components:

1. Early and continuous risk assessment
2. Health education and promotion
3. Medical monitoring, intervention, and follow-up.

**Policy**

Maternity care services are covered for all members of childbearing age, eligible for ALTCS and Targeted Support Coordination. Maternity care services include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary education and prenatal services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. In addition, related services such as outreach and family planning services (see Division Medical Policy 420) are provided, whenever appropriate, based on the member’s current eligibility and enrollment.

All maternity care services must be delivered by qualified physicians and non-physician practitioners, and they must be provided in compliance with the most current American
Congress of Obstetricians and Gynecologists (ACOG) standards for obstetrical and gynecological services. Prenatal care, labor/delivery, and postpartum care services may be provided by licensed midwives, within their scope of practice, while adhering to AHCCCS risk-status consultation/referral requirements. According to ACOG guidelines, cesarean section deliveries must be medically necessary. Inductions and cesarean section deliveries prior to 39 weeks must be medically necessary. Cesarean sections and inductions performed prior to 39 weeks that are not found to be medically necessary based on nationally established criteria are not eligible for payment.

A. Requirements for Providing Maternity Care Services

The Division’s AdSS must establish and operate a maternity care program with program goals directed at achieving optimal birth outcomes. The minimum requirements of the maternity care program are:

1. Employment of sufficient numbers of appropriately qualified local personnel to meet the requirements of the maternity care program for eligible members and achieve contractual compliance.

2. Provision of written member educational outreach related to:
   a. Risks associated with elective inductions and cesarean sections prior to 39 weeks’ gestation
   b. Healthy pregnancy measures (e.g., addressing nutrition, sexually transmitted infections, substance abuse and other risky behaviors)
   c. Dangers of lead exposure to mother and baby during pregnancy
   d. Postpartum depression
   e. Importance of timely prenatal and postpartum care
   f. Other selected topics at a minimum of once every 12 months.

These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the twelve-month period. The AdSS may use multiple different venues to meet these requirements.

3. Conducting of outreach and education activities to identify currently enrolled members who are pregnant, and enter them into prenatal care as soon as possible.
   a. Service providers notify the Division/assigned AdSS promptly when members test positive for pregnancy.
   b. In addition, the AdSS must have an ongoing process to monitor and evaluate the effectiveness of outreach activities for all members who are pregnant. If activities prove to be ineffective, the AdSS must
implement different activities.

4. Participation in community and quality initiatives within the communities served by the AdSS.

5. Implementation of written protocols to inform members who are pregnant and maternity care providers of voluntary prenatal HIV testing and the availability of counseling, if the test is positive.
   a. Each AdSS must include information to encourage members who are pregnant to be tested and provide instructions on where testing is available at least annually in the member newsletter, new member welcome packet, maternity packet, provider instructions, and the member handbook.
   b. Semiannually, each AdSS must report to the Division the number of members who are pregnant who have been identified as HIV positive within the timeframes indicated in Section F3, Contractor Chart of Deliverables.

6. Designation of a maternity care provider for each member who is pregnant for the duration of her pregnancy and postpartum care. Such designations must allow for freedom of choice, while not compromising the continuity of care. Members who transition to a different AdSS or become newly enrolled with an AdSS 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.

7. Provision of information, regarding the opportunity to change AdSS to ensure continuity of prenatal care, to newly-assigned members who are pregnant and those currently under the care of a non-network provider.

8. Inclusion of new member assessment procedures for the provider that include identifying risk factors through the use of a comprehensive assessment tool covering psychosocial, nutritional, medical and educational factors (available from the American Congress of Obstetricians and Gynecologists [ACOG] or the Mutual Insurance Company of Arizona [MICA]).

9. Mandatory availability of maternity care coordination services for members who are pregnant, who are determined to be medically or socially at-risk/high-risk by the maternity care provider or the AdSS. This includes identified difficulties with navigating the health care system, evident by missed visits, transportation difficulties, or other perceived barriers.

10. Demonstration of an established process for assuring:
   a. Network physicians, practitioners, and licensed midwives adhere to the highest standards of care, including the use of a standardized medical risk assessment tool for initial and ongoing risk assessments, and appropriate consults/referrals for increased-risk or high-risk
pregnancies using ACOG or MICA criteria.

b. Maternity care providers educate members about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breast-feeding; other infant care information; and postpartum follow-up.

c. Members are referred for support services to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as other community-based resources to support healthy pregnancy outcomes. If a member loses eligibility, the member must be notified where they may obtain low-cost or no-cost maternity services.

d. Maternity care providers maintain a complete medical record, documenting all aspects of maternity care.

e. High-risk members who are pregnant have been referred to and are receiving appropriate care from a qualified physician.

f. Postpartum services are provided to members within 60 days of delivery.

11. Mandatory provision of initial prenatal care appointments within the established timeframes. The established timeframes are as follows:

a. First trimester - within 14 days of a request for an appointment

b. Second trimester - within seven days of a request for an appointment

c. Third trimester - within three days of a request for an appointment, or

d. High-risk pregnancy care must be initiated within three days of identification or immediately, if an emergency exists.

12. Primary verification of members who are pregnant, to ensure that the above-mentioned timeframes are met, and to effectively monitor members are seen in accordance with those timeframes.

13. Monitoring and evaluation of infants born with low/very low birth weight, and implementation of interventions to decrease the incidence of infants born with low/very low birth weight.

14. Monitoring and evaluation of cesarean section and elective induction rates prior to 39 weeks’ gestation, and implementation of interventions to decrease occurrence.

15. Identification of postpartum depression and referral of members to the
appropriate health care providers.

AdSS may refer to Tool Kit for the Management of Adult Postpartum Depression (AMPM Appendix F), which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral for behavioral health services if clinically indicated.

16. Process for monitoring provider compliance for perinatal/postpartum depression screenings being conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained.

17. Return visits in accordance with ACOG standards. A process, with primary verification, must be in place to monitor these appointments and ensure timeliness. The AdSS must include the first and last prenatal care dates of service and the number of obstetrical visits that the member had with the provider on claim forms to the Division regardless of the payment methodology. The AdSS must continue to pay obstetrical claims upon receipt of claim after delivery, and must not postpone payment to include the postpartum visit. Rather, the AdSS must require a separate “zero-dollar” claim for the postpartum visit.

18. Timely provision of medically necessary transportation services, as described in Division Medical Policy 310-BB, Transportation.

19. Postpartum activities must be monitored and evaluated, and interventions to improve the utilization rate implemented, where needs are identified.

20. Participation of the AdSS in reviews of the maternity care services program conducted by the Division or AHCCCS as requested, including provider visits and audits.

B. Requirements for the Maternity/Family Planning Services Annual Plan

Each AdSS must have a written Maternity/Family Planning Services Annual Plan that addresses minimum AdSS requirements as specified in the prior section (numbers 1 through 20), as well as the objectives of the AdSS’s program that are focused on achieving Division and AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements; see Maternity/ Family Planning Services Annual Plan Checklist (AHCCCS Medical Policy Manual [AMPM] Exhibit 400-2A) as adopted for use by the Division. The Maternity/Family Planning Services Annual Plan must be submitted to Division Health Care Services Unit through the Division Compliance Unit as required on the Contract, Section F3, Contractor Chart of Deliverables and is subject to approval (see AMPM Exhibit 400-1, Maternal and Child Health Reporting Requirements). The Maternity/Family Planning Services Annual Plan must contain, at a minimum, the following:
1. Maternity/Family Planning Services Care Plan – A written, narrative description of all planned activities to address the AdSS minimum requirements as specified in the prior section (Requirements for Providing Maternity Care Services - Numbers 1 through 20) for maternity care and family planning services, including participation in community and/or quality initiatives within the communities served by the AdSS. The narrative description must also include AdSS activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate and medically necessary treatment is received in a timely manner.

2. Maternity/Family Planning Services Work Plan Evaluation – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies and interventions used toward meeting stated objectives.

3. Maternity/Family Planning Services Work Plan that includes:
   a. Specific measurable objectives
      These objectives must be based on Division and AHCCCS established minimum performance standards. In cases where Division and AHCCCS minimum performance standards have been met, other generally accepted benchmarks that continue the AdSS improvement efforts must be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop additional specific measurable goals and objectives aimed at enhancing the maternity program when Division and AHCCCS Minimum Performance Standards have been met.
   b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the Maternity/Family Planning Services program)
   c. Targeted implementation and completion dates of work plan activities
   d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective
   e. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation.

4. Relevant policies and procedures, referenced in the Maternity/Family Planning Services Annual Plan, submitted as separate attachments.

C. Maternity Care Provider Requirements

1. Physicians and practitioners must follow the American Congress of Obstetricians and Gynecologists standards of care, including the use of a standardized medical risk assessment tool and ongoing health risk
assessment.

2. Licensed midwives, if included in the AdSS provider network, adhere to the requirements contained within Division and AHCCCS policy, procedures, and contracts.

3. All maternity care providers will ensure that:

   a. High-risk members have been referred to a qualified provider and are receiving appropriate care.

   b. All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling must be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.

   c. Members are educated about healthy behaviors during pregnancy, including the importance of proper nutrition; dangers of lead exposure to mother and child; tobacco cessation; avoidance of alcohol and other harmful substances, including illegal drugs; screening for sexually transmitted infections; the physiology of pregnancy; the process of labor and delivery; breastfeeding; other infant care information; and postpartum follow-up.

   d. Perinatal/Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made, if a positive screening is obtained. Postpartum depression screening is considered part of the global service and is not a separately reimbursable service.

   Providers should refer to AHCCCS Medical Policy Manual, Appendix F, Tool Kit for the Management of Adult Postpartum Depression, which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral for Behavioral Health Services if clinically indicated.

   e. Member medical records are appropriately maintained and document all aspects of the maternity care provided.

   f. Members must be referred for support services to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), as well as other community-based resources, in order to support healthy pregnancy outcomes. The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, are recorded on all claim forms submitted to the AdSS regardless of the payment methodology used.
g. Postpartum services must be provided to members within 60 days of delivery using a separate "zero-dollar" claim for the postpartum visit.

D. Additional Covered Related Services

Additional covered related services with special policy and procedural guidelines must be shared with the AdSS providers, as appropriate. Special policy and procedural guidelines include, but are not limited to:

1. Circumcision of Newborn Male Infants

   Circumcision is a covered service under EPSDT for males who are eligible for ALTCS or Targeted Support Coordination, when it is determined to be medically necessary. The procedure requires Prior Authorization (PA) by the AdSS Medical Director or designee for enrolled members.

2. Extended Stays for Newborns Related to Status of Mother’s Stay

   a. The Division covers up to 48 hours of inpatient hospital care for a vaginal delivery without complications and up to 96 hours of inpatient hospital care for a cesarean delivery without complications.

   b. The mother of the newborn may be discharged prior to the minimum 48/96 hour stay, if agreed upon by the mother in consultation with the physician or practitioner. In addition, if the mother's stay is to extend beyond 48/96 hours, an extended stay for the newborn should be granted if the mother's condition allows for mother-infant interaction and the child is not a ward of the state or is not to be adopted.

3. Home Uterine Monitoring Technology

   a. Medically necessary home uterine monitoring technology is covered for members with premature labor contractions before 35 weeks’ gestation, as an alternative to hospitalization.

   b. If the member has one or more of the following conditions, home uterine monitoring may be considered:

      i. Multiple gestation, particularly triplets or quadruplets,

      ii. Previous obstetrical history of one or more births before 35 weeks’ gestation

      iii. Hospitalization for premature labor before 35 weeks’ gestation with a documented change in the cervix, controlled by tocolysis and ready to be discharged for bed rest at home.

   c. These guidelines refer to home uterine activity monitoring technology and do not refer to daily provider contact by telephone or home visit.
4. Labor and Delivery Services Provided in Freestanding Birthing Centers

a. For members who meet medical criteria specified in this policy, the Division covers freestanding birthing centers when labor and delivery services are provided by licensed physicians or certified nurse practitioners in midwifery (a.k.a. certified nurse midwives).

b. Freestanding birthing centers are defined as out-of-hospital, outpatient obstetrical facilities, licensed by the Arizona Department of Health Services and certified by the Commission for the Accreditation of Free Standing Birth Centers. They are equipped to manage uncomplicated, low-risk labor and delivery. These facilities must be affiliated with, and close to, an acute care hospital for the management of complications, should they arise.

c. Labor and delivery services rendered through freestanding birthing centers must be provided by a physician, (i.e., the member’s primary care provider or an obstetrician with hospital admitting privileges) or by a registered nurse who is accredited/certified by the American College of Nurse Midwives and has hospital admitting privileges for labor and delivery services.

d. Only members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated may be scheduled to deliver at a freestanding birthing center. Risk status must be determined by the attending physician or certified nurse midwife, using the standardized assessment tools for high-risk pregnancies (American Congress of Obstetricians and Gynecologists, Mutual Insurance Company of Arizona, of National Association of Childbearing Centers). In any area of the risk assessment where standards conflict, the most stringent will apply. The age of the member must also be a consideration in the risk status evaluation; members younger than 18 years of age are generally considered high risk. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk deliveries, nor appropriate for planned home-births or births in freestanding birthing centers.

5. Labor and Delivery Services Provided in a Home Setting

a. For members who meet medical criteria specified in this policy, the Division covers labor and delivery services provided in the home by the member’s maternity provider (physicians, certified nurse midwives, and licensed midwives).

b. Only members, for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated, may be scheduled to deliver in the member’s home. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not considered low-risk
deliveries nor appropriate for planned home-births or births in freestanding birthing centers.

c. Risk status must initially be determined at the time of the first visit, and each trimester thereafter, by the member’s attending physician, practitioner, or licensed midwife, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

d. A risk assessment must be conducted when a new presenting complication or concern arises to ensure appropriate care and referral to a qualified provider, if necessary.

e. Physicians and practitioners who render home labor and delivery services must have admitting privileges at an acute care hospital close to the site where the services are provided in the event of complications during labor and/or delivery.

f. For each anticipated home labor and delivery, licensed midwives who render home labor and delivery services must have an established plan of action, including methods of obtaining services at an acute care hospital close to the site where services are provided. In addition, referral information to an AHCCCS registered physician who can be contacted immediately, if management of complications is necessary, must be included in the plan.

g. Upon delivery of the newborn, the physician, certified nurse midwife, or licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (refer to A.A.C. R9-16-111 through 113).

6. Licensed Midwife Services

a. The Division covers maternity care and coordination provided by licensed midwives for members, if licensed midwives are included in the AdSS provider network.

b. Licensed midwife services may be provided only to members for whom an uncomplicated prenatal course and a low-risk labor and delivery can be anticipated. The age of the member must be included as a consideration in the risk status evaluation. Refer to A.A.C. R9-16-111 through 113 for a more detailed explanation of what are not
considered low-risk deliveries, nor appropriate for planned home-
births, or births in freestanding birthing centers.

c. Risk status must initially be determined at the time of the first visit, and each trimester thereafter, using the current standardized assessment criteria and protocols for high-risk pregnancies from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona.

d. A risk assessment from the American Congress of Obstetrics and Gynecology or Mutual Insurance Company of Arizona must be conducted when a new presenting complication or concern arises to ensure proper care and referral to a qualified physician if necessary.

e. Before providing licensed midwife services, documentation certifying the risk status of the member’s pregnancy must be submitted to the member’s assigned AdSS. In addition, a consent form signed and dated by the member must be submitted, indicating that the member has been informed and understands the scope of services that will be provided by the licensed midwife. Members determined to have a high-risk pregnancy, must immediately be referred to an AHCCCS registered physician within the provider network of the member’s assigned AdSS for maternity care services.

f. Labor and delivery services provided by a licensed midwife cannot be provided in a hospital or other licensed health care institution. Licensed midwives must have a plan of action, including the name and address of an AHCCCS registered physician and an acute care hospital close to the planned location of labor and delivery for referral, if complications should arise. This plan of action must be submitted to the AdSS Medical Director or designee for members enrolled with an AdSS.

g. Upon delivery of the newborn, the licensed midwife is responsible for conducting newborn examination procedures, including a mandatory Bloodspot Newborn Screening Panel and referral of the infant to an appropriate health care provider for a mandatory hearing screening, as well as a second mandatory Bloodspot Newborn Screening Panel and a second newborn hearing screening (if infant refers on first testing). Refer the infant and/or member to an appropriate health care provider for follow-up care of any assessed problematic conditions (refer to A.A.C. R9-16-111 through 113).

h. In addition, the licensed midwife must notify the mother’s AdSS, of the birth no later than three days after the birth, to enroll the newborn with AHCCCS.

7. Supplemental Stillbirth Payment
Stillbirth refers to those infants, either pre-term or term, delivered in the third trimester of a documented pregnancy, who were deemed a fetal demise. For AdSS to be eligible to receive this payment, criteria must be met. The stillborn infant must have:

a. Attained a weight of at least 600 grams
b. Attained a gestational age of at least 24 weeks, as verified by Provider’s obstetrical prenatal records (History & Physical) including an Estimated Date of Confinement (EDC). An ultrasound report may also be used to verify EDC, when completed prior to 20 weeks’ gestation. A Ballard Assessment, done at delivery by nursing and/or physician staff to determine physical maturity of the infant, confirming a gestational age of at least 24 weeks may also be used.

For stillbirths meeting one of the above medical criteria, AdSS must submit to Division’s Health Care Services Unit through the Division’s Compliance Unit medical documentation to confirm infant’s weight and/or gestational age, as well as the date/time of delivery and zero APGARs, using the AHCCCS Request for Stillbirth Supplement form (AMPM Attachment 410-B) as adopted for use by the Division. For American Indian Health Program (AIHP), the request must be submitted to the Division’s Health Care Services through the Division’s Compliance Unit using secure email to the Division’s Health Care Services at dddqocaudits@azdes.gov and copying dddaltcscompliance@azdes.gov or by mailing it to the address indicated below.

EPSDT Maternal Child Health Manager in the Division’s Health Care Services Clinical Quality Management Unit/MCH Manager

Mail Drop 2C91
3443 N. Central Ave.
Phoenix, AZ 85012

No supplemental payment is provided for labor and delivery services rendered during the prior period coverage timeframe, or if the member was not assigned to the AdSS at the time labor and delivery services were rendered.

AdSS requests for the payment must be made within four months of the delivery date, unless an exemption is granted by the Division’s Chief Medical Officer or Medical Director through the Health Care Services Unit. Exemptions will be considered on a case-by-case basis.

8. Pregnancy Termination (including Mifepristone [Mifeprex or RU-486])

a. Termination Criteria
Pregnancy termination is covered if one of the following criteria is present:

i. The pregnant member suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.

ii. The pregnancy is a result of incest.

iii. The pregnancy is a result of rape.

iv. The pregnancy termination is medically necessary per the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health conditions for the pregnant member by:
   - Creating a serious physical or behavioral health conditions for the pregnant member
   - Seriously impairing a bodily function of the pregnant member
   - Causing dysfunction of a bodily organ or part of the pregnant member
   - Exacerbating a health problem of the pregnant member,
   - Preventing the pregnant member from obtaining treatment for a health problem.

b. Conditions, Limitations and Exclusions

The attending physician must acknowledge that a pregnancy termination was necessary based on the above criteria by submitting the AHCCCS Certificate of Necessity for Pregnancy Termination (AMPM Attachment 410-C) and supporting clinical documentation to DDD and the AdSS.

The certificate must be submitted to the Division’s and AdSS Chief Medical Officer or designee for enrolled pregnant members eligible for ALTCS. The Certificate must certify that, in the physician’s professional judgment, one or more of the above criteria have been met.

c. Additional Required Documentation
i. A written informed consent must be obtained by the provider and kept in the member’s chart for all pregnancy terminations. If the pregnant member is younger than 18 years of age, or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. 14-5101), a dated signature of the pregnant member’s parent or legal guardian indicating approval of the pregnancy termination procedure is required.

ii. When the pregnancy is the result of rape or incest, documentation must be obtained that the incident was reported to the proper authorities, including the name of the agency to which it was reported, the report number (if available), and the date the report was filed.

d. Additional Considerations Related to Use of Mifepristone

i. Mifepristone (also known as Mifeprex or RU-486) is not a post-coital emergency oral contraceptive. The administration of Mifepristone for the purposes of inducing intrauterine pregnancy termination is covered when a minimum of one required criterion is met for pregnancy termination, as well as the following conditions specific to Mifepristone:

- Mifepristone can be administered through 49 days of pregnancy.
- If the duration of pregnancy is unknown or if ectopic pregnancy is suspected, ultrasonography should be used for confirmation.
- Any Intrauterine Device (“IUD”) should be removed before treatment with Mifepristone begins.
- 400 mg. of Misoprostol must be given two days after taking Mifepristone unless a complete abortion has already been confirmed.
- Pregnancy termination by surgery is recommended in cases when Mifepristone and Misoprostol fail to induce termination of the pregnancy.

ii. When Mifepristone is administered, documentation of the following is also required:

- Duration of pregnancy in days
- The date IUD was removed if the member had one
- The date Mifepristone was given
e. Pregnancy Termination Monthly Report

Note: Contractors must submit a standardized AHCCCS Monthly Pregnancy Termination Report (AMPM Attachment 410-E), as adopted for use by the Division, to Division’s Health Care Services Unit, which documents the number of pregnancy terminations performed during the month (including pregnancy terminations resulting from the use of Mifepristone). If no pregnancy terminations were performed during the month, the monthly report must still be submitted to attest to that information.

When pregnancy terminations have been authorized by the AdSS, the following information must be provided with the monthly report:

i. A copy of the completed AHCCCS Certificate of Necessity for Pregnancy Termination form, which has been signed by the AdSS’s Medical Director

ii. A copy of the completed AHCCCS Verification of Diagnosis by Contractor for a Pregnancy Termination Request (AMPM Attachment 410-D) confirming requirements for pregnancy termination have been met

iii. A copy of the official incident report, in the case of rape or incest

iv. A copy of documentation confirming pregnancy termination occurred, and

v. A copy of the clinical information supporting the justification/necessity for pregnancy termination.

f. Prior Authorization

Except in cases of medical emergencies, the provider must obtain a PA for all covered pregnancy terminations from the Division’s Chief Medical Officer or designee. All PA requests must include:

i. AHCCCS Certificate of Necessity for Pregnancy Termination (AMPM Attachment 410-C)

ii. AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request (AMPM Attachment 410-D)
iii. Any lab, radiology, consultation or other testing results that support the justification/necessity for pregnancy termination.

The AdSS, or the Division for members eligible for AIHP, must contact the provider to confirm the qualifying diagnosis/condition within 24 hours of receiving the PA request for a pregnancy termination and must include a signature attesting that an authorization decision was made after contact with the provider to determine that the member had the qualifying diagnosis/condition and the supporting documentation had been received. The Division’s Chief Medical Officer or designee will review the PA request, the AHCCCS Certificate of Necessity for Pregnancy Termination, and the AHCCCS Verification of Diagnosis by Contractor for Pregnancy Termination Request forms and expeditiously authorize the procedure, if the documentation meets the criteria for justification of pregnancy termination.

In cases of medical emergencies, the provider must submit all documentation of medical necessity to the Division for members eligible for AIHP or the AdSS PA Unit within two working days of the date on which the pregnancy termination procedure was performed.
420 FAMILY PLANNING

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36.2904(L), 42 CFR 50.203 and 204, AMPM Attachment 420-B

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Family planning services, when provided by physicians or practitioners, are covered for male and female members who voluntarily choose to delay or prevent pregnancy. Family planning services include covered medical, surgical, pharmacological, and laboratory benefits specified in this policy. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available, as discussed below under “Covered Services.” Members may choose to obtain family planning services and supplies from any appropriate provider with the AdSS’s network.

Members whose eligibility continues, may remain with their assigned maternity provider or exercise their option to select another provider for family planning services.

Covered Services

A. Covered family planning services for members include the following medical, surgical, pharmacological, and laboratory services as well as contraceptive devices (including Intrauterine Devices [IUDs] and subdermal implantable contraceptives):

1. Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, Long-Acting Reversible Contraceptives (LARC), diaphragms, condoms, foams, and suppositories

2. Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning

3. Treatment of complications resulting from contraceptive use, including emergency treatment,

4. Natural family planning education or referral to qualified health professionals

5. Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (Mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception)

6. Sterilization

Clarification Related to Hysteroscopic Tubal Sterilization

a. Hysteroscopic tubal sterilization is not immediately effective upon insertion of the sterilization device. It is expected that the procedure will be an effective sterilization procedure three months following insertion. Therefore, during the first three months the member must continue using another form of birth control to prevent pregnancy.
b. At the end of the three months, it is expected that a Hysterosalpingogram will be performed confirming that the member is sterile. After the confirmatory test the member is considered sterile.

B. Coverage for the following family planning services are as follows:

1. Pregnancy screening is a covered service.
2. Pharmaceuticals are covered when associated with medical conditions related to family planning or other medical conditions.
3. Screening and treatment for Sexually Transmitted Infections (STI) are covered services for both male and female members.
4. Sterilization services are covered for both male and female members when the requirements specified in this policy for sterilization services are met (including hysteroscopic tubal sterilizations).
5. Pregnancy termination is covered only as specified in Division Medical Policy 410 [including Mifepristone (Mifeprex or RU-486)].

C. Limitations

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

1. Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility,
2. Pregnancy termination counseling,
3. Pregnancy terminations except as specified in Division Medical Policy 410 [including Mifepristone (Mifeprex or RU-486)], and
4. Hysterectomies for the purpose of sterilizations

AdSS Requirements for Providing Family Planning Services

The AdSS must ensure that service delivery, monitoring, and reporting requirements are met. The AdSS must:

A. Plan and implement an outreach program to notify members of reproductive age of the specific covered family planning services available and how to request them. Notification must be in accordance with A.R.S. § 36.2904(L). The information provided to members must include, but is not limited to:

1. A complete description of covered family planning services available
2. Information advising how to request/obtain these services
3. Information that assistance with scheduling is available
4. A statement that there is no charge for these services.

B. Have policies and procedures in place to ensure that maternity care providers are educated regarding covered and non-covered services, including family planning services available to members.

C. Have family planning services that are:
   1. Provided in a manner free from coercion or behavioral/mental pressure
   2. Available and easily accessible to members
   3. Provided in a manner which assures continuity and confidentiality
   4. Provided by, or under the direction of, a qualified physician or practitioner
   5. Documented in the medical record. In addition, documentation must be recorded that each member of reproductive age was notified verbally or in writing of the availability of family planning services.

D. Incorporate medical audits for family planning services with quality management activities to determine conformity with acceptable medical standards.

E. Establish quality/utilization management indicators to effectively measure/monitor the use of family planning services.

F. Have written practice guidelines that detail specific procedures for the provision of LARC. (For more information on LARC, see “Arizona DRG Payment Policies” on the AHCCCS website at www.azahcccs.gov). These guidelines must be written in accordance with acceptable medical standards.

G. Implement a process to ensure that, prior to insertion of intrauterine and subdermal implantable contraceptives, the maternity care provider has provided proper counseling to the eligible member to minimize the likelihood of a request for early removal. Counseling information is to include a statement to the member indicating if the implant is removed within two years of insertion, the member may not be an appropriate candidate for reinsertion for at least one year after removal.

Protocol for Member Notification of Family Planning Services and AdSS Reporting Requirements

The AdSS is responsible for providing family planning services and notifying members regarding the availability of covered services. The AdSS must establish processes to ensure the sterilization reports specified in this policy comply with the procedural guidelines for encounter submissions. The Division will notify all members eligible under the category of pregnant woman who become ineligible for DD-long term care.

The AdSS will provide information about covered family planning services. Member notification of these covered services must meet the following minimum requirements:
Medical Policy for Maternal and Child Health

A. In accordance with A.R.S. § 36-2904(L), the AdSS must notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them, and a plan to deliver those services to members who request them. Notification must include provisions for written notification, other than the member handbook, and verbal notification during a member’s visit with the member’s primary care physician or primary care practitioner.

B. Notification of family planning services must include provision for written notification in addition to the Member Handbook and the member newsletter. Communications and correspondence dealing specifically with notification of family planning services are acceptable methods of providing this information. The communications and correspondence must be approved by the Division and conform to confidentiality requirements.

C. Notification must be given at least once a year and must be completed by November 1st. For members who enroll with the AdSS after November 1st, notification must be sent at the time of enrollment.

D. Notification must include all of the covered family planning services and instructions to members regarding how to access these services.

E. As with other member notifications, notification must be written at an easily understood reading level.

F. Notification must be presented in accordance with cultural competency requirements.

G. The AdSS must monitor compliance to ensure the maternity care providers verbally notify members of the availability of family planning services during office visits.

H. The AdSS must report all members under 21 years of age, undergoing a procedure that renders the member sterilized, using the AHCCCS Sterilization Reporting Form for Members under 21 Years of Age (AMPM Attachment 420-B) as adopted for use by the Division. Documentation supporting the medical necessity for the procedure must be submitted with the reporting form.

**Sterilization**

The following requirements regarding member consent for sterilization services apply to AdSSs (For more information refer to 42 CFR 50.203 and 204).

A. The following criteria must be met for the sterilization of a member to occur:
   1. The member is at least 21 years of age at the time the consent is signed (AMPM Attachment 420-B).
   2. The member has not been declared mentally incompetent.
   3. Voluntary consent was obtained without coercion.
4. Thirty days, but not more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of a premature delivery of emergency abdominal surgery. Members may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since they gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

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

1. Consent form requirements (See 42 CFR. 50.204)
2. Answers to questions asked regarding the specific procedure to be performed
3. Notification that withdrawal of consent can occur at any time prior to surgery without affecting future care and/or loss of federally funded program benefits
4. Advice that the sterilization procedure is considered to be irreversible
5. A thorough explanation of the specific sterilization procedure to be performed
6. A description of available alternative methods
7. A full description of the discomforts and risk that may accompany or follow the performing of the procedure, including an explanation of the types and possible effects of any anesthetic to be used
8. A full description of the advantages or disadvantages that may be expected as a result of the sterilization
9. Notification that sterilization cannot be performed for at least 30 days post consent.

C. Sterilization consents may not be obtained when a member:

1. Is in labor or childbirth, or
2. Is seeking to obtain, or is obtaining, a pregnancy termination, or
3. Is under the influence of alcohol or other substances that affect that member’s state of awareness.
430 EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT SERVICES

REVISION DATE: 10/1/2019

REFERENCES: 42 CFR 441.58, 42 CFR 441.56(B)(1), 441.50; 42 U.S.C. 1396d(a) and (r), 1396a (a) (43); A.R.S. § 36-135; A.A.C. R9-13-201 et seq, A.A.C. R9-4-302, A.A.C. R9-22-201 et seq; Division Medical Policy 310-P; AMPM Exhibits 400-1, 400-2B, 400-3, 430-1, 430-2, 430-3, 430-4, and 431-1; AMPM Appendices A, B, E, and F; AMPM Chapter 800

DELIVERABLES: Children’s Provider Case Manager Caseload Inventories and Ratios

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention, treatment, correction, and improvement of physical and behavioral/mental health conditions for members eligible for ALTCS and Targeted Support Coordination under 21 years of age. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, and to assist members in effectively using 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 members under 21 years of age.

EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory, and optional services listed in federal law 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and behavioral/mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. All members age out of Oral Health & EPSDT services at age 21. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit. EPSDT services include all screenings and services described in this Policy and as referenced in AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) located in the AHCCCS Medical Policy Manual.

The Division has adopted Appendix B, EPSDT Standards and Tracking Forms in the AHCCCS Medical Policy Manual, which are to be used by providers to document all age-specific, required information related to EPSDT screenings and visits.

Providers must use the EPSDT Tracking Forms referenced above or electronic equivalent that includes all components found in the hard copy form, at every EPSDT visit.

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and "such other necessary health care, diagnostic services, treatment and other measures described in 42 U.S.C. 1396d (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan.” This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the optional and mandatory categories of “Medical Assistance”, as defined in the Medicaid Act. Services covered under EPSDT include all 29 categories of services in the Federal Law, even when they are not listed as covered services in the
AHCCCS State Plan, statutes, rules, or policies, as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of:

A. Inpatient and outpatient hospital services
B. Laboratory and x-ray services
C. Physician and nurse practitioner services
D. Medications and medical supplies
E. Dental services
F. Therapy services
G. Behavioral health services
H. Orthotics and prosthetic devices
I. Eyeglasses
J. Transportation
K. Family planning services
L. 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) must ensure members receive required health screenings in compliance with the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule, 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; see AHCCCS EPSDT Periodicity Schedule (AMPM Exhibit 430-1) and AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1). The service intervals are minimum requirements, and any services determined by a Primary Care Provider (PCP) to be medically necessary must 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.

A. EPSDT Definitions
Early - in the case of a child already enrolled with an AdSS or AHCCCS Contractor, as early as possible in the child's life, or in other cases, as soon after the member's eligibility for services has been established.

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

Screening - 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 EPSDT program, screening and diagnosis are not synonymous.

Diagnostic - 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.

Treatment - 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 or diagnostic procedures.

B. Covered Services During an EPSDT Visit

Comprehensive periodic screenings must be performed by a clinician, according to the timeframes identified in the AHCCCS EPSDT Periodicity Schedule and the AHCCCS Dental Periodicity Schedule, and inter-periodic screenings, as appropriate, for each member. All covered services during an EPSDT visit are provided by the AdSS.

The AdSS must:

1. Implement processes to ensure age-appropriate screening and care coordination when member needs are identified.

2. Ensure providers use the-approved standard developmental screening tools and complete training in the use of these tools, as indicated by the American Academy of Pediatrics.

3. Monitor providers and implement interventions for non-compliance.

4. Ensure that the Bloodspot Newborn Screening Panel and hearing tests are conducted, including initial and secondary screenings, in accordance with Arizona Administrative Code (A.A.C.) R9-13-201 et seq.

The AHCCCS EPSDT Periodicity Schedule is based on recommendations by the Arizona Medical Association and is closely aligned with the guidelines of the American Academy of Pediatrics. The service intervals are minimum requirements. Any services determined by a PCP to be medically necessary must be provided, regardless of the interval.
EPSDT visits are all-inclusive visits. The payment for the EPSDT visit is intended to cover all elements outlined in the AHCCCS EPSDT Periodicity Schedule. Exceptions to payments are noted in each of the paragraphs below. Only services specifically identified below as a separately billable service may be billed separately or in addition to the EPSDT visit.

EPSDT visits must 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

   Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. Payment for the assessment of nutritional status provided by the member's PCP is part of the EPSDT screening specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member’s PCP. Payment for nutritional assessments are included in the EPSDT visit and are not a separately billable service.

3. Behavioral Health Screening and Services provided by a PCP

   The Division covers behavioral health services for members eligible for EPSDT. EPSDT behavioral health services include the services listed in 42 U.S.C. 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services, whether or not the services are covered under the (AHCCCS) State Plan. PCPs may treat Attention Deficit Hyperactivity Disorder (ADHD), depression and anxiety.

   All other behavioral health conditions must be referred to the entity for which the member is assigned for behavioral health services. American Indian members may receive behavioral health services through an Indian Health Service or Tribal operated 638 facility, regardless of AdSS enrollment. PCPs that prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. Payment for behavioral health screenings and assessments are part of an EPSDT visit and not separately billable services.

   Note: CPT code 96101 PSYCHOLOGICAL TESTING (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology) is not a separately billable service. The code may be billed on the claim to indicate the service was performed, but payment will be included in the fee paid for the EPSDT visit.
4. Developmental Screening Tools used by a PCP

AHCCCS-approved developmental screening tools should be used for developmental screening by all participating PCPs who care for EPSDT-age members. PCPs must be trained in the use and scoring of the developmental screening tools, as indicated by the American Academy of Pediatrics. A list of available training resources may be found in the Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php. The developmental screening should be completed for EPSDT members from birth through three years of age during the nine-month, 18-month, and 24-month EPSDT visits. A copy of the screening tool must be kept in the medical record. Use of AHCCCS approved developmental screening tools may be billed separately using CPT-4 code 96110 (Developmental screening, with interpretation and report, per standardized instrumentation) for the nine-month, 18-month and 24-month visit when the developmental screening tool is used. A developmental screening CPT code (with EP modifier) must be listed in addition to the preventive medicine CPT codes. Other CPT-4 codes, such as 96111 – Developmental Testing (includes assessment of motor, language, social, adaptive) are not considered screening tools and are not separately billable. To receive the developmental screening tool payment, the modifier EP must be added to the 96110. For claims to be eligible for payment of code 96110; the provider must have satisfied the training requirements, the claim must be a 9, 18, or 24-month EPSDT visit, and an AHCCCS approved developmental screening tool must have been completed.

Approved developmental screening tools include:

a. The Parent’s Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org

b. Ages and Stages Questionnaire (ASQ) tool, which may be obtained from www.agesandstages.com

c. The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a PCP, for members 16-30 months of age, to screen for autism when medically indicated. Copies of the completed tools must be retained in the medical record.

5. A comprehensive unclothed physical examination

6. Appropriate immunizations according to age and health history (administration of the immunizations may be billed in addition to the EPSDT visit using the CPT-4 code appropriate for the immunization with an SL modifier)

Combination vaccines are paid as one vaccine. Providers must be registered as Vaccines for Children (VFC) providers and VFC vaccines must be used.
7. Laboratory tests, including blood lead screening assessment and blood lead testing appropriate to age and risk, 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)

EPSDT covers blood lead screening. Required blood lead screening for children under six 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, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning. For more information refer to Blood Lead Screening section in this policy for more information.

Payment for laboratory services that are not separately billable and part of the payment made for the EPSDT visit include but are not limited to: CPT Codes 99000, 36415, 36416, 36400, 36406, and 36410. In addition, payment for all laboratory services must be in accordance with limitations or exclusions specified in contract.

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

These are not separately billable services, and they are part of the EPSDT visit payment.

9. 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

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

10. Appropriate vision, hearing, and speech screenings

These screenings are covered during an EPSDT visit.

EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Payment for vision and hearing exams, (including, but not limited to CPT codes 92015, 92081, 92285, 92551, 92552, 92553, 92567, 92568, 92285, 92286, 92587, 92588, 95930, and 99173) or any other procedure that may be interpreted as fulfilling the vision and hearing requirements provided in a PCP’s office during an EPSDT visit, are part of the EPSDT visit and are not a separately billable services.

Ocular photo screening with interpretation and report, bilateral (CPT code 99177) is covered for children age three to five as part of the EPSDT visit due
to challenges with a child’s ability to cooperate with traditional vision screening techniques. Ocular photo screening is limited to a lifetime coverage limit of one. This procedure, although completed during the EPSDT visit, is a separately billable service.

Note: Automated visual screening, described by CPT code 99177, is not recommended for or covered by the Division when used to determine visual acuity for purposes of prescribing glasses or other corrective devices.

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

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

The AdSS must ensure:

a. Each hospital or birthing center screens all newborns using a physiological hearing screening method prior to initial hospital discharge.

b. Each hospital or birthing center provides outpatient re-screening for babies who were missed or are referred from the initial screening. Outpatient re-screening must be scheduled at the time of the initial discharge and completed between two and six weeks of age.

c. When there is an indication that a newborn or infant may have a hearing loss or congenital disorder, the family must be referred to the PCP for appropriate assessment, care coordination and referral(s).

d. All infants with confirmed hearing loss receive services before turning six months of age.

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 five 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.

C. EPSDT Service Standards

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking Forms must be used to document services provided and be in compliance with Division standards. The tracking forms must be signed by the clinician who performs the screening. The AdSS must monitor PCPs’ use of and submission of EPSDT Tracking Forms, whether hard copy or electronic, to the AdSS Maternal and Child Health Unit.

All EPSDT services are provided by the AdSS. EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations** - EPSDT covers all child and adolescent immunizations, as specified in the Centers for Disease Control and Prevention (CDC) recommended childhood immunization schedules. All appropriate immunizations must be provided to establish, and maintain, up-to-date immunization status for each EPSDT age member. (Refer to the CDC website for current immunization schedules.)

   The Division covers the human papilloma virus (HPV) vaccine for female and male EPSDT members age 11 to 21 years of age. The Division will cover members nine and 10 years of age, if the member is deemed to be in a high-risk situation. For adult immunizations, refer to Chapter 310-M, *Immunizations* in this Policy Manual. Providers must coordinate with the Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule. (Refer to the CDC website.) The AdSS must ensure providers enroll and re-enroll annually with the VFC program, in accordance with contract requirements. The AdSS must not use funding from the Division to purchase vaccines covered through the VFC program for members younger than 19 years of age.

   The AdSS must ensure providers:

   a. Document each EPSDT-age member’s immunizations in the Arizona State Immunization Information System (ASIIS) registry.

   b. Maintain the ASIIS immunization records of each EPSDT member in ASIIS, in accordance with A.R.S. § 36-135.

   The AdSS must monitor provider’s compliance with immunization registry reporting requirements and take action to improve reporting when issues are identified.
2. **Eye Examinations and Prescriptive Lenses** - EPSDT covers eye examinations as appropriate to age, according to the AHCCCS EPSDT Periodicity Schedule, and as medically necessary using standardized visual tools. Vision exams provided in a PCP’s office during an EPSDT visit are not a separately billable service. 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.

3. **Blood Lead Screening** - EPSDT covers blood lead screening. Required blood lead screening for children under six 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, as specified in the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

   a. Children living in a targeted high-risk zip code: All children living in a high risk zip code as identified by the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning must have a blood lead test at 12 and 24 months of age. Children between 36 and 72 months of age must receive a screening blood lead test, if they have not been previously screened for lead poisoning.

   b. Children living outside of the targeted high-risk zip codes: Children living in Arizona, but not in a targeted high-risk zip code must receive an individual risk assessment according to the AHCCCS periodicity schedule (when the child is 6, 9, 12, 18, and 24 months of age and then annually through age 6 years), with appropriate follow-up action taken for those children who are determined to be at high risk based on criteria included within the Arizona Department of Health Services Targeted Lead Screening Plan for the Prevention of Childhood Lead Poisoning.

   A blood lead test result, equal to or greater than 10 micrograms of lead per deciliter of whole blood obtained by capillary specimen or finger stick, must be confirmed using a venous blood sample. A verbal blood lead screening risk assessment must be completed at each EPSDT visit for children six through 72 months of age (six years of age) to assist in determining risk.

   The AdSS must ensure that providers report blood lead levels equal to or greater than ten micrograms of lead per deciliter of whole blood to ADHS (A.A.C. R9-4-302).

   The AdSS must implement protocols for:

   a. Care coordination for members with elevated blood lead levels (parents, PCP and ADHS) to ensure timely follow-up and retesting
b. Appropriate care coordination for an EPSDT child, who has an elevated blood lead level and is transitioning to or from another AdSS

c. Referral of members who lose AHCCCS or Division eligibility to low-cost or no-cost follow-up testing and treatment for those members that have a blood lead test result equal to or greater than ten micrograms of lead per deciliter of whole blood

Refer to Chapter 500, Care Coordination Requirements in this Policy Manual for more information related to transitioning members.


5. **Tuberculosis (TB) Screening** - EPSDT covers TB screening. The AdSS must implement protocols for care and coordination of members who received TB testing to ensure timely reading of the TB skin test and treatment, if medically necessary.

6. **Nutritional Assessment and Nutritional Therapy**

a. **Nutritional Assessments**

Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutritional intervention. The Division covers the assessment of nutritional status provided by the member's PCP as a part of the EPSDT screenings, as specified in the AHCCCS EPSDT Periodicity Schedule and on an inter-periodic basis, as determined necessary by the member's PCP. The Division also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT-eligible members who are underweight or overweight.

To initiate the referral for a nutritional assessment, the PCP must use the AdSS referral form in accordance with AdSS protocols.

If a member qualifies for nutritional therapy due to a medical condition (as described in the Nutritional Therapy section below), the AdSS is the primary payor for:

i. Infant formulas above the amount provided through the WIC program or formula types deemed medically necessary that are not provided through the Women, Infants and Children (WIC) program

Note: This does not include formulas outside of those offered through the WIC program that are not medically
necessary, such as formula types selected based on brand preference.

For members, under the age of five, requiring formula types deemed medically necessary that are not provided through the WIC program, the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) must be submitted directly to the member’s AdSS, as WIC is a secondary payor of specialty exempt formulas.

For members who are infants (0-1 year), requiring infant formulas above the amount provided through the WIC program, the AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) must be submitted directly to the member’s AdSS for the amount of formula that exceeds that provided through the WIC program.

Note: WIC is a secondary payor of infant formulas above the amount provided through the WIC program.

ii. Medical foods

iii. Parenteral feedings

iv. Enteral feedings.

If a 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 Chapter 320-H, Metabolic Medical Food in this Policy Manual.

b. Nutritional Therapy:

The Division covers nutritional therapy for EPSDT-eligible members on an enteral, parenteral, or oral basis, when determined medically necessary to provide either complete daily dietary requirements or to supplement a member’s daily nutritional and caloric intake. The AdSS is the primary payor for parenteral and enteral feedings, unless nutritional therapy is covered by a member’s primary insurance.

i. Enteral nutritional therapy: Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by Jejunostomy tube (J-tube), Gastrostomy Tube (G-tube) or Nasogastric (N/G) tube. Refer to the specific AdSS for managed care members and the Division’s AIHP (Fee-For-Service) regarding Prior Approval (PA) requirements.
ii. Parenteral nutritional therapy: Provides nourishment through the venous system to members with severe pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength. Refer to the Division for managed care members and the Division’s AIHP (Fee-For-Service) regarding PA requirements.

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

PA is required from the member’s AdSS the Division for Fee-For-Service members for commercial oral nutritional supplements, unless the member is also currently receiving nutrition through enteral or parenteral feedings.

Medical necessity for commercial oral nutritional supplements must be determined 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 must use the AHCCCS-approved form, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (AMPM Exhibit 430-2) to obtain authorization from the member’s AdSS or the Division for FFS members.

The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which of the following 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, 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 American Academy of Pediatrics, and there are no alternatives for adequate nutrition.

OR:

(b) 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 six months, or more than three months if member is an infant less than one year of age.
- Demonstrated a medically significant decline in weight within the three month period prior to the assessment.
- Can consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources.

Additionally, each of the following requirements must be met:

(a) 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).

(b) 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 AHCCCS Medical Policy Manual, Exhibit 430-2), 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.

iv. 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:

(a) 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 dietician.

Clinical notes or other supporting documentation dated within three 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.

(b) Ongoing Requests

Subsequent submissions must include a clinical note or other supporting documentation dated within three 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 dietician 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.

c. AdSS Requirements

The AdSS must:

i. Develop guidelines for use by the PCP in providing:

- Information necessary to obtain PA for commercial oral nutrition therapy
nutritional supplements

- Encouragement and assistance to the caregiver in weaning the member from the necessity for supplemental nutritional feedings

- Education and training, if the member’s parent or guardian elects to prepare the member’s food, regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member.

ii. Implement protocols for transitioning a child who is receiving nutritional therapy, to or from another AdSS or another service program (e.g., Women, Infants and Children).

iii. Implement a process for verifying medical necessity of nutritional therapy, through the receipt of supporting medical documentation dated within three months of the request, prior to giving initial or ongoing authorizations for nutritional therapy. Documentation must include clinical notes or other supporting documentation from the member’s PCP, specialty provider, or registered dietitian including a detailed history and thorough physical assessment that provides evidence of member meeting all of the required criteria, as indicated on the Certificate of Medical Necessity.

d. Provider Requirements

When requesting initial or ongoing Prior Authorization (PA) for commercial oral nutritional supplements, providers must ensure:

i. Documents are submitted with the completed Certificate of Medical Necessity to support all of the necessary requirements for Commercial Oral Nutritional Supplements as detailed above.

ii. If the member's parent or guardian elects to prepare the member's food, education and training regarding proper sanitation and temperatures to avoid contamination of foods that are blended or specially prepared for the member is provided.

iii. Ongoing monitoring is conducted to assess member adherence/tolerance to the prescribed nutritional supplement regimen and determine necessary adjustments to the prescribed amount of supplement are appropriate based on the member’s weight loss/gain.
iv. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from the necessity for supplemental nutritional feedings, when appropriate.

e. Oral Health Services – As part of the physical examination, the physician, physician’s assistant, or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Referral to a dentist or dental home must be made as outlined in policy. Refer to AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) for more details pertaining to covered services, and provider and AdSS requirements.

7. Cochlear and Osseointegrated Implantation

a. Cochlear Implantation

Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or postlingual. The Division covers medically necessary services for cochlear implantation solely for member of EPSDT age. Cochlear implantation is limited to one functioning implant per member. The Division will not cover cochlear implantation in instances where individuals have one functioning cochlear implant.

i. Candidates for cochlear implants must meet criteria for medical necessity, including but not limited to, the following indications:

- 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

- 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

- No known contraindications to surgery

- Demonstrated age-appropriate cognitive ability to use auditory clues
• The device must be used in accordance with the FDA approved labeling.

ii. Coverage of cochlear implantation includes:

• Complete auditory testing and evaluation by an otolaryngologist, speech-language pathologist or audiologist
• Presurgery inpatient/outpatient evaluation by a board certified otolaryngologist
• Diagnostic procedures and studies, including CT scan or other appropriate radiologic evaluation, for determining candidacy suitability
• Preoperative psychosocial assessment/evaluation by psychologist or counselor
• Prosthetic device for implantation (must be non-experimental/non-investigational and be Food and Drug Administration approved and used according to labeling instructions)
• Surgical implantation and related services
• Postsurgical rehabilitation, education, counseling and training
• Equipment maintenance, repair and replacement of the internal/external components or both if not operating effectively and is cost effective. Examples include but are not limited to: the device is no longer functional or the used component compromises the member’s safety. Documentation that establishes the need to replace components not operating effectively must be provided at the time prior authorization is sought.

Cochlear implantation requires PA from the AdSS Medical Director, or from the Division Medical Director or designee for Division AIHP (Fee-For-Service) members.

b. Osseointegrated Implants (Bone Anchored Hearing Aid [BAHA])

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 used due to congenital malformation, chronic disease, severe sensorineural hearing loss or surgery. Osseointegrated implantation requires PA from the Division Medical Director, or from the Division Medical Director or designee, for Division AIHP (Fee-For-Service) members. Maintenance is the same as in Item 7.a.ii above.

8. Conscious Sedation – The Division covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to:
   a. Tolerate an unpleasant procedure while continuously maintaining adequate cardiovascular and respiratory function.
   b. Respond purposely to verbal command and/or tactile stimulation.

   Except as specified below, coverage is limited to:
   a. Bone marrow biopsy with needle or trocar
   b. Bone marrow aspiration
   c. Intravenous chemotherapy administration, push technique
   d. Chemotherapy administration into central nervous system by spinal puncture
   e. Diagnostic lumbar spinal puncture
   f. Therapeutic spinal puncture for drainage of cerebrospinal fluid.

   Additional applications of conscious sedation for members receiving EPSDT services are considered on a case by case basis and require medical review and prior authorization by the AdSS Medical Director for enrolled members or by the Division Chief Medical Officer or designee for Division AIHP (Fee-For-Service) members.

9. Behavioral Health Services –

   The Division covers behavioral health services for members eligible for EPSDT services, as described in Policy 310 of this Policy Manual. EPSDT behavioral health services include the services listed in 42 U.S.C. 1396d (a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the (AHCCCS) State Plan.

   The Division has adopted the following AHCCCC Medical Policy Manual appendices: Appendix E for children and adolescents and Appendix F for adults. For the diagnosis of Attention Deficit Disorder/Attention Deficit
Hyperactivity Disorder (ADHD), depression (including postnatal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. PCPs are to use the clinical guidelines as an aid in treatment decisions. PCPs that prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member’s behavioral health condition and treatment plan. The AdSS must establish a medication management process that results in the annual assessment being completed by the PCP in order for ADHD, depression, and anxiety medication prescriptions to continue beyond a 12-month period. To ensure there is not a gap in medications for these conditions, the AdSS must identify and conduct outreach to members approaching the 12-month reassessment timeframe and provide assistance in scheduling the appointment with the member’s PCP.

The Division has implemented the following 12 Principles to maintain the integrity of the best practices and approaches to providing behavioral health services for children. The AdSS must integrate these principles in the provision of behavioral health services for members of EPSDT age:

a. **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. Parent 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.

b. **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.

c. **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, parents, any foster parent, and any individual important in the child’s life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including as appropriate, the child’s teacher, the child’s Department of Child Safety case worker and/or Division of Developmental Disabilities Support Coordinator, and the child’s probation officer. The team develops a common assessment of the child’s and family’s strengths and needs, develops an Individualized Service Plan/Person Centered Plan and monitors the implementation of the plan and makes adjustments in the plan if it is not succeeding.

d. **Accessible Services:** Children have access to a comprehensive array
of behavioral health services, sufficient to ensure that they receive the treatment they need. Case management is provided as needed. Behavioral health services plans identify transportation the parents and the 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.

e. Best Practices: Behavioral health services are provided by competent individuals who are adequately trained and supervised. 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 are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, the need for stability and the need to promote permanency in the members’ lives, especially members in foster care. Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.

f. 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 meet 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.

g. Timeliness: Children identified as needing behavioral health services are assessed and served promptly.

h. 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.

i. Stability: Behavioral health service places strive to minimize multiple placements. Service plans identify whether a 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 crisis 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 the criminal justice system. Behavioral health service plans anticipate and appropriately plan for transition in children’s lives, including transitions to new schools and new placements, and
transitions to adult services.

j. 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.

k. 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 needs for training and support to participate as partners in the assessment process, and in the planning and delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with the understanding of written materials, will be made available.

l. Connection to natural supports: The behavioral health system identifies and appropriately uses 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.

Note: PCPs are encouraged to implement postpartum depression screenings to identify and refer mothers who would benefit from additional treatment due to concerns related to postpartum depression during EPSDT visits for infants up to one year of age.

11. Religious Non-medical Health Care Institution Services – The Division covers religious non-medical health care institution services for members eligible for EPSDT services as described in Division Medical Policy Manual Chapter 300, Policy 310.

12. Care Management Services – The Division covers care management services for 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.

13. Chiropractic Services – The Division covers chiropractic services to members eligible for EPSDT services, when ordered by the member's PCP and approved by the AdSS in order to ameliorate the member's medical condition.

14. Personal Care Services – The Division covers personal care services, as appropriate, for members eligible for EPSDT services.
15. Incontinence Briefs

a. The AdSS must provide incontinence briefs, including pull-ups and incontinence pads, for members between 3 and 21 years of age and who are eligible for ALTCS. Briefs may be provided in order to prevent skin breakdown and to enable participation in social, community, therapeutic, and education activities. These supplies will be provided under the following circumstances when:

i. The member is incontinent due to a documented disability that caused incontinence of bowel and/or bladder.

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

iii. 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.

iv. The member obtains incontinence briefs from providers in the AdSS network.

v. Appropriate prior authorization requirements are applied. Prior authorization 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.

Prior authorization is permitted to ascertain that:

- The member is over age 3 and under age 21.
- The member has a disability that causes incontinence of bladder and/or bowel.
- 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 brief supplied by the AdSS.
- The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.

b. The Division provides incontinence briefs for members who are between 3 and 21 years of age who are:

i. Group home residents that do not qualify for Medicaid (ALTCS or targeted).
ii. Group home residents that qualify for Medicaid (ALTCS) and have been denied incontinence briefs by the AdSS and other medical insurance coverage (e.g., Medicare), if applicable.

c. Authorized services must be for at least a 12-month period of time.

d. The AdSS may require a new prior authorization to be issued no more frequently than every 12 months.

e. Payments for the use of incontinence briefs for the convenience of caregivers will not be authorized.

f. If a member is eligible for Fee-For-Service coverage, the Health Care Services Unit will prior authorize using the same criteria outlined above. Health Care Services Prior Authorization can be contacted by calling 602-771-8080.

g. Any exceptions to this policy section must have the approval of the Assistant Director.

h. For information regarding incontinence briefs for members over the age of 21, see the Division Medical Policy Manual, 310-P, Medical Supplies, Durable Medical Equipment, and Prosthetic Devices (Acute Care Services.)

16. Medically Necessary Therapies – The Division 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.

When medically necessary, inpatient and outpatient therapies are covered. For children identified by the PCP as needing early intervention services, the AdSS must provide services in the natural environment whenever possible.

The Division has adopted Exhibit 430-3 in the AHCCCS Medical Policy Manual, to Procedures for the Coordination of Services under Early Periodic Screening, Diagnostic and Treatment, and Early Intervention (AMPM Exhibit 430-3). This Exhibit provides more information related to the coordination and referral process for early intervention services.

D. Sick Visit Performed in Addition to an EPSDT Visit

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

1. An abnormality is found or a preexisting problem is addressed while performing an EPSDT service and the problem or abnormality requires more work to perform the key components of a problem-oriented E/M service.

2. The “sick visit” is documented on a separate note.
3. History, Exam, and Medical Decision Making components of the separate “sick visit” already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT Code 99201-99215).

4. The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

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

Acute diagnosis codes not applicable to the current visit should not be billed.

An insignificant or trivial problem/abnormality that is encountered during the preventive medicine evaluation and management service, but 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. Requirements for Providing EPSDT Services

The AdSS must:

1. Develop policies and procedures to:
   a. Identify the needs of EPSDT-age members, inform members of the availability of EPSDT services, coordinate their care, provide care management, conduct appropriate follow up, and ensure members receive timely and appropriate treatment.
   b. Monitor, evaluate, and improve EPSDT participation.

2. Employ sufficient numbers of appropriately qualified local personnel to meet the health care needs of members and fulfill federal, state, and contractual EPSDT requirements.

3. Inform all participating PCPs about EPSDT requirements and monitor compliance with the requirements.

   This must include informing PCPs of Federal, State and AHCCCS and Division policy requirements for EPSDT and updates of new information as it becomes available.

4. Ensure PCPs providing care to children are trained to use implemented developmental screening tools. This will also include a process to monitor the use of an approved developmental screening tools (ASQ and PEDS Tool) for members at 9, 18, and 24 months of age. The MCHAT may be used for members 16-30 months of age to assess the risk of autism spectrum disorders in place of the ASQ or PEDS Tool when medically indicated. Providers are expected to be trained as specified by the American Academy of
Pediatrics, in order for the PCP to obtain additional reimbursement for use of an approved developmental screening tool during an EPSDT visit.

Note: Approved developmental screening tool training resources may be found on the Arizona Department of Health Services website.

5. Develop, implement, and maintain a program to inform members about EPSDT services within 30 days of enrollment with the AdSS. This information must include:

   a. The benefits of preventive health care
   b. Information that an EPSDT visit is a well-child visit
   c. A complete description of the services available as described in this section
   d. Information on how to obtain these services and assistance with scheduling appointments
   e. Availability of care management assistance in coordinating EPSDT covered services
   f. A statement that there is no copayment or other charge for EPSDT screening and resultant services, and
   g. A statement that assistance with medically necessary transportation and scheduling appointments is available to obtain EPSDT services.

6. The AdSS must conduct written and other member educational outreach related to immunizations, available community resources (WIC, AzEIP, and Head Start), dangers of lead exposure and recommended/mandatory testing, childhood obesity and prevention measures, age-appropriate risk prevention efforts (addressing injury and suicide prevention, bullying, violence, and risky sexual behavior), education on importance of using PCP in place of ER visits for non-emergent concerns, recommended periodicity schedule, and other AdSS-selected topics at least once every 12 months. These topics may be addressed separately or combined into one written outreach material; each topic must be covered during the twelve month period. EPSDT related outreach material, must include a statement informing members that an EPSDT visit is synonymous to a well-child visit. The Division has adopted Exhibit 400-3 in the AHCCCS Medical Policy Manual, AHCCCS Maternal Child Health/EPSDT Member Outreach which serves as an easy reference guide regarding member outreach.

Outreach requirements for AdSS are included in the Division’s Operations Policy Manual, Chapter 404.

7. Provide EPSDT information (as defined in paragraphs #5 and #6 above), in a second language, in addition to English, in accordance with the
requirements of the in Chapter 405-Cultural Competency in the Division’s Operations Manual, Chapter 405.

8. Develop and implement processes to assist members and their families regarding community health resources, including but not limited to WIC, AzEIP, and Head Start.

9. Develop and implement processes to ensure the identification of member’s needing care management services and the availability of care management assistance in coordinating EPSDT covered services.

10. Participate in community and/or quality initiatives, to promote and support best local practices and quality care, within the communities served by the AdSS.

11. Attend EPSDT-related meetings when requested by the Division.

12. Coordinate with other entities when the AdSS determines a member has other payor coverage.

13. Develop, implement, and maintain a procedure for ensuring timeliness and care coordination of re-screening and treatment for all conditions identified, including behavioral health services, as a result of examination, screening, and diagnosis. Treatment, if required, must occur on a timely basis, generally initiating services no longer than six months beyond the request for screening services, unless stated otherwise in this policy (refer to the AdSS Requirements section of this Policy).

14. Develop, implement, and maintain a process to provide appropriate follow-up care for members who have abnormal blood lead test results.

15. Develop and implement a process for monitoring that providers use the most current EPSDT Tracking Forms at every EPSDT visit and that all age-appropriate screenings and services are conducted during each visit. If an electronic medical record is used, the electronic medical record must include all of the elements of the most current age-appropriate EPSDT Tracking Form.

16. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules. Processes other than mailings must be pre-approved by the Division. This procedure must include:
   a. Notification to members or responsible parties regarding due dates of each EPSDT visit. If an EPSDT visit has not taken place, a second written notice must be sent.
   b. Notification to members or responsible parties regarding due dates of biannual (one visit every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.
18. Develop and implement processes to reduce no-show appointment rates for EPSDT services, and provide targeted outreach to those members who did not show for appointments.

Note: The AdSS must encourage all providers to schedule the next EPSDT screening at the current office visit, particularly for children 24 months of age and younger.

19. Implement processes to print two part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the AdSS Maternal Child Health/EPSDT Coordinator).

20. Distribute EPSDT Tracking Forms to contracted providers who do not use and submit electronic EPSDT forms to the AdSS.

21. Require the use of the AHCCCS EPSDT and Dental Periodicity Schedules and approved, standardized EPSDT Tracking Forms by all contracted providers. The AHCCCS EPSDT and Dental Periodicity Schedules give providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

The AdSS must require providers to complete all of the following requirements:

a. Use the EPSDT Tracking Forms (or electronic equivalent) at every EPSDT visit. The AdSS must monitor the anticipated volume of EPSDT Tracking Forms received based on the number and age of the PCPs EPSDT age member panel.

b. Perform all age-appropriate screening and services during each EPSDT visit in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules, including, but not limited to, using the approved developmental screening tools, as described in this Chapter.

c. Sign EPSDT Tracking Forms and place them in the member’s medical record. If an electronic medical record is used, an electronic signature by the provider must be included.

d. Send copies of the EPSDT Tracking Forms (or electronic equivalent) to the AdSS. Providers are not required to submit EPSDT Tracking Forms to the Division.

e. Providers of Fee-For-Service members must maintain a copy of the EPSDT Tracking Forms (or electronic equivalent), per Division policy, in the medical record. Providers do not need to send copies to the Division. If an electronic medical record is used, an electronic signature by the provider must be included.

22. Submit the EPSDT/Adult Monitoring and Performance Measure Quarterly Report to the Division, a detailed progress report that describes the activities
of the quarter and the progress made in reaching the established goals of the plan, within 15 days of the end of each reporting quarter. The Division has adopted Exhibit 400-1-Maternal and Child Health Reporting Requirements in the AHCCCS Medical Policy Manual that outlines the requirements. Quarterly reports must include documentation of monitoring and evaluation of EPSDT requirements, and implementation of improvement processes. The quarterly report must include results of ongoing AdSS monitoring of performance rates, in a format that will facilitate comparison of rates in order to identify possible need for interventions to improve or sustain rates. The report must also identify the goals established by the AdSS; see EPSDT/Adult Monitoring and Performance Measure Quarterly Report (AMPM Appendix A), which has been adopted for use by the Division.

23. Participate in an annual review of EPSDT requirements conducted by the Division; including, but not limited to, AdSS results of on-site visits to providers and medical record audits.

24. Include language in PCP contracts that requires PCPs to:
   a. Provide EPSDT services for all assigned members from birth to 21 years of age in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.
   b. Agree to use the standardized AHCCCS EPSDT Tracking Forms or, if electronic medical records are use, they must contain all the elements of the current AHCCCS EPSDT Tracking Forms.
   c. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements.
   d. Implement protocols to ensure that health problems are diagnosed and treated early, before they become more complex and the treatment more costly (including follow-up related to blood lead screening and tuberculosis screening).
   e. Have a process for to assisting members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure members receive appropriate support services.
   f. Implement protocols for coordinating care and services with the appropriate state agencies for members eligible for EPSDT, and ensure members are referred to support services, as well as other community-based resources to support good health outcomes.
   g. Refer eligible members to Head Start and the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services. Ensure medically necessary nutritional supplements are covered by the AdSS (For more
information, refer to the Nutritional Assessment and Nutritional Therapy section of this policy).

h. Use the criteria specified in this policy when requesting medically necessary nutritional supplements (refer Nutritional Assessment and Nutritional Therapy section of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements in the AHCCCS Medical Policy Manual.

i. Coordinate with Arizona Early Intervention Program (AzEIP) to identify children 0-3 years of age with developmental disabilities needing services, including family education and family support needs focusing on each child’s natural environment, to optimize child health and development (EPSDT services, as defined in A.A.C. R9-22-201 et seq, must be provided by the AdSS). AdSS must require their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member’s AzEIP enrollment. Refer to Procedures for the Coordination of Services Under EPSDT and Early Intervention in the AHCCCS Medical Policy Manual (AMPM Exhibit 430-3) for more information related to the coordination and referral process for early interventions services.

25. Educate providers to comply with AHCCCS/AzEIP in the AMPM Exhibit 430-3, when the need for medically necessary services are identified for members birth to three years of age. This includes:

   a. Ensuring medically necessary services are initiated within 45 days of a completed Individual Family Service Plan (IFSP), when services are requested by the AzEIP service coordinator.

   b. Reimbursing all AHCCCS registered AzEIP providers, whether or not they are contracted with the AdSS. Non-contracted AHCCCS registered AzEIP providers will be reimbursed for authorized services at the Fee-For-Service (FFS) rates. IFSP services must be reviewed for medical necessity prior to reimbursement.

26. Provide education and assists with referrals of eligible members to the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services and ensures medically necessary nutritional supplements are covered. Refer to C, EPSDT Service Standards and Nutritional Assessment and Nutritional Therapy sections of this policy and Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements in the AHCCCS Medical Policy Manual.

27. Provide education and assists with referrals of eligible members to Head Start to ensure eligible members receive appropriate EPSDT services to optimize child health and development.

F. Each AdSS must have a written EPSDT Annual Plan that addresses minimum AdSS
requirements as specified in the prior section (Requirements for Providing EPSDT Services and Requirements for Oral Health Care), as well as the objectives of the AdSS’ program that are focused on achieving Division and AHCCCS requirements. It must also incorporate monitoring and evaluation activities for these minimum requirements (see Exhibit 400-2B, EPDST Annual Plan Checklist).

The EPSDT Annual Plan must be submitted to the Division Health Care Services unit through the Division’s Compliance Unit no later than December 15th for review and approval; see Maternal and Child Health Reporting Requirements (AMPM Exhibit 400-1). The written EPSDT Annual Plan must contain, at a minimum, the following:

1. **EPSDT Narrative Plan** – A written description of all planned activities to address the Division’s minimum requirements for EPSDT services, as specified in the prior section (AdSS Requirements for Providing EPSDT Services), including, but not limited to, informing providers and members that EPSDT is a comprehensive child health program of prevention, treatment, correction, and improvement (amelioration) of physical and behavioral/mental health problems for members under the age of 21. The narrative description must also include AdSS activities to identify member needs, coordination of care, and follow-up activities to ensure appropriate treatment is received in a timely manner.

2. **EPSDT Work Plan Evaluation** – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

3. **EPSDT Work Plan** that includes:
   a. Specific measurable objectives based on Division established Minimum Performance Standards. When Division Minimum Performance Standards have been met, other generally accepted benchmarks that continue the improvement efforts by the AdSS will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop its own specific measurable goals and objectives aimed at enhancing the EPSDT program when Minimum Performance Standards have been met. Objectives must include a focus toward blood lead testing and follow-up for abnormal blood lead test levels identified, childhood obesity, care coordination efforts, and member utilization.
   
   b. Strategies and specific measurable interventions to accomplish objectives (e.g., member outreach, provider education and provider compliance with mandatory components of the EPSDT program).
   
   c. Targeted implementation and completion dates of work plan activities.
   
   d. Assigned local staff position(s) responsible and accountable for meeting each established goal and objective.
e. Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation.

4. Relevant policies and procedures, referenced in the EPSDT Annual Plan, submitted as separate attachments.

G. Fee-for-Service/EPSDT Provider Requirements

This section discusses the procedural requirements for FFS EPSDT service providers. FFS providers must:

1. Provide EPSDT services in accordance with 42 U.S.C. 1396d(a) and (r), 1396a (a) (43), 42 CFR 441.50 et seq., AHCCCS rules, and AHCCCS and Division policies.

2. Provide and document EPSDT screening services in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.

3. Refer members for follow up, diagnosis and treatment, ensuring that treatment is initiated within 60 days of screening services.

4. If appropriate, document in the medical record the member’s or responsible person’s decision not to use EPSDT services or receive immunizations.

5. Document a health database assessment on each EPSDT participant. The database must be interpreted by a physician or licensed health professional who is under the supervision of a physician, and Provide health counseling/education at initial and follow up visits.

H. Claim Forms

Claims for EPSDT services must be submitted on a CMS (formerly HCFA) 1500 form. Providers must bill for preventative EPSDT services using the preventative service, office or other outpatient services and preventive medicine CPT codes (99381 – 99385, 99391 – 99395) with an EP modifier. EPSDT visits are paid at a global rate for the services specified in this Chapter. With the exception of those items listed above as separately reimbursable services, no additional reimbursement is allowed. Providers must use an EP modifier to designate all services related to the EPSDT well child check-ups, including routine vision and hearing screenings.
431 ORAL HEALTH CARE (EPSDT-AGE MEMBERS)

EFFECTIVE DATE: October 1, 2019
REFERENCES: 9 A.A.C. 22, Article 2; A.R.S. § 14-5101; AMPM Exhibits 400-1, 400-2C, 430-1 and 431-1

This policy applies to Division members under 21 years of age who are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. As part of the physical examination, the physician, physician’s assistant, or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but it is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist must be made.

Appointment Standards

Emergent: Within 24 hours of request

Urgent: As expeditiously as the member’s health condition requires but no later than three days of request

Routine: Within 45 calendar days of request

An oral health screening must be part of an EPSDT screening conducted by a Primary Care Provider (PCP). However, it does not substitute for examination through direct referral to a dentist. PCPs must refer members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral must be documented on the EPSDT Tracking Form and in the member’s medical record.

PCPs who have completed the AHCCCS-required training may be reimbursed for fluoride varnish applications completed at the EPSDT visits for members who are at least six months of age with at least one tooth eruption. Additional applications occurring every six months during an EPSDT visit, up until member’s second birthday, may be reimbursed according to AHCCCS-approved fee schedules. Application of fluoride varnish by the PCP, does not take the place of a dental (oral health) visit.

AHCCCS-recommended training for fluoride varnish application is located on the Smiles for Life oral health website. Refer to Training Module 6, titled Caries Risk Assessment, Fluoride Varnish, and Counseling. Upon completion of the required training, providers must submit a copy of their certificate to each of the contracted health plans in which they participate, as this is required prior to issuing payment for PCP-applied fluoride varnish. This certificate may be used in the credentialing process to verify completion of training necessary for reimbursement.

Additional training resources may be found on the Arizona Department of Health Services website.
**Dental Home**

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

A. Comprehensive oral health care including acute care and preventive services in accordance with AHCCCS Dental Periodicity Schedule

B. Comprehensive assessment for oral diseases and conditions

C. Individualized preventive dental health program based upon a caries-risk assessment and a periodontal disease risk assessment

D. Anticipatory guidance about growth and development issues (e.g., teething, digit, pacifier habits)

E. Plan for acute dental trauma

F. Information about proper care of the child’s teeth and gingivae, including the prevention, diagnosis, and treatment of disease of the supporting and surrounding tissues and the maintenance of health, function, and esthetics of those structures and tissues.

G. Dietary counseling

H. Referrals to dental specialists when care cannot directly be provided within the dental home

Members must be assigned to a dental home by one year of age and seen by a dentist for routine preventative care according to the AHCCCS Dental Periodicity Schedule (AHCCCS Medical Policy Manual [AMPM] Exhibit 431-1). Members must be referred for additional oral health care concerns requiring additional evaluation and/or treatment.

The AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1) identifies when routine referrals begin, however, PCPs may refer EPSDT members for a dental assessment at an earlier age, if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the Administrative Services Subcontractor’s (AdSS’s) provider network.

**Covered Services**

Members receiving EPSDT and Oral Health services through the Regional Behavioral Health Authority (RBHA) are only covered for members 18 to 21 years of age. All members age out of Oral Health & EPSDT services at age 21.

EPSDT covers the following dental services:
A. Emergency dental services including:

1. Treatment for pain, infection, swelling and/or injury

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

3. General anesthesia, conscious sedation, or anxiolysis (minimal sedation; members respond normally to verbal commands), when local anesthesia is contraindicated or when management of the member requires it. (See Division Medical Manual, Policy 430, regarding conscious sedation.)

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

1. Diagnostic services including comprehensive and periodic examinations

   All AdSS must allow two oral examinations and two oral prophylaxis and fluoride treatments per member per year (one every six months) for members 12 months to 21 years of age.

2. Radiology services screening for diagnosis of dental abnormalities and/or pathology, including panoramic or full-mouth x-rays, supplemental bitewing x-rays, and occlusal or periapical films, as medically necessary and following the recommendations by the American Academy of Pediatric Dentistry.

   EPSDT covers panorex films as recommended by the American Academy of Pediatric Dentistry, up to three times maximum per provider for children between the ages of three to 20. Further panorex films needed above this limit must be deemed medically necessary through the AdSS’s Prior Authorization (PA) process.

3. Preventive services, which include:

   a. Oral prophylaxis performed by a dentist or dental hygienist that includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian

   b. Application of topical fluorides.

      The use of a prophylaxis paste containing fluoride or fluoride mouth rinses does not meet the AHCCCS standard for fluoride treatment.

   c. Dental sealants for first and second molars (every three years up to 15 years of age, with a two-time maximum benefit.)

      Additional applications must be deemed medically necessary and require Prior Approval (PA) through the AdSS.
Division of Developmental Disabilities  
Administrative Services Subcontractors  
Medical Policy Manual  
Chapter 400  
Medical Policy for Maternal and Child Health

Medical Policy for Maternal and Child Health

431 Oral Health Care (EPSDT-Age Members)  
Page 4 of 9

d. Space maintainers when posterior primary teeth are lost and when deemed medically necessary through the AdSS’s PA process.

C. All therapeutic dental services, when they are considered medically necessary and cost effective, but they may be subject to PA by the AdSS (or the Division for AIHP members). These services include, but are not limited to:

1. Periodontal procedures, scaling/root planning, curettage, gingivectomy, and osseous surgery

2. Crowns:
   a. When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or crowns with esthetic coatings should be used for anterior primary teeth, or
   b. Precious or cast semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are 18 to 21 years of age.

3. Endodontic services including pulp therapy for permanent and primary teeth, except third molars (unless a third molar is functioning in place of a missing molar)

4. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations, unless the member is 18 to 21 years of age and has had endodontic treatment

5. Restorations of anterior teeth for children under the age of five, when medically necessary.  
   Children five years and over with primary anterior tooth decay should be considered for extraction, if presenting with pain or severely broken-down tooth structure, or be considered for observation until the point of exfoliation as determined by the dental provider.

6. Removable dental prosthetics, including complete dentures and removable partial dentures.

7. Orthodontic services and orthognathic surgery, only when these services are necessary to treat a handicapping malocclusion.

Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is cosmetic.

Examples of conditions that may require orthodontic treatment include the following:
a. Congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services

b. Trauma requiring surgical treatment in addition to orthodontic services

c. Skeletal discrepancy involving maxillary and/or mandibular structures.

Services or items furnished solely for cosmetic purposes are excluded from Division and AHCCCS coverage (9 A.A.C. 22, Article 2).

**Provider Requirements**

Informed consent is a process by which the dental provider advises the member/member’s parent or legal guardian of the diagnosis, proposed treatment, and alternate treatment methods, with associated risks and benefits of each and the associated risks and benefits of not receiving treatment.

Informed consents for oral health treatment include:

A. A written consent for examination and/or any preventative treatment measure, which does not include an irreversible procedure, as mentioned below (this consent is completed at the time of initial examination and is updated at each subsequent six-month follow-up appointment) and

B. A separate written consent for any irreversible, invasive procedure, including but not limited to dental fillings, pulpotomy.

In addition, both parties must review and sign a written treatment plan, as described below, with the member’s parent or legal guardian receiving a copy of the complete treatment plan.

All providers must complete the appropriate consents and treatment plans for Division members as listed above, in order to provide quality and consistent care in a manner that protects and is easily understood by the member and/or the member’s parent or legal guardian. Consents and treatment plans must be in writing and signed/dated by both the provider and the member, or the member’s parent or legal guardian, if the member is under 18 years of age or is 18 years of age or older and considered an incapacitated adult (as defined in A.R.S. § 14-5101). Providers must maintain completed consents and treatment plans in the member’s chart, and these charts are subject to audit.

**AdSS Requirements**

The AdSS must:

A. Conduct annual outreach efforts to members receiving oral health care through school-based or mobile unit providers (in or out of network), to:

   1. Ensure members are aware of their dental home provider and contact information.
2. Let members know when school-based or mobile unit providers are not accessible, they can receive ongoing-access to care through the dental home provider.

B. Conduct written member educational outreach related to dental home, importance of oral health care, dental decay prevention measures, recommended dental periodicity schedule, and other AdSS-selected topics at least once every 12 months. These topics may be addressed separately or combined into one written outreach material; however, each topic must be covered during the 12-month period.

C. Educate providers in the importance of offering continuously accessible, coordinated, family-centered care.

D. Develop processes to:

1. Ensure members are enrolled into a dental home by one year of age, to allow for an ongoing provision of comprehensive oral health care. This process should allow members the choice of dental providers from within the AdSS’s provider network and provide members instructions on how to select or change a dental home provider. Members not selecting a dental home provider will be automatically assigned a provider by the AdSS.

2. Connect all members to a dental home before one year of age or upon assignment to the AdSS, informing members of selected or assigned dental home provider contact information and recommended dental visit schedule.

3. Monitor member participation with the dental home and provide outreach to members who have not completed visits as specified in the AHCCCS Dental Periodicity Schedule (AMPM Exhibit 431-1).

4. Develop, implement, and maintain a procedure to notify all members/responsible parties of visits required by the AHCCCS EPSDT and Dental Periodicity Schedules (AMPM Exhibits 430-1 and 431-1). Processes other than mailings must be preapproved by the Division. This procedure must include notification to members or responsible parties regarding due dates of biannual (once every six months) dental visits. If a dental visit has not taken place, a second notice must be sent.

5. Monitor provider engagement related to scheduling and follow-up of missed appointments, to ensure care consistent with the recommended AHCCCS Dental Periodicity Schedule (Exhibit 431-1) for assigned members.

E. Develop and implement processes to reduce no-show appointment rates for dental services.

F. Provide targeted outreach to those members who did not show for appointments.

The AdSS must encourage all providers to schedule the next dental screening at the current office visit, particularly for children 24 months of age and younger.
G. Require the use of the AHCCCS Dental Periodicity Schedules (Exhibit 431-1) by all contracted providers. The AHCCCS Dental Periodicity Schedule gives providers necessary information regarding timeframes in which age-related required screenings and services must be rendered by providers.

H. Adhere to the Dental Uniform Prior Authorization List (List) as agreed upon by the AdSS. Refer to the AHCCCS website under Resources: Guides-Manuals-Policies. All requests for changes to the List must be submitted to the AHCCCS DHCM designated Operations and Compliance Officer for review. Requests must include supporting documentation and rationale for the proposed changes.

I. (Effective 08/01/18) Adhere to the Uniform Warranty List as agreed upon by the AdSS. Refer to the AHCCCS website under Resources-Guides-Manuals-Policies. All requests for changes to the list must be submitted to the AHCCCS DHCM designated Operations and Compliance Officer for review. Requests must include supporting documentation and rationale for the proposed changes.

Note: The Division will reach out to AIHP members under age 21 to provide education and resources regarding dental/oral health services.

**The Division and the Administrative Services Subcontractors Requirements for the Dental Annual Plan**

Each AdSS must have a written Dental Annual Plan that:

- Addresses minimum requirements as specified in this policy
- Addresses the objectives of the AdSS’s program that are focused on achieving Division requirements
- Incorporate monitoring and evaluation activities for these minimum requirements (see AMPM Exhibit 400-2C, Dental Annual Plan Checklist).

The AdSS must submit the Dental Annual Plan no later than December 15th to the Division’s Healthcare Services Clinical Administrator through the Compliance Unit for review and approval (see AMPM Exhibit 400-1, Maternal and Child Health Reporting Requirements).

The written Dental Annual Plan must contain, at a minimum, the following:

A. Dental Narrative Plan – A written narrative description of all planned activities to address the AdSS’s minimum requirements for dental services, as specified in this policy. The narrative description must also include the AdSS activities to identify member needs and coordination of care, as well as follow-up activities to ensure appropriate treatment is received in a timely manner.

B. Dental Work Plan Evaluation – An evaluation of the previous year’s Work Plan to determine the effectiveness of strategies, interventions, and activities used toward meeting stated objectives.

C. Dental Work Plan that includes:
1. **Specific measurable objectives**

   These objectives must be based on AHCCCS established Minimum Performance Standards as adopted by the Division. In cases where the Minimum Performance Standards have been met, other generally accepted benchmarks that continue the Contractor’s improvement efforts will be used (e.g., National Committee on Quality Assurance, Healthy People 2020 standards). The AdSS may also develop its own specific measurable goals and objectives aimed at enhancing the Dental program when Minimum Performance Standards have been met.

2. **Strategies and specific measurable interventions to accomplish objectives**

   (e.g., member outreach, provider education, and provider compliance with mandatory components of the Dental program)

3. **Targeted implementation and completion dates of work plan activities**

4. **Assigned local staff position(s) responsible and accountable for meeting each established goal and objective**

5. **Identification and implementation of new interventions, continuation of or modification to existing interventions, based on analysis of the previous year’s Work Plan Evaluation**

6. **Relevant policies and procedures, referenced in the Dental Annual Plan, submitted as separate attachments.**

**AFFILIATED PRACTICE DENTAL HYGIENIST**

In addition to the requirements specified in A.R.S. §§ 32-1281 and 32-1289, the Division requires the following:

A. **Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.**

B. **A current copy of the affiliated practice agreement between the dentist and the affiliated practice hygienist and notification when changes to this agreement are made or the agreement is terminated.**

C. **The affiliated practice dental hygienist must maintain individual patient records of Division members in accordance with the Arizona State Dental Practice Act. At a minimum this must include member identification, parent/guardian/designated representative identification, signed authorization (parental consent) for services, patient medical history, and documentation of services rendered.**

D. **When practicing under the scope of an affiliated practice dental hygienist, the affiliated practice dental hygienist must register with AHCCCS and must be identified as the treating provider under his or her individual AHCCCS provider identification number / NPI number. In addition, if the services are to be billed to an AdSS, the affiliated practice dental hygienist and the dentist with whom he or she is affiliated must be a credentialed network provider of the AdSS.**
E. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with state statute and regulations, AHCCCS/Division policy and provider agreement, and their affiliated practice agreement.

F. Reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.

Refer to AMPM Chapter 820 for information related to prior authorization requirements.
450 OUT-OF-STATE PLACEMENTS FOR CHILDREN OR YOUNG ADULTS FOR BEHAVIORAL HEALTH TREATMENT

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS Behavioral Health Covered Services Guide, AMPM Exhibit 450-1
DELIVERABLES: Out of State Placements

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division contracts with AdSS and delegates the responsibility of implementing this policy.

The purpose of this Policy is to provide criteria and procedures for the Division’s AdSS in the event that an out-of-state placement is clinically necessary and supported by the Child and Family Team (CFT) or Adult Recovery Team (ART).

It may be necessary to consider an out-of-state placement for a child or young adult eligible for the Division to meet the member’s unique circumstances or clinical needs. The following factors may lead a member’s CFT or ART to consider the temporary out-of-state placement:

A. The member requires specialized programming not currently available in Arizona to effectively treat a specified behavioral health condition.

B. An out-of-state placement’s approach to treatment incorporates and supports the unique cultural heritage of the member.

C. A lack of current in-state bed capacity, and/or

D. Geographical proximity encourages support and facilitates family involvement in the member’s treatment.

General Requirements

Decisions to place members in out-of-state placements for behavioral health care and treatment must be examined and made after the CFT or ART have reviewed all other in-state options. Other options may include single case agreements with in-state providers or the development of an Individual Service Plan (ISP) that incorporates a combination of support services and clinical interventions.

Services provided out-of-state must meet the same requirements as those rendered in-state. AdSS must also ensure that out-of-state providers follow all Division reporting requirements, policies, and procedures, including appointment standards and timelines specified in AdSS Operations Manual, Policy 417.

Out of state placement providers must coordinate with the AdSS to provide required updates.
The following circumstances must exist in order to consider an out-of-state placement for a member:

A. The CFT or ART explore all applicable and available in-state services and placement options and,
   1. Determine that the services do not adequately meet the specific needs of the member, or
   2. In-state facilities decline to accept the member.

B. The member’s family/guardian agrees with the out-of-state placement (for minors and members between 18 and under 21 years of age under guardianship).

C. The out-of-state placement is registered as an AHCCCS provider.

D. Prior to placement, the AdSS ensures the member has access to non-emergent medical needs by an AHCCCS registered provider,

E. The out-of-state placement meets the Arizona Department of Education Academic Standards, and

F. A plan for the provision of non-emergency medical care is established.

**Conditions Before a Referral for Out-of-State Placement is Made**

The AdSS must ensure that documentation in the clinical record indicates the following conditions have been met before a referral for an out-of-state placement is made:

A. All less restrictive, clinically appropriate approaches have either been provided or considered by the CFT or ART and found not to meet the member’s needs.

B. A minimum of three in-state facilities have declined to accept the member.

C. The CFT or ART has been involved in the service planning process and is in agreement with the out-of-state placement.

D. The CFT or ART has documented how they will remain active and involved in service planning once the out-of-state placement has occurred.

E. An ISP has been developed.

F. All applicable prior authorization requirements have been met, including a second-level review completed by the Division’s Chief Medical Officer/designee.

G. The Arizona Department of Education has been consulted to ensure that the educational program in the out-of-state placement meets the Arizona Department of Education Academic Standards and the specific educational needs of the member.

H. Coordination has occurred with all other state agencies involved with the member, including notification to the Medical Director of the Division of Developmental Disabilities (DDD).
I. Coordination has occurred between the member’s primary care provider and the AdSS to develop a plan for the provision of any necessary, non-emergency medical care. The AdSS must identify who is responsible for this coordination. All providers are registered AHCCCS providers.

**Individual Service Plan (ISP)**

For a member placed out-of-state, the ISP developed by the CFT or ART (including the member’s Support Coordinator) must require that:

A. Discharge planning is initiated at the time of admission and includes:
   1. The measurable treatment goals being addressed by the out-of-state placement and the criteria necessary for discharge back to in-state services
   2. The possible or proposed in-state residence where the member will be returning
   3. The recommended services and supports required once the member returns from the out-of-state placement
   4. How effective strategies implemented in the out-of-state placement will be transferred to the members’ subsequent in-state placement
   5. The actions necessary to integrate the member into family and community life upon discharge, and
   6. Review by the CFT or ART of the member’s progress with the clinical staff at least every 30 days.

B. When appropriate, the member’s family/guardian is involved throughout the duration of the placement. Involvement may include family counseling in person or by teleconference or video-conference.

Home passes are allowed as clinically appropriate and in accordance with the AHCCCS Behavioral Health Covered Services Guide. For youth in Department of Child Safety (DCS) custody, approval of home passes are determined in collaboration with DCS.

C. The member’s needs, strengths, and cultural considerations have been addressed.

**Initial Notification to Division Health Care Services**

A. The AdSS must notify the Division by emailing a completed AHCCCS Out-of-State Placement Form (AMPM Exhibit 450-1, adopted by the Division for use by the AdSS) to Division Health Care Services under the following circumstances:
   1. Upon notification or discovery that a member is in an out-of-state behavioral health residential treatment facility
   2. Prior to a referral for an out of state placement (approval from the Division of
all planned out of state placements must be obtained prior to making a referral for out-of-state placement, in accordance with the criteria outlined in this Policy)


B. Prior authorization is required for all out-of-state placements.

C. The Division Health Care Services will review the information on the AHCCCS Out-of-State Placement Form (Exhibit 450-1) and render an approval within 1-3 business days. If the information is incorrect or incomplete, the form will be returned for correction. The corrected form must be resubmitted for approval.

**Required Updates to Division Health Care Services**

A. The AdSS must submit updates to the Division Health Care Services regarding the member’s progress in meeting the identified criteria for discharge.

B. The progress update, using the AHCCCS Out-of-State Placement Form (Exhibit 450-1), must be emailed to Division Health Care Services every 30 days that the member remains in the out-of-state placement. The 30-day update timeline is based upon the date of Division approval of the out-of-state placement. If a 30-day update date falls on a weekend or holiday, it must be submitted on the next business day.

**Required Reporting of an Out-of-State Provider**

All out-of-state providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, injuries from seclusion/restraint implementations as described in Division Medical Manual Policy 960.
510 PRIMARY CARE PROVIDERS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-2901; A.R.S. Title 32, Chapter 13 or Chapter 17; A.R.S. Title 32, Chapter 25; A.R.S. Title 32, Chapter 15

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Definitions

A. Medication Assisted Treatment (MAT) - The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.

B. Primary Care Provider (PCP) - An individual who meets the requirements of A.R.S. § 36-2901 and who is responsible for the management of the member’s health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of persons, such as a clinic.

Primary Care Provider Role and Responsibilities

The primary responsibilities of Primary Care Provider (PCP) include, but are not be limited to:

A. Providing initial and primary care services to assigned members

B. Initiating, supervising, and coordinating referrals for specialty care and inpatient services, and maintaining continuity of member care

C. Maintaining the member’s medical record.

Provision of Initial and Primary Care Services

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to the member. These services include, at a minimum:

A. Treatment of routine illness

B. Maternity services if applicable

C. Immunizations

D. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members under age 21

E. Adult health screening services

F. Medically necessary treatments for conditions identified in an EPSDT or adult health screening
G. Each member eligible for EPSDT must receive health screening/examination services as specified in Chapter 400 of this Policy Manual.

Behavioral Health Medications Prescribed by the PCP for the Treatment of Anxiety, Depression, Attention Deficit Hyperactivity Disorder (ADHD) and Opioid Use Disorder (OUD)

The Division and its AdSS shall provide coverage for medically necessary, cost-effective, and federally and state reimbursable behavioral health medications prescribed by a PCP when used to treat anxiety, depression (including postpartum depression), ADHD, and/or OUD, this includes the monitoring and adjustments of behavioral health medications. For OUD the PCP must refer the member to a behavioral health provider for the psychological and/or behavioral therapy component of the MAT model and coordinate care with the behavioral health provider.

**Primary Care Provider Care Coordination Responsibilities**

PCPs, in their care coordination role, serve as the referral agent for specialty and referral treatments and services provided to the members eligible for the Division who are assigned to them, and they attempt to ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

A. Referring members to providers or hospitals within the AdSS’s network, as appropriate, and if necessary, referring members to out-of-network specialty providers

B. Coordinating with the AdSS in prior authorization procedures for members

C. Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers, and/or hospitals

D. Coordinating the medical care of members assigned to them, including at a minimum:

1. Oversight of drug regimens to prevent negative interactive effects
2. Follow-up for all emergency services
3. Coordination of inpatient care
4. Coordination of services provided on a referral basis
5. Assurance that care rendered by specialty providers is appropriate and consistent with each member’s health care needs.
Maintenance of the Members Medical Record

Refer to Division Medical Policy Manual, Policy 940, Medical Records and Communication of Clinical Information, for information regarding the maintenance of the member's medical record.

Primary Care Provider Assignment and Appointment Standards

The AdSS must:

- Make provisions to ensure that newly enrolled members are assigned to a PCP and notified after the assignment within 12 calendar days of the enrollment notification.
- Ensure that PCPs under contract with them register with the AHCCCS Administration as an approved service provider and receive an AHCCCS provider ID number.

AHCCCS allows licensed providers from several medical disciplines to qualify as PCPs. These medical disciplines include physicians and certified nurse practitioners in the specialty areas of general practice, family practice, pediatrics, internal medicine, and obstetrics and gynecology. In addition, physician assistants under physician supervision may serve as PCPs. There may be circumstances when the specialist is the PCP (e.g., a member is designated with special health care needs).

AdSS are required to keep a current file of member PCP assignments. Each AdSS must maintain accurate tracking of PCP assignments in order to facilitate continuity of care, control use, and obtain encounter data.

The AdSS must allow the member freedom of choice of the PCPs available within its network. If the member does not select a PCP, the member will be automatically assigned to a PCP by the AdSS. The AdSS must ensure that their network of PCPs is sufficient to provide members with available and accessible service within the following time frames specified in the AdSS Operations Manual, Policy 417.

The AdSS must develop procedures to ensure that newly enrolled pregnant members are assigned to a PCP who provides obstetrical care or are referred to an obstetrician, in accordance with Division Medical Policy Manual, Policy 410 Maternity Care Services. Women may elect to use a specialist in obstetrics and/or gynecology for well woman services.

Physician Extender Visits in a Nursing Facility

Initial and any or all subsequent visits to a Division-enrolled member in a Nursing Facility (NF) or Skilled Nursing Facility (SNF), made by a physician extender, are covered services when all of the following criteria are met:

A. The physician extender is working in collaboration with a physician.
B. The physician extender is not an employee of the facility.
C. The source of payment for the NF/SNF stay is Medicaid.
For the purposes of this policy, the Division defines “physician extenders” as nurse practitioners and physician assistants working within the scope of their practice.

### Medical Resident Visits Under Specific Circumstances

Residents providing service without the presence of a teaching physician must have completed more than six months (post graduate) of an approved residency program. Medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

### Referrals and Appointment for Specialty Care

The AdSS must have adequate referral procedures in place in order to ensure appropriate availability and monitoring of health care services. Referral procedures must include:

A. Use of an AdSS-specific referral form

B. Definition of who is responsible for writing referrals, authorizing referrals, and adjudicating disputes regarding approval of a referral (referral to either a contracting or non-contracting provider)

C. Specifications addressing the timely availability of specialty referral appointments as specified in AdSS Operations Manual, Policy 417:

1. Specifications and procedures for linking specialty and other referrals to the financial management system; such as through the prior authorization process.

Refer to Division Medical Policy Manual, Policy 420, Family Planning, for family planning services information.
520 MEMBER TRANSITIONS

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 431.300 et seq

The Division of Developmental Disabilities (Division) and its Administrative Services Subcontractors (AdSSs) must identify and facilitate coordination of care for all members eligible for ALTCS during changes or transitions between AdSSs and changes in service areas and/or health care providers. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols is developing to address these situations. Special circumstances include members designated as having “special health care needs” and members who:

A. Have medical conditions or circumstances such as:
   1. Pregnancy (especially women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date)
   2. Major organ or tissue transplantation services which are in process
   3. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other facilities, and/or
   4. Significant medical conditions (e.g., diabetes, hypertension, pain control, or orthopedics) that require ongoing specialist care and appointments

B. Are in treatment such as:
   1. Chemotherapy and/or radiation therapy
   2. Dialysis

C. Have ongoing needs such as:
   1. Durable medical equipment, including ventilators and other respiratory assistance equipment
   2. Home health services
   3. Medically necessary transportation on a scheduled basis
   4. Prescription medications
   5. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment-eligible members

D. At the time of transition, have received prior authorization or approval for:
   1. Scheduled elective surgery(ies)
   2. Procedures and/or therapies to be provided on dates after their transition,
including post-surgical follow-up visits

3. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period

4. Appointments with a specialist located out of the AdSS service area

5. Nursing facility admission.

**Notifications Required of AdSS**

A. The relinquishing AdSS must provide relevant information regarding members who transition to a receiving AdSS. The *ALTCS Enrollment Transition Information (ETI)* (*DDD-1541A*) form must be sent to the Division for at least those members with special circumstances, listed in this policy, who are transitioning enrollment to another AdSS.

B. The relinquishing AdSS that fails to notify the receiving AdSS of transitioning members with special circumstances, or fails to send the completed *ALTCS Enrollment Transition Information (ETI)* (*DDD-1541A*), will be responsible for covering the member's care resulting from the lack of notification, for up to 30 days.

C. The relinquishing and receiving AdSSs must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, subcontractors or other providers, as appropriate during times of transition.

D. The receiving AdSS must provide new members with its handbook and emergency numbers as specified in contract.

E. The receiving AdSS must follow up appropriately for the needs identified on *ALTCS Enrollment Transition Information (ETI)* (*DDD-1541A*).

**Transition Policies**

The Division has specific policies for member transition issues including, but not limited to:

A. Transition from the Division to an acute care contractor

1. If a member is determined through Pre-Admission Screening (PAS) reassessment to no longer need long term care through ALTCS or the ALTCS-Transitional program, and the member is determined eligible for acute care enrollment, he/she will be transitioned to an acute care contractor.

2. The Division will receive a prior plan list for members that are being dis-enrolled. The Division uses this list to identify members needing an *ALTCS Enrollment Transition Information (ETI)* (*DDD-1541A*), completes, and forwards it and any other appropriate information to the acute care contractor.
3. The member's Division Support Coordinator and AdSS must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained.

4. The Division and the AdSS must implement protocols for the special circumstances that members transitioning from ALTCS may experience. The following protocols must be included:
   a. Conduct a comprehensive evaluation to determine the treatment and service regimen.
      i. The member must continue receiving the Division treatment and service regimen until that determination is made.
      ii. The exception is for Division services that are not covered by acute care contractors (e.g., attendant care or home delivered meals).
      iii. The evaluation must encompass each service the member is currently receiving from the Division and the AdSS.
   b. Develop an individualized treatment plan based on the member's needs, past progress and projected outcomes, using information gathered from the comprehensive evaluation, the care plan, medical history, and information obtained from the Division Support Coordinator and the AdSS.

B. Transition of members hospitalized during an enrollment change

1. The AdSS must make provisions for the smooth transition of care for members who are hospitalized on the day of an enrollment change. The provisions must include protocols for the following:
   a. Authorization of treatment by the receiving AdSS on an individualized basis. The receiving AdSS must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.
   b. Notification to the hospital and attending physician of the transition by the relinquishing AdSS.
      i. The relinquishing AdSS must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving AdSS for authorization of continued services.
      ii. If the relinquishing AdSS fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing AdSS will be
Division of Developmental Disabilities
Administrative Services Subcontractors
Medical Policy Manual
Chapter 500
Care Coordination Requirements

responsible for coverage of services rendered to the hospitalized member for up to 30 days. This includes, but is not limited to, elective surgeries for which the relinquishing AdSS issued prior authorization.

c. Coordination with providers regarding activities relevant to concurrent review and discharge planning must be addressed by the receiving AdSS, along with the mechanism for notification regarding pending discharge.

d. Transfer of care to a physician and/or hospital affiliated with the receiving AdSS.

i. Transfers from an out-of-network provider to one of the receiving AdSS providers cannot be made if harmful to the member’s health and must be determined medically appropriate.

ii. The transfer may not be initiated without approval from the relinquishing AdSS Primary Care Provider (PCP), or the receiving AdSS Medical Director.

2. Members in critical care units, intensive care units, and neonatal intensive care units require close consultation between the attending physician and the receiving AdSS physician. If a member is admitted to an inpatient facility while still assigned to the relinquishing AdSS, and discharged after transition to the receiving AdSS, both must work together to coordinate discharge activities.

3. The relinquishing AdSS will be responsible for coordination with the receiving AdSS regarding each specific prior authorized service.

4. For members known to be transitioning, the relinquishing AdSS must not authorize hospital services such as elective surgeries scheduled less than 15 days prior to enrollment with the receiving AdSS.

5. If authorized to be provided during this time frame, the service for the transitioning member will be the financial responsibility of the AdSS who authorized the service.

C. Transition during major organ and tissue transplantation services

1. If there is a change in AdSS enrollment, both the relinquishing and receiving AdSS will be responsible for coordination of care and coverage for members awaiting major organ or tissue transplantation from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery.

2. If a member changes AdSS enrollment while undergoing transplantation at
an AHCCCS-contracted transplant center, the relinquishing AdSS is responsible for contracted components or modules of the service up to and including completion of the service modules that the member is receiving at the time of the change.

3. The receiving AdSS is responsible for the remainder of the module components of the transplantation service.

4. If a member changes to a different AdSS while undergoing transplantation at a transplant center that is not an AHCCCS-contracted provider, each AdSS is responsible for its respective dates of service. If the relinquishing AdSS has negotiated a special rate, it is the responsibility of the receiving AdSS to coordinate the continuation of the special rate with the respective transplant center.

**Enrollment Changes for Members Receiving Outpatient Treatment for Significant Conditions**

A. AdSSs must have protocols for ongoing care of active and/or chronic "high risk" (e.g., outpatient chemotherapy, home dialysis) members and pregnant members during the transition period. The receiving AdSS must have protocols to address the timely transition of the member from the relinquishing PCP to the receiving PCP, in order to maintain continuity of care.

B. The receiving AdSS must address methods to continue the member's care, such as contracting on a negotiated rate basis with the member's current provider(s) and/or assisting members and providing instructions regarding their transfer to providers affiliated with the receiving AdSS.

C. Receiving AdSS are also responsible for coordinating the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new AdSS within the last trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

**Medically Necessary Transportation**

Service delivery locations may necessitate changes in transportation patterns for the transitioning member. The AdSS must have protocols for at least the following:

A. Information to new members on what, and how, medically necessary transportation can be obtained

B. Information to providers on how to order medically necessary transportation.

**Transfer and Interim Coverage of Prescription Medications**

The AdSS must address the issues of dispensing and refilling prescription medications during the transition period, and develop protocols for at least the following:
A. Relinquishing AdSS must cover the dispensation of the total prescription amount of either continuing or time-limited medications, if filled before midnight on the last day of enrollment. The relinquishing AdSS must also provide sufficient continuing medications for up to 15 days after the transition date.

B. The receiving AdSS must address prior authorization of prescription medication and refills of maintenance medication within 14 days of the member’s transition.

C. The relinquishing AdSS must provide notice to the receiving AdSS primary care provider of transitioning members who are currently taking prescription medications for medical conditions requiring ongoing use of medication, such as, but not limited to, immunosuppressant, psychotropic and cardiovascular medications, or unusually high cost medications.

Disposition of Durable Medical Equipment, Orthotics, Prosthetics and Other Medical Supplies

A. The AdSS must address the disposition of durable medical equipment (DME) and other medical equipment during a member's transition period and develop protocols for non-customized DME.

B. The relinquishing AdSS must provide transitioning members with DME for up to 15 days after the transition date or until the receiving AdSS supplies the service. The receiving AdSS must supply necessary DME within 14 days following the transition date.

C. To facilitate continuity of services, the receiving AdSS is encouraged to:
   1. Negotiate and/or contract for continued services with the member's current provider, and/or
   2. Provide instructions and assistance to new members on how to transfer to a DME provider who belongs to the new AdSS network.

D. The receiving AdSS must assess medical necessity of DME if equipment was rented by the relinquishing AdSS.

Customized DME

A. For purposes of this policy, customized DME is defined as equipment that has been altered or built to specifications unique to a member’s medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

B. Customized DME purchased for members by the relinquishing AdSS will remain with the member after the transition. The cost of the equipment is the responsibility of the relinquishing AdSS.

C. Customized DME ordered by the relinquishing AdSS but delivered after the transition to the receiving AdSS will be the financial responsibility of the relinquishing AdSS.
D. Maintenance contracts for customized DME purchased for members by a relinquishing AdSS will transfer with the member to the receiving AdSS. Contract payments due after the transition will be the responsibility of the receiving AdSS if they elect to continue the maintenance contract.

**Transfer of Medical Records**

A. Medical records must be forwarded when there is significant consequence to current treatment, or if requested by the receiving PCP or specialty provider. The cost of copying and transmitting of the medical record information specified in this policy will be the responsibility of the relinquishing PCP unless otherwise noted.

B. To ensure continuity of member care during the time of enrollment change, the AdSS must have the following procedures in place to ensure timely medical records transfer:

1. Procedure to be used by the relinquishing AdSS PCP to transfer member records to the receiving AdSS PCP.

2. Procedure regarding:
   a. The portions of a medical record to copy and forward to the receiving AdSS PCP.

   The relinquishing PCP must transmit at least those records related to diagnostic tests and determinations, current treatment services, immunizations, hospitalizations with concurrent review data and discharge summaries, medications, current specialist services, behavioral health quarterly summaries and emergency care.

   b. A defined timeframe for the receipt of medical records by the receiving PCP (e.g., on the date of transfer, after hospital discharge, prior to transfer)

   c. Maintaining confidentiality of each member's medical records. In accordance with federal or state laws and court orders, contractors must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.

   d. Transfer of other requested medical records, exceeding the requirements of this policy, including resolution of payment for copying and transmitting medical record data.
540 OTHER CARE COORDINATION ISSUES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. §§ 15-765, 36-552(C), 36-558(A), 36-560(B); A.A.C. R9-28-509; and, Social Security Act § 1915(k).

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

**Problem Resolution**

The AdSS must establish policies that address problem resolution.

**Members Presenting for Care Outside the AdSS’s Provider Network**

The AdSS must establish procedures for assisting members when they present to a non-contracted provider that include, but are not limited to:

A. Identification of a specific AdSS contact person for assistance
B. Identification of a telephone number to obtain AdSS information
C. Electronic and hard copy (if requested) provider directories.

**Members with Special Health Care Needs**

A. Members with special health care needs includes all members eligible for the Division.
B. The AdSS must implement mechanisms to assess each member identified as having special health care needs, in order to identify any ongoing special conditions requiring treatment or regular care monitoring. The assessment mechanism must identify appropriate health care professionals.
C. The AdSS must share, with other entities providing services to that member, the results of its identification and assessment of that member’s needs.
D. For members requiring a specialized course of treatment or regular care monitoring, the AdSS must have procedures in place to allow members direct access to a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs.

**Coordination of Urgent Response for Children Involved With DCS**

When a child is removed from his/her home, to the protective custody of the Department of Child Safety (DCS), the AdSS must consider this to be an urgent behavioral health situation. Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. The urgent response process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself.

In cases where DCS notifies the AdSS within five days of physical removal of the child, the AdSS must implement the urgent response process within 72 hours from initial contact by
DCS, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child. If notification is received after the fifth day of removal, the AdSS, in collaboration with the DCS Specialist, has the discretion to initiate an urgent response or schedule the child for a regular intake appointment, depending on the specific circumstances surrounding the referral. If the DCS Specialist has initiated behavioral health services through the Arizona Department of Health Services (ADHS) Behavioral Health System, the Children’s Rehabilitative Services (CRS) Contractor may authorize continued services with the behavioral health provider that has established a treatment relationship with the child until a safe transition to a contracted behavioral health provider can be completed.

The urgent response process must include:

A. Contact the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how-when-where the removal occurred, any known special needs of the child, any known supports for the child, current disposition of siblings, any known needs of the new caregiver, etc.

B. Conduct a comprehensive assessment identifying immediate safety needs and presenting problems of the child. At this time, trauma issues such as grief and loss should be addressed. In addition, the assessment process is expected to consider an extended assessment period to more accurately identify any emerging/developing behavioral health needs that are not immediately apparent following the child’s removal.

C. Stabilization of behavioral health crises and offering of immediate services.

D. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term.

E. The provision of needed behavioral health services to the child’s caregiver, including guidance about how to respond to the child’s immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of a contact within the behavioral health provider network.

F. Provide the DCS Case Manager and DDD Support Coordinator with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child’s removal.

G. If the child is placed with temporary caregivers, services should support the child’s stability by addressing the child’s behavioral health needs, identifying any risk factors for placement disruption, and anticipating crisis that might develop. Behavioral health services must proactively plan for transitions in the child’s life. Transitions may include changes in placement, educational setting, and/or reaching the age of majority.
541 COORDINATION OF CARE WITH OTHER GOVERNMENT AGENCIES

EFFECTIVE DATE: October 1, 2019


This policy applies to the Division's Administrative Services Subcontractors (AdSS) as delineated within policy.

The AdSS is required to develop and maintain collaborative relationships with other government entities that deliver services to members and their families, ensure access to services, and coordinate care with consistent quality.

Appropriate authorizations to release information must be obtained prior to releasing information.

Definitions

A. Adult Recovery Team (ART) - 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's guardian/designated representative (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include the enrolled 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 members identified by the enrolled member.

B. Child and Family Team (CFT) - A defined group of individuals that includes, at a minimum, the child and his or her family, the assigned Support Coordinator, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like Department of Child Safety (DCS) or the Division of Developmental Disabilities (DDD), which includes AzEIP. 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 Planning Document, and can therefore expand and contract as necessary to be successful on behalf of the child.

C. Rapid Response - A process in which, a behavioral health service provider is dispatched within 72 hours, to assess a child’s immediate behavioral health needs, and refer for further assessments through the behavioral health system when a child first enters into DCS custody.
D. **Service Plan (Behavioral Health)** - A complete written description of all covered behavioral health services and other informal supports that includes individualized goals, family support services, care coordination activities, and strategies to assist the member in achieving an improved quality of life.

E. **State Placing Agency** - The Department of Juvenile Corrections, Department of Economic Security, Department of Child Safety, the Arizona Health Care Cost Containment System or the Administrative Office of the Court. (A.R.S. §15-1181(12)).

F. **Team Decision Making (TDM)** - When an emergency removal of a child has occurred or the removal of a child is being considered, a TDM Meeting is held. The purpose of the meeting is to discuss the child’s safety and where they will live.

**Policy**

The AdSS must develop policies, protocols, and procedures that describe how member care will be coordinated and managed with other governmental entities. The AdSS is responsible for ensuring collaboration with government agencies, including but not limited to involvement in the member’s Planning Team.

The AdSS must ensure that all required protocols and agreements with state agencies are delineated in provider manuals. AdSS must develop mechanisms and processes to identify barriers to timely services for members served by other governmental entities and work collaboratively to remove barriers to care and to resolve any quality of care concerns.

A. **Arizona Department of Child Safety (DCS)**

AdSS is required to work in collaboration with DCS as outlined below:

1. **General Requirements:**
   a. Coordinate development of the Service Plan with the DCS case plan to avoid redundancies and/or inconsistencies;
   b. Provide the DCS Specialist and the juvenile court with preliminary findings and recommendations on behavioral health risk factors, symptoms and service needs for court hearings;
   c. 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;
   d. 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 CFT;
e. Attend team meetings such as Team Decision Making (TDM) providing input about the child and family’s behavioral health needs. When it is possible, TDM and CFT meetings should be combined;

f. Coordinate necessary services to stabilize in-home and out-of-home placements provided by DCS;

g. Coordinate provision of behavioral health services in support of family reunification and/or other permanency plans identified by DCS;

h. Coordinate activities and service delivery that supports the child and family Plans and facilitates adherence to established timeframes (see AdSS Operations Manual Policy 417 and AHCCCS Behavioral Health System Practice Tools: Transition to Adulthood, Unique Behavioral Health Services for Needs of Children, Youth and Families involved with DCS, and Child and Family Team; and

i. Coordinate activities including coordination with the adult service providers rendering services to adult family members.

2. Rapid Response Process:

The AdSS must consider the removal of a child from home to the protective custody of the DCS to be an urgent behavioral health situation. Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. The Rapid Response process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself.

a. In all cases where DCS notifies the AdSS of physical removal of the child, the AdSS must implement the Rapid Response process within 72 hours from initial contact by DCS, unless the AdSS and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child.

i. If notification is received after 72 hours of removal, the AdSS, in collaboration with the DCS Specialist, must initiate a Rapid Response. The child may also be scheduled for an initial behavioral health assessment, depending on the specific circumstances surrounding the referral. If the DCS Specialist has initiated behavioral health services, the AdSS may authorize continued services with the behavioral health provider that has established a treatment relationship with the child; and

ii. The AdSS must assist DCS in identifying members already receiving behavioral health services.
b. The AdSS must ensure the Rapid Response process includes:

i. Contacting the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how, when, and where the removal occurred, any known medical, behavioral, or special needs of the child, any known medications, any known supports for the child, current disposition of siblings, and any known needs of the new caregiver, etc.;

ii. Conducting a comprehensive assessment identifying immediate safety needs and presenting problems of the child. At this time, trauma issues such as grief and loss should be addressed. In addition, the assessment process is expected to consider an extended assessment period to more accurately identify any emerging/developing behavioral health needs that are not immediately apparent following the child’s removal;

iii. Stabilization of behavioral health crises and offering of immediate services. The AdSS must require its Rapid Response providers to distribute the most recent Foster and Kinship Care Resources Packet to the placement during the Rapid Response visit. The Resource Packet is available on the AHCCCS website: https://www.azahcccs.gov/Members/AlreadyCovered/MemberResources/Foster;

iv. The provision of behavioral health services to the child with the intention of reducing the stress and anxiety that the child may be experiencing, and offering a coherent explanation to the child about what is happening and what can be expected to happen in the near-term;

v. The provision of needed behavioral health services to the child’s caregiver, including guidance about how to respond to the child’s immediate needs in adjusting to foster care, behavioral health symptoms to watch for and report, assistance in responding to any behavioral health symptoms the child may exhibit, and identification of contacts within the behavioral health system;

vi. Providing the DCS Specialist with findings and recommendations for medically necessary covered behavioral health services for the initial Preliminary Protective Hearing, which occurs within five to seven days of the child’s removal; and
vii. If the child is placed with temporary caregivers, services should support the child’s stability by addressing the child’s behavioral health needs, identifying any risk factors for placement disruption, and anticipating crisis that might develop. Behavioral health services must proactively plan for transitions in the child’s life. Transitions may include changes in placement, educational setting, or reaching the age of majority.


1. The AdSS must ensure that behavioral health providers coordinate with parents/families/caregivers referred through the Arizona Families F.I.R.S.T. (AFF) Program (hereafter referred to as the AFF Program) and that the providers participate in the family’s Planning Team to coordinate services for the family and temporary caregivers.

2. The AFF Program provides expedited access to substance use treatment for parents/families/caregivers referred by DCS and the ADES/Family Assistance Administration (FAA) Jobs Program. AHCCCS participates in statewide implementation of the program with DCS. The AdSS must ensure behavioral health providers coordinate the following:
   a. Accept referrals for members eligible for the Division and ALTCS and families referred through the AFF Program.
   b. Accept referrals for members eligible for the Division and ALTCS and families referred through the AFF Program and provide services, if eligible.
   c. Collaborate with DCS, the ADES/FAA Jobs Program and substance use disorder treatment providers to minimize duplication of assessments.
   d. Develop procedures for collaboration in the referral process to ensure effective service delivery through the AdSS behavioral health system. Appropriate authorizations to release information must be obtained prior to releasing information.

3. Substance use disorder treatment for families involved with DCS must be family-centered, provide for sufficient support services and must be provided in a timely manner to promote permanency for children, stability for families, to protect the health and safety of abused and/or neglected children and promote economic security for families.

C. Arizona Department of Education (ADE), Schools, or Other Local Educational Authorities
1. The AdSS are required to work in collaboration with the ADE and assist with resources and referral linkages for children with behavioral health needs. For children eligible for the Division, AHCCCS has delegated to the Division its authority as a State Placing Agency under A.R.S. § 15-1181 for children receiving special education services pursuant to A.R.S. § 15-761 et seq. This includes the authority to place a student at a Behavioral Health Inpatient Facility that provides care, safety, and treatment.

2. The AdSS must ensure that behavioral health providers collaborate with schools and help a child achieve success in school as follows:
   a. Work with the school and share information to the extent permitted by law and authorized by the child’s parent or legal guardian. Refer to Division Medical Manual Policy 550;
   b. For children who receive special education services, include information and recommendations contained in the Individualized Education Program (IEP) during the ongoing assessment and service planning process (see Division Medical Manual Policy 300). The AdSS must invite the Behavioral health providers to IEP meetings to partner in the implementation of behavioral health interventions;
   c. For children in the custody of DCS, the behavior health provider must communicate and involve the DCS Specialist with the development of the IEP;
   d. Invite teachers and other school staff to participate in the CFT if agreed to by the child and legal guardian;
   e. Understand the IEP requirements as described in the Individuals with Disabilities Education Act (IDEA) of 2004;
   f. Support accommodations for students with disabilities who qualify under Section 504 of the Rehabilitation Act of 1973; and
   g. Ensure that transitional planning occurs prior to and after discharge of an enrolled child from any out-of-home placement.

D. **Courts and Corrections**

1. AdSS must collaborate and coordinate care, and ensure that behavioral health providers collaborate and coordinate care for members with 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), or
2. AdSS must collaborate with courts or correctional agencies to coordinate member care as outlined in AHCCCS AMPM Policy 1020 and as follows:

   a. Work in collaboration with the appropriate staff involved with the member;

   b. Invite probation or parole representatives to participate in the development of the Service Plan and all subsequent planning meetings for the CFT and ART with the member’s/guardian’s/designated representatives’ approval;

   c. Actively consider information and recommendations contained in probation or parole case plans when developing the Service Plan; and

   d. Ensure that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member’s release.
560 CRS CARE COORDINATION AND SERVICE PLAN MANAGEMENT

EFFECTIVE DATE: October 1, 2018

This policy applies to the Administrative Services Subcontractors (AdSS).

This policy establishes requirements regarding Children’s Rehabilitative Services (CRS) care coordination for ALTCS members designated as having a CRS condition and defines the process for development and management of the member’s service plan.

The AdSS is responsible for ensuring that:

- Every member has a Service Plan initiated upon notice of enrollment; and updating the Service Plan as the member’s health condition or treatment plans change.
- Care is coordinated according to the Service Plan and in cooperation with other State Agencies, AHCCCS Contractors, or Fee-For-Service (FFS) programs with which the member is enrolled, and Community Organizations.

AHCCCS identifies members who meet a qualifying condition(s) for CRS and who require active medical, surgical, or therapy treatment for medically disabling or potentially disabling conditions, as defined in A.A.C. R9-22-1303. The AHCCCS Division of Member Services (DMS) will provide information to the AdSS related to the CRS qualifying condition(s) that are identified during the determination process. DMS may also provide information received for purposes of a CRS designation regarding care, services or procedures that may have been approved or authorized by the member’s current health plan or FFS program.

Service delivery must be provided in a family-centered, coordinated and culturally competent manner in order to meet the unique physical, behavioral and holistic needs of the member.

Members with a CRS designation may receive care and specialty services from an MSIC or community based provider in independent offices that are qualified to treat the member’s condition. The AdSS must ensure availability of alternative methods for providing services such as field clinics and telemedicine in rural areas.

The AdSS must ensure the development and implementation of a Service Plan for members designated as having a CRS Condition and are responsible for coordination of the member’s health care needs and collaboration as needed with providers, communities, agencies, service systems, and members/guardians/designated representatives in development of the Service Plan.

The AdSS must ensure the Service Plan is accessible to all service providers and contains the behavioral health, physical health, and administrative information necessary to monitor a coordinated and integrated treatment plan implementation.

Definitions

A. Active Treatment - a current need for treatment. The treatment is identified on the member’s service plan to treat a serious and chronic physical, developmental or behavioral condition requiring medically necessary services of a type or amount beyond that generally required by members that lasts, or is expected to last one year or longer, and requires ongoing care not generally provided by a primary care provider.
provider.

B. **CRS Condition** - any of the covered medical conditions in A.A.C. R9-22-1303 which are referred to as covered conditions in A.R.S. 36-2912.

C. **Designated Representative** - parent, guardian, relative, advocate, friend, or other person, designated in writing by a member or guardian who, upon the request of the member, assists the member in protecting the member’s rights and voicing the member’s service needs. See A.A.C. R9-22-101.

D. **Field Clinic** - “clinic” consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis.

E. **Multi-Specialty Interdisciplinary Clinic (MSIC)** - established facility where specialists from multiple specialties meet with members and their families for the purpose of providing interdisciplinary services to treat members.

F. **Multi-Specialty Interdisciplinary Team (MSIT)** - team of specialists from multiple specialties who meet with members and their families for the purpose of determining an interdisciplinary treatment plan.

G. **Service Plan** - complete written description of all covered health services and other informal supports which includes individualized goals, family support services, care coordination activities and strategies to assist the member in achieving an improved quality of life.

**Care Coordination**

The AdSS must establish a process to ensure coordination of care for members that includes:

A. Coordination of member health care needs through a Service Plan

B. Collaboration with members/guardians/designated representatives, other individuals identified by the member, groups, providers, organizations and agencies charged with the administration, support or delivery of services that is consistent with federal and state privacy laws

C. Service coordination and communication, designed to manage the transition of care for a member who no longer meets CRS eligibility requirements or makes the decision to transition to another Division Contractor after the age of 21 years

D. Service coordination to ensure specialty services related to a member’s CRS condition(s) care completed, as clinically appropriate prior to the member’s 21st birthday. Appropriate service delivery and care coordination must be provided regardless of the member’s CRS designation ending.

**Service Plan Development and Maintenance**

A. The AdSS is responsible for ensuring that:
• Each member designated to have a CRS Condition has a member-centric Service Plan and that the member's first provider visit occurs within 30 days of designation.

• Services are provided according to the Service Plan.

The Service Plan serves as a working document that integrates the member’s multiple treatment plans, including behavioral health, into one document in a manner and format that is easily understood by the member/guardian/designated representative, and shared with the member/guardian/designated representative upon request or as part of the Multi-Specialty Interdisciplinary Team (MSIT), Child Family Team (CFT), or Adult Recovery Team (ART) meetings. The Service Plan identifies desired outcomes, resources, priorities, concerns, personal goals, and strategies to meet the identified objectives. The Service Plan must identify the immediate and long-term healthcare needs of each newly enrolled member and must include an action plan. The AdSS is responsible for ensuring that every member has an initial Service Plan developed by the AdSS within 14 days of the notice of designation utilizing information provided by AHCCCS DMS. The Service Plan must be monitored regularly and updated when there is a change in the member’s health condition, desired outcomes, personal goals or care objectives.

B. A comprehensive Service Plan must be developed within 60 calendar days from date of the first appointment for the CRS qualifying condition and must include, but is not limited to, all the following required elements:

a. Member demographics and enrollment data
b. Medical diagnoses, past treatment, previous surgeries (if any), procedures, medications, and allergies
c. Action plan
d. The member’s current status, including present levels of functioning in physical, cognitive, social, behavioral, and educational domains
e. Barriers to treatment, such as member/guardian/designated representative’s inability to travel to an appointment
f. The member/guardian/designated representative’s strengths, resources, priorities, and concerns related to achieving mutual recommendations and caring for the family or the member
g. Services recommended to achieve the identified objectives, including provider or person responsible and timeframe requirements for meeting desired outcomes.

C. The AdSS must identify an interdisciplinary team to implement and update the Service Plan as needed.

D. The AdSS must modify and update the Service Plan when there is a change in the member’s condition or recommended services. This will occur periodically as determined necessary by the member/guardian/designated representative, or provider(s).
E. The AdSS must identify a care coordinator responsible for ensuring implementation of interventions and the dates by which the interventions must occur, and who identifies organizations and providers with whom treatment must be coordinated.

**Specialty Referral Timelines**

The AdSS must have a policy and procedure that ensures adequate access to care through scheduling of appointments as specified in ACOM Policy 417.
580 BEHAVIORAL HEALTH REFERRAL AND INTAKE PROCESS

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 8-512.01; CFR 45-164.520 (c)(1)(B)

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

This policy outlines requirements for referral and intake in order to ensure members eligible for the Division and ALTCS are able to gain prompt access to behavioral health services.

Definitions
A. Assessment - The ongoing collection and analysis of a member’s medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists, if there is a need for behavioral health services, and on an ongoing basis ensure that the member’s planning document is designed to meet the member’s (and family’s) current needs and long term goals.

B. Initial Evaluation (Intake) - The collection by appropriately trained staff of basic demographic information and preliminary determination of the member’s needs.

C. Referral - Any oral, written, faxed, or electronic request for behavioral health services made by a member, or member’s legal guardian, a family member, an AHCCCS health plan, primary care provider, hospital, jail, court, probation and parole officer, tribal government, Indian Health Services, school, or other governmental or community agency; and for members in the legal custody of the Department of Child Safety (DCS), the out-of-home placement, in accordance with A.R.S. § 8-512.01 in accordance with AdSS Operations Manual 449.

D. SMI Determination - A determination as to whether or not a member meets the diagnostic and functional criteria established for the purpose of determining a person’s eligibility for SMI services.

Policy
A. General Requirements for Behavioral Health Services Referral and Intake

To facilitate a member’s access to behavioral health services in a timely manner, the AdSS is to ensure an effective referral and intake process is in place for behavioral health services. This process must include:

1. Engaging with the member and/or member’s legal guardian/family member
2. Communicating to potential referral sources the process for making referrals
3. Keeping information or documents collected in the referral process confidential and protected in accordance with applicable federal and state statutes, regulations and policies
4. After obtaining appropriate consents, informing the referral source as appropriate about the final disposition of the referral
5. Conducting intakes that ensure the accurate collection of all the required information and ensure that members who have difficulty communicating because of a disability or who require language services are afforded appropriate accommodations to assist them in fully expressing their needs.

6. Collecting sufficient information about the member to determine the urgency of the situation and subsequently scheduling an assessment within the required timeframes and with an appropriate provider. (For appointment standards, see AdSS Operations Manual, Policy 417.)

B. Referrals for Individuals Admitted to a Hospital

The AdSS must respond to referrals regarding individuals admitted to a hospital for psychiatric reasons. The AdSS must attempt to conduct a face-to-face intake evaluation with the individual prior to discharge from the hospital.

C. Referrals Initiated by Department of Child Safety (DCS) Pending the Removal of a Child

Upon notification from DCS that a child has been placed in DCS custody, or is at risk of disruption of placement, the AdSS must ensure that the behavioral health providers respond according to A.R.S. § 8-512.01 and AdSS Operations Manual, Policy 449. Foster caregivers and adoptive parents may call for and consent to an urgent crisis response and/or 72 hour rapid response in accordance with AdSS Operations Manual, Policy 449.

D. Sending Referrals

AdSS’ provider directories must be maintained in accordance with AdSS Operations Manual, Policies 406 and 416 and must indicate which providers are accepting referrals and conducting initial intake evaluations. Providers must promptly notify the AdSS of any changes that would impact the accuracy of the provider directory (e.g. change in telephone or fax number, no longer accepting referrals).

Referrals may be submitted in written format or provided orally. Oral referrals must be documented in writing.

E. Accepting Referrals

1. AdSS must ensure referrals are accepted for behavioral health services 24 hours a day, seven days a week.

2. Timely triage and processing of referrals must not be delayed due to missing or incomplete information.

3. When psychotropic medications are a part of a member’s treatment or have been identified as a need by the referral source, the AdSS must ensure referrals meet the time requirements as outlined in AdSS Operations Manual, Policy 417.
4. When a Serious Mental Illness (SMI) eligibility determination is being requested as part of the referral or by the member directly, the AdSS, Indian Health Service facilities, or Tribally owned or operated facilities must ensure an eligibility assessment is conducted in accordance with the Division’s Medical Policy Manual, Policy 320-P. The SMI eligibility assessment, and pending determination, must not delay behavioral health service delivery to the member, regardless of Title XIX or Title XXI eligibility as funding allows.

F. Final Dispositions

1. Within 30 days of receiving the intake evaluation, or if the member declines behavioral health services, the AdSS must ensure notification regarding the final disposition be provided to the referring individual or entity, with appropriate release of information signed by the member, as applicable including but not limited to:
   a. Designated Support Coordinator
   b. Behavioral Health Coordinator
   c. PCP
   d. Arizona Department of Child Safety and adoption subsidy
   e. Arizona Department of Corrections
   f. Arizona Department of Juvenile Corrections
   g. Administrative Offices of the Court
   h. Arizona Department of Economic Security/Rehabilitation Services Administration, and
   i. Arizona Department of Education and affiliated school districts.

2. The final disposition must include:
   a. The date the member was seen for the intake evaluation, and the name and contact information of the provider who will assume primary responsibility for the member’s behavioral health care, or
   b. If no services will be provided, the reason why. Authorization to release information will be obtained prior to communicating the final disposition to the referral sources referenced above.
G. Documenting and Tracking Referrals

The AdSS must ensure referrals for behavioral health services are tracked and include at a minimum, the following information:

1. Member name and, if available, AHCCCS identification number
2. Date of birth
3. Name and affiliation of referral source
4. Type of referral per AdSS Operations Manual, Policy 417
5. Date and time the referral was received
6. If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment, and
7. Final disposition of the referral.

H. Intake

1. The intake process by the provider must include:
   a. Collection of member contact and insurance information
   b. Reason why the member is seeking services and information on any accommodations the member may require to effectively participate in treatment services (e.g. need for oral interpretation or sign language services, consent forms in large font)
   c. Collection of required demographic information and completion of member demographic information sheet, including the member’s primary/preferred language in accordance with the Division Technical Interface Guidelines
   d. Completion of any applicable authorizations for the release of information to other parties
   e. Dissemination of a Member Handbook to the member
   f. Review and completion of a general consent to treatment
   g. Collection of financial information, including the identification of third party payers
   h. Review and dissemination of AdSS’ Notice of Privacy Practices (NPP) and the AHCCCS Notice of Privacy Practices (NPP) in compliance with CFR 45-164.520 (c)(1)(B), and
i. Review of the member’s rights and responsibilities, including an explanation of the Title XIX member grievance and appeal process, if applicable. The member and/or the member’s legal guardian/family member, advocate, and/or person providing special assistance, may complete some of the paperwork associated with the intake evaluation, if acceptable to the member and/or the member’s legal guardian/family members, advocate, and/or person providing special assistance as referenced in the Division’s Medical Policy Manual, Policy 320-R.

2. Behavioral health providers conducting intake interviews must be appropriately trained in accordance with the Division’s Medical Policy Manual, Policy 1060, and must approach the member and family in a strength-based manner and possess a clear understanding of the information that needs to be collected.
ADVANCE DIRECTIVES

EFFECTIVE DATE: October 1, 2019
REFERENCES: A.R.S. § 36-3231; 42 CFR 489.102; 42 U.S.C. 1396

The Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities must ensure their providers (e.g., hospitals, nursing facilities, hospice providers, home health agencies) comply with federal and state laws regarding advance directives for members who are adults. An Advance Directive is 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.

A. At a minimum, providers must:

1. Maintain written policies for 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 members regarding the provider's policies concerning advance directives, including any conscientious objections.

3. Document in the member’s medical record whether or not the 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 to members, and when the member is incapacitated or unable to receive information, the member’s family or surrogate as defined in A.R.S. § 36-3231, written information regarding advance directives as delineated in 42 CFR 489.102(e), concerning:
   a. The member’s rights, regarding advance directives under Arizona State law
   b. The AdSS’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
   c. A description of the applicable state law and information regarding the implementation of these rights
   d. The member’s right to file complaints directly with the Division or AHCCCS
   e. Written policies including a clear and precise statement of limitations if the provider cannot implement an advance directive as a matter of
conscience. This statement, at a minimum, should:

i. Clarify institution-wide conscientious objections and those of individual physicians

ii. Identify state legal authority permitting such objections

iii. Describe the range of medical conditions or procedures affected by the conscience objection.

B. The provider is not relieved of its obligation to provide the above information to the individual once the individual is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

C. The provider must also provide the above information to an individual upon each admission to a hospital or nursing facility and each time the individual comes under the care of a home health agency.

D. Providers must provide a copy of a member’s executed advance directive, or documentation of refusal, to the member’s Primary Care Provider for inclusion in the member’s medical record; and, provide education to staff on issues concerning advance directives.
670  Федерально квалифицированные здравоохранительные центры и руслочные здравоохранительные центры

有效日期: 2019年10月1日

目的: 为行政服务承揽商建立要求,以便为个案管理,行为健康小组治疗,Telehealth和Telemedicine服务为联邦资格健康中心(FQHC)和农村健康诊所(RHC)提供补偿。

定义：

行为健康技术人员，如在AAC R9-10-101中所述，是个体，其不是行为健康专业人员，为健康机构提供行为健康服务，根据健康机构的政策和程序，如下：

1. 如行为健康服务是在许可的健康机构外提供，那么该个体需要根据A.R.S.第32章第33节，被许可为行为健康专业人员。
2. 提供临床监督的行为健康专业人员。

案管理意味着为协助会员，符合州计划，居住在社区环境或正在过渡到社区环境，通过获得必要的医疗服务，如医疗服务，教育，社会服务或其他服务，不包括在按42 CFR §441.18提供直接医疗服务。

FQHC/RHC服务，为本政策目的，特定许可专业人员的服务，为其服务提供时的其他服务，以及任何其他在FQHC/RHC中提供的服务，包括在州医疗保险计划中。

FQHC/RHC访问是面对面的会诊与一个被AHCCCS注册的许可专业人员在同一个日子里和同一地点的同一个服务。多个在相同日子里和同一地点的同一专业的会议，以及同一专业人员的多个会诊，构成一个单独的单独访问，除非患者，从第一次会诊后，发生疾病或伤害，需要额外的诊断或治疗。在这种情况下，随后的会诊被认为是单独的访问。一个在另外服务上提供的服务，无论是同一天，还是在同一地点，被认为是同一访问的组成部分，不被补偿。
Services “incident to” a visit means: (a) Services and supplies that are an integral, though incidental, part of the physician’s or practitioner's professional service (e.g., medical supplies, venipuncture, assistance by auxiliary personnel such as a nurse or medical assistant); or (b) Diagnostic or therapeutic ancillary services provided on an outpatient basis as an adjunct to basic medical or surgical services (e.g., x-ray, medication, laboratory test).

**Prospective Payment System (PPS) Rate**, for purposes of this policy, an all-inclusive per visit rate for reimbursing FQHC/RHC services.

**POLICY**

A. **FQHC/RHC Reimbursement for Case Management (T1016)**

1. Case Management is not an FQHC/RHC visit reimbursable at the all-inclusive per visit PPS rate. Case Management (T1016) is reimbursed at the capped fee-for-service fee schedule when provided by a provider within their scope of practice.

2. FQHCs/RHCs are entitled to reimbursement at the all-inclusive per visit PPS rate for encounters that meet the definition of “FQHC/RHC visit.”

3. Provider Case Management is not a reimbursable service for Tribal ALTCS. This service is provided through the Tribal ALTCS Programs.

B. **FQHC/RHC Reimbursement for Behavioral Health Technician Provided Services**

Excluding case management, the services of a BHT may qualify as a FQHC/RHC visit only when those services meet the requirements of 42 CFR Part 405, Subpart X.

C. **Behavioral Health Group Therapy/Group Services**

Behavioral health group therapy and/or any other services provided to a group do not satisfy the requirements of a face-to-face encounter; therefore, these services are not reimbursable at the all-inclusive per visit PPS rate.

D. **Telehealth and Telemedicine for FQHC/RHC Service**

Telehealth and Telemedicine may qualify as a FQHC/RHC visit if it meets the requirements as specified in AdSS Medical Policy 320-I.

For additional information regarding FQHC/RHC reimbursement, refer to AHCCCS Fee- For-Service Provider Manual, Chapter 10 addendum. For Provider Type C5, refer to AHCCCS IHS/Tribal Provider Billing Manual Chapter 20.
680-C PRE-ADMISSION SCREENING AND RESIDENT REVIEW

EFFECTIVE DATE: October 1, 2019
REFERENCES: CFR 42-483.100-483.138, 42-483.112(c), 42-483.112 (c-2), 42-483.12 (a) 1-7, 42-431 (E), and, 42- 447.

Federal nursing home reform legislation enacted through the 1987 Omnibus Reconciliation Act (OBRA) established the Pre-Admission Screening and Resident Review (PASRR) Program. The PASRR regulations mandate that all members entering a Title XIX (Medicaid) certified nursing facility be screened for a cognitive/intellectual disability or a related diagnosis and/or mental illness to avoid inappropriate placement. In addition, the OBRA specifies that placement for members with a cognitive/intellectual disability or mental illness are made based on their needs for nursing facility services and for specialized services.

State Medicaid agencies are required to develop a two-stage identification and evaluation process, which accomplishes the following:

A. **PASRR Level I** – Identification of potential cognitive/intellectual disability or mental illness - Determines whether the member has any diagnosis or other presenting evidence that suggests the potential of a cognitive/intellectual disability or mental illness.

B. **PASRR Level II (Determination)** – Determines whether the member does indeed have a cognitive/intellectual disability or mental illness. If the member has been determined to have a cognitive/intellectual disability or mental illness, this stage of the evaluation process determines whether the member requires the level of services provided by a nursing facility and/or specialized services.

Service Description

The procedures described in this section will apply to all members seeking admission of a 30-day or longer stay in a Title XIX or Medicaid certified nursing facility.

State Agreement Requirements

Referrals for a PASRR Level II determination of cognitive/intellectual disability are handled by the Arizona Department of Economic Security (DES) through the Division of Developmental Disabilities (DDD). Interagency agreements between the Arizona Health Care Cost Containment System(AHCCCS) Administration and the Division have been established to develop and maintain the Level II process to determine whether each member referred by primary care providers, nursing facilities or the AHCCCS/Arizona Long Term Care System (ALTCS) Administration (Pre-Admission Screening Assessors) requires the level of services provided by a nursing facility and/or specialized services for a cognitive/intellectual disability.

Cognitive/intellectual disability

Developmental disability is defined as a chronic disability which is attributable to a cognitive/intellectual disability, cerebral palsy, epilepsy, autism, and any related condition. The disability results in the impairment of general intellectual functioning or adaptive behavior and requires medical treatment or services. The impairment must be manifested before the age of 22. The impairment must be likely to continue indefinitely and result in substantial functional limitations in major life activities. When determined by a medical
professional the range of intellectual functioning (mild, moderate, severe, or profound) will be documented on the PASRR Level II Evaluation.

Specialized Services (as pertaining to cognitive/intellectual disability)

The services specified by the cognitive/intellectual disability authority which, when combined with services provided by the nursing facility or other service providers, result in treatment which includes aggressive, consistent implementation of a program of specialized, and/or generic services, and related services that are directed toward the following:

A. The acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible; and

B. The prevention or deceleration of regression or loss of current optimal functional status.

If there are indications of a cognitive/intellectual disability or a related diagnosis, the completed PASRR Level I and all supporting documentation should be forwarded to the Division. Supporting documentation may include the Minimum Data Set (MDS), health and progress notes, assessments, or other documentation by a medical professional that suggests the presence of a cognitive/intellectual disability. Specialized services include aggressive, consistent implementation of a program of specialized and/or generic services, and related services that are directed toward the acquisition of behaviors necessary for the member to function with as much self-determination and independence as possible, and the prevention or declaration of regression or loss of current optimal functional status.

The PASRR Level I is reviewed by the PASRR Coordinator who then determines if a Level II is necessary. If so:

A. The PASRR Coordinator will contact the facility and speak to the referring member to confirm the current placement and that the medical files for the resident will be reviewed.

B. The MDS in the member’s file will also be reviewed for information concerning the member’s functioning level and medical problems. The information gathered from the MDS and the member's resident's medical files will assist in completing the Level II. PASRR Level II determinations must be completed within an average of seven to nine working days of receipt of referral.

IF THE MEMBER IS AWAITING DISCHARGE FROM A HOSPITAL, THE LEVEL II WILL BE COMPLETED AS SOON AS POSSIBLE, AND IF NECESSARY BEFORE THE FEDERALLY MANDATED SEVEN TO NINE WORKING DAYS TIMEFRAME.

Pre-Admission Screening And Resident Review Determination

The PASRR Level II evaluation instrument and necessary procedures developed by the Division gather pertinent information needed to determine and recommend appropriate levels of care and services and when applicable in the least restrictive environment that could continue to provide the needed medical treatment. The criteria used in making a decision about appropriate placement will not be affected by the availability of placement alternatives.
Evaluation Requirements

PASRR reviews will be adapted to the member’s cultural background, language, ethnic origin, and means of communication. Current and relevant assessment information obtained prior to the initiation of the PASRR process may be used. Findings must be accurate and correspond to the members’ current functional level and must be descriptive.

The Division may convey the determinations verbally to the referring agency and the member and then confirm them in writing in accordance with 42 CFR 483.112 (c-2).

Copies of the completed PASRR Level II are forwarded to the referring agency, facility, AHCCCS and if dually diagnosed (cognitive/intellectual disability and mental illness) to Arizona Department of Health Services, the primary care physician and the member and/or representative, with a notice of the member’s right to appeal the determinations.

The Division is responsible for ensuring that appropriate level of care and medical services are provided to those members who have been diagnosed prior to their 22nd birthday to have a cognitive/intellectual disability or a related diagnosis.

The Division’s PASRR Coordinator is responsible for interpretation of the PASRR findings to the person or designated family member and/or representative if the applicant for admission or resident is incapable of understanding the PASRR findings.

ANNUAL REVIEWS ARE NOW REVISED REVIEWS AND WILL BE CONDUCTED WHEN: A significant change has occurred in the member’s physical or mental condition. It is a federal requirement for a nursing facility to notify the state authority promptly when and if a significant change has occurred utilizing the Minimum Data Sets (MDS) guidelines for significant change requirements to ensure that all members with a cognitive/intellectual disability or related diagnosis continue to require nursing facility services and or specialized services. The Division’s PASRR Coordinator also will search the database every month and contact the facility to inquire if any significant changes have occurred to warrant a revised PASRR Level II. If no change has occurred, a letter is sent to confirm the conversation and is placed in the resident’s file. If a significant change has occurred, pertinent information is gathered again, and the resident is scheduled for a Revised Review.

A REVISED PASRR LEVEL II IS NOT NEEDED FOR RE-ADMISSIONS FROM THE HOSPITAL OR INTER-FACILITY TRANSFERS.

Cease Process and Documentation Situation

If, at any time during this process it is found that the member does not have a cognitive/intellectual disability or related diagnosis or has a principal/primary diagnosis of Dementia, Alzheimer’s Disease, or any related disorder or has any condition identified in section B of the PASRR Level I, that situation will be documented and the process will be stopped. If the illness results in a level of impairment so severe the member could not be expected to benefit from specialized services the process will be stopped.

THE DIVISION WILL RE-ASSESS THE MEMBER WHEN NOTIFIED BY THE NURSING FACILITY OF AN IMPROVEMENT IN HIS/HER CONDITION.

Nursing Facility Level of Care Inappropriate

The nursing facility in accordance with the state authority must provide or arrange for the
safe and orderly discharge of the resident in accordance with 42 CFR 483.12 (a) 1-7, the member shall be prepared and oriented for discharge.

Any members who are currently enrolled with the Division of Developmental Disabilities Division who have been found to be unsuitable for a Skilled Nursing Facility should be informed of less restrictive placement options and when in agreement, discharged to a less restrictive setting. Their Support Coordinator must ensure that the Member Support Plan process is followed, including participation by the member or responsible representative, primary care physician, nursing facility staff, District discharge planning team and other relevant members.

**Appeal Mechanism**

The Division will ensure that the person or their designee is informed of the appeals process available to them: appeal of determination for members who are adversely affected (members for whom the screening process indicated that admission to nursing facility would not be appropriate) the appeals process must follow the guidelines contained in 42 CFR 431 Subpart E. The Division will also recommend appropriate placement alternatives.

**Referral Designation**

The Division will maintain case records for all Level II evaluations for a period of five years in accordance with 42 CFR parts 447.
Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. Actions Reported to the NPDB (National Provider Databank) or a Regulatory Board
2. Adverse Action Reporting (Including Limitations and Terminations)
3. Health Care Acquired Conditions (HCAC) and Other Provider-Preventable Condition (OPPC)
4. Quality Management/Performance Improvement (QM/PI) Program Annual Plan
5. Quality Management (QM) Report
910 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM
ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: 42 CFR 438.242 et seq.; AMPM Policy 910; AMPM Exhibits 400-2A, 2B, 2C, and 910-1; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Integrated Health Care Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Quality Management/Performance Improvement Plan

A. The Administrative Services Subcontractors (AdSS) must develop a written Quality Management/Performance Improvement (QM/PI) Plan, as specified in Section F3, Contractor Chart of Deliverables, that addresses the proposed methodology to meet or exceed the standards and requirements in the contract and this chapter.

B. The QM/PI Plan must describe how program activities will improve the quality of care, service delivery, and satisfaction for Arizona Long Term Care System (ALTCS)-eligible members.

C. The QM/PI Plan, and any subsequent modifications must be submitted to the Division Quality Management Unit for review and approval prior to implementation.

D. The QM/PI Plan must include, at a minimum, in paginated detail, the following components:

1. QM/PI Program Administrative Oversight

   The AdSS’s QM/PI Program must be administered through a clear and appropriate administrative structure. The governing or policymaking body must oversee and be accountable for the QM/PI Program. The AdSS must provide:

   a. A description to ensure ongoing communication and collaboration between the QM/PI Program and the other functional areas of the organization (e.g., Medical Management, Member Services, Behavioral Health, Provider Relations, Grievance and Appeals, Fraud, Waste, and Abuse)

   b. A description of the AdSS’s administrative structure for oversight of its QM/PI Program as required by this policy, which includes the role and responsibilities of:

      i. The governing or policy making body

      ii. The Medical Director

      iii. The QM/PI Committee

      iv. The Peer Review Committee
v. The Credentialing Committee
vi. The AdSS’s Executive Management
vii. QM/PI Program Staff

c. An organizational chart which shows the reporting relationships for
QM/PI activities and the percent of time dedicated to the position for
each line of business

This chart must also show direct oversight of QM/PI activities by the
local Medical Director and the implemented process for reporting to
Executive Management.

d. Documentation that the Board of Directors and in the absence of a
Board the executive body has reviewed and approved the Plan

e. Documentation that the Board of Directors and in the absence of a
Board the executive body has formally evaluated and documented the
effectiveness of its QM/PI program strategy and activities, at least
annually.

2. QM/PI Committee

The AdSS must have an identifiable and structured local (Arizona) QM/PI
Committee that is responsible for QM/PI functions and responsibilities.

a. At a minimum, the membership must include:

i. The local Medical Director as the chairperson of the Committee

   The local Medical Director may designate the local Associate
   Medical Director as their designee only when the Medical
   Director is unable to attend the meeting. The local Chief
   Executive Officer may be identified as the co-Chair of the QM/PI
   Committee.

ii. The QM/PI Manager

iii. Representation from the functional areas within the
organization

iv. AdSS staff with experience with Developmental Disabilities,
Behavior Health, and medically fragile physical health
conditions.

v. Representation of contracted or affiliated providers serving
members eligible for the Division

vi. Appropriate clinical representatives.
b. The local Medical Director is responsible for implementation of the QM/PI Plan and must have substantial involvement in the implementation, assessment, and resulting improvement of the QM/PI activities.

c. The QM/PI Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest by having signed statements on file and/or QM/PI Committee sign-in sheets with requirements noted.

d. The QM/PI Committee must meet, at a minimum, quarterly or more frequently. The frequency of committee meetings must be sufficient to monitor all program requirements and to monitor any required actions.

e. The QM/PI Committee must review the QM/PI Program objectives, policies and procedures as specified in contract and must modify or update the policies when processes/activities are changed substantially. The QM/PI policies and procedures, and any subsequent modification to them, must be available upon request for review by the Division.

f. The QM/PI Committee must develop procedures for QM/PI responsibilities and clearly document the processes for each QM/PI function and activity.

g. The QM/PI Committee must develop and implement procedures to ensure the AdSS staff and providers are informed of the most current QM/PI requirements, policies and procedures.

h. The QM/PI Committee must develop and implement procedures to ensure the providers are informed of information related to their performance (e.g., Performance Measures, profiling data, medical record review results, utilization data).

i. If deficiencies are noted, the QM/PI Committee meeting minutes must clearly document discussions of the following:

   i. Identified issues
   ii. Responsible party for interventions or activities
   iii. Proposed actions
   iv. Evaluation of the actions taken
   v. Timelines including start and end dates
   vi. Additional recommendations or acceptance of the results as applicable.
3. Peer Review

The AdSS must have a peer review process with the purpose of improving the quality of medical care provided to members by providers, both individual and organizational providers. The peer review scope includes cases where there is evidence of deficient quality, or the omission of the care or service provided by a participating, or non-participating health care professional or provider whether delivered in or out of state. Peer review must be defined by specific policies and procedures that must include the following:

a. The AdSS must not delegate functions of peer review to other entities.

b. The Peer Review Committee must be scheduled to meet at least quarterly.

c. Peer review activities may be carried out as a stand-alone committee or in an executive session of the AdSS’s Quality Management Committee.

d. At a minimum, the Peer Review Committee must consist of:

   i. The AdSS’s local Chief Medical Officer as Chair

   ii. AdSS medical providers, from the community, that serve members eligible for the Division. The peer review process must ensure that providers of the same or similar specialty participate in review and recommendation of individual peer review cases. If the specialty being reviewed is not represented on the AdSS’s Peer Review Committee, the AdSS may utilize peers of the same or similar specialty through external consultation.

   iii. A Behavioral Health provider must be part of the Peer Review Committee when a behavioral health case is being reviewed.

e. Peer Review Committee members must sign (may be an electronic signature) a confidentiality and conflict of interest statement at each Peer Review Committee meeting. Committee members must not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.

f. The Peer Review Committee must evaluate the case referred to peer review based on all information made available through the quality management process.

g. The Peer Review Committee is responsible for making recommendations to the AdSS’s Medical Director. The Peer Review Committee must determine appropriate action (e.g., peer contact, education, credentials, limit on new member enrollment, sanctions) and other corrective actions. Adverse actions taken as a result of the Peer Review Committee must be reported to the Division within 24 hours.
hours of an adverse decision being made.

h. The Peer Review Committee is responsible for making appropriate recommendation for the AdSS’s Medical Director to make referrals to the Department of Child Safety, Adult Protective Services, and the Department of Health Services Licensure Unit, the appropriate regulatory agency or board, and the Division, for further investigation or action. Notification must occur when the Peer Review Committee determines care was not provided according to the medical community standards. Initial notification may be verbal but must be followed by a written report to the Division within 24 hours.

i. Peer Review Committee policies and procedures must assure that all information used in the peer review process is kept confidential and is not discussed outside of the peer review process. The AdSS’s Peer Review Committee reports, meetings, minutes, documents, recommendations, and participants must be kept confidential except for implementing recommendation made by the Peer Review Committee.

j. The AdSS must make peer review documentation available to the Division for purposes of quality management, monitoring, and oversight.

k. The AdSS must demonstrate how the peer review process is used to analyze and address clinical issues.

l. The AdSS must demonstrate how providers are made aware of the peer review process and peer review grievance procedure.

m. Matters appropriate for peer review may include, but are not limited to:

i. Cases where there is evidence of deficient quality

ii. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider

iii. Questionable clinical decisions, lack of care and/or substandard care

iv. Inappropriate interpersonal interactions or unethical behavior, physical, psychological, or verbal abuse of a member, family, staff, or other disruptive behavior

v. Allegations of criminal or felonious actions related to practice

vi. Issues that immediately impact the member and that are life threatening or dangerous
vii. Unanticipated death of a member; issues that have the potential for adverse outcome

viii. Allegations from any source that bring into question the standard of practice.

4. QM/PI Staffing

The QM/PI Program must have qualified local personnel to carry out the functions and responsibilities specified in this Chapter in a timely and competent manner. The AdSS is responsible for contract performance whether or not subcontractors or delegated entities are used. Policies and procedures must demonstrate:

a. Staff qualifications including education, certifications, experience and training for each QM/PI position

b. A current organizational chart that demonstrates the reporting structure, responsibilities, number of full time and part time positions, and their percent of time by line of business for the QM/PI Program

c. The AdSS’s Quality Management Coordinator must attend Division contractor meetings unless attendance is specified as optional by the Division.

d. The AdSS must participate in applicable community initiatives, such as, but not limited to:

i. Quality Management and quality improvement

ii. Maternal child health

iii. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

iv. Disease management

v. Behavioral health

vi. The Division may require AdSS participation in specific community initiatives and collaborations

e. The AdSS must develop a process to ensure that all staff who may have contact with members or providers are trained on how to refer suspected quality of care issues to the Quality Management Unit. This training must be provided during employee orientation and, at a minimum annually thereafter.
5. Delegated Entities

The AdSS must oversee and maintain accountability for all functions and responsibilities described in this Chapter that are delegated to other entities. The AdSS must include a description of how delegated activities are integrated into the overall QM/PI Program and the methodologies for oversight and accountability of all delegated functions. Accredited agencies must be included in the AdSS’ oversight process.

a. As a prerequisite to delegation, the AdSS must provide a written analysis of its historical provisions of QM/PI oversight function which includes past goals and objectives. The level of effectiveness of the prior QM/PI oversight functions must be documented. Examples may include the number of claims, concerns, grievances or network gaps.

b. The AdSS must have policies and procedures requiring the delegated entity report to the AdSS all allegations of quality of care and quality of service issues. Quality of care or service investigation and resolution processes may not be delegated.

   i. The AdSS must evaluate the entity’s ability to perform the delegated activities prior to delegation, evidence of which includes the following: Review of appropriate internal areas, such as quality management

   ii. Review of policies and procedures and the implementation of them

   iii. Documented evaluation and determination that the entity is able to effectively perform the delegated activities.

c. Prior to delegation, a written contract must be established that specifies the delegated activities and reporting responsibilities of the entity to the AdSS. The agreement must include the AdSS’s right to ruminant the contract or perform other remedies for inadequate performance.

d. The performance of the entity and the quality of services provided are monitored on an ongoing basis and are annually reviewed by the AdSS. Annually, the AdSS must review a minimum of 30 randomly selected files per line of business for each function that is delegated. Documentation must be kept on file for review by the Division. Monitoring should include, but is not limited to:

   i. Utilization

   ii. Member and provider satisfaction

   iii. Quality of care concerns

   iv. Complaints.
e. The following documentation must be kept on file and available for Division review:

i. Evaluation reports

ii. Results of the AdSS’s annual monitoring review of the delegated entity utilizing Division required standards for the contracted functions

iii. Corrective Action Plans

iv. Appropriate follow up of the implementation of corrective action plans to ensure quality and compliance with Division requirements for all delegated activities or functions are met.

6. Chapter 900 Requirements

The AdSS must have policies and procedures to describe the implementation of the following:

a. The AdSS’s method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with Division Medical Policy 920

b. How members’ rights and responsibilities are defined, implemented, and monitored to meet requirements of Policy 930 of Chapter

c. Documentation that the AdSS has implemented policies and procedures in compliance with Division Medical Policy 940 to ensure medical records and communication of clinical information for each member reflect all aspects of member care, including ancillary and behavioral health services. Policies must include processes for digital (electronic) signatures when electronic documents are used.

d. The AdSS’s temporary/provisional credentialing, initial credentialing and re-credentialing process for individual providers and assessment and reassessment of organizational providers contracted with the AdSS, as required by Division Medical Policy 950.

e. The AdSS’s process for grievance resolution, tracking and trending that meet standards set in Division Medical Policy 960 of this Chapter and 42 CFR 438.242 et seq.

f. Documentation of the AdSS’s planned activities to meet or exceed Division mandated performance measures minimum performance standards and performance improvement project goals as specified in contract and required by Division Medical Policies 970 and 980.

g. Indication or documentation of input from contracted or affiliated providers.
h. Indication or documentation of input from members eligible for the Division.

i. How the AdSS monitors the quality and coordination of behavioral health services. The description must include procedures used to ensure timely updates from primary care providers to behavioral health providers regarding a member’s change in health status. The update must include but is not limited to diagnosis of chronic conditions, all medication prescribed, and any other information pertinent to the continuing care of the member.

j. The comprehensive and coordinated delivery of integrated services including administrative and clinical integration of health service delivery. Integration strategies and activities must focus on improving individual health outcomes, enhancing care coordination and increasing member satisfaction.

7. Health Information System Policies and Procedures

The AdSS must maintain a health information system that collects, integrates, analyzes, validates and reports data necessary to implement its QM/PI Program (42 CFR 438.242). The AdSS must include a description of the process used by the AdSS related to the health information system and how the system is used to collect, integrate, analyze, validate, and report data necessary to implement the QM/PI program. Data elements must include:

a. Member demographics
b. Provider characteristics
c. Services provided to members
d. Other information necessary to guide the selection of, and meet the data collection requirements for PIPs and QM/PI oversight.

8. Policies and Procedures

The AdSS must have written policies and procedures, by line of business, to ensure that:

a. Information/data received from providers is accurate, timely, and complete
b. Reported data is reviewed for accuracy, completeness, logic and consistency, and the review and evaluation processes used are clearly documented
c. Information rejected must be tracked to ensure errors are corrected and the data is resubmitted and accepted
d. All member and provider information protected by federal and state
Contractor staff and providers are kept informed of at least the following:

i. QM/PI requirements, activities, updates or revisions
ii. Study and Performance Improvement Project (PIP) results
iii. Performance measures and results
iv. Utilization data
v. Profiling results.

Annual Work Plan

A. The annual work plan is a work plan by line of business that includes all requirements of Division Medical Policy 920 and guidelines suggested by the Division, and supports the AdSS’s QM/PI goals and objectives. The AdSS must develop and implement a work plan with timelines that includes, but is not limited to, the following information:

1. A description of all planned goals and objectives for both clinical care and AdSS monitoring of access and availability of covered services
   Once a goal has been achieved and sustained, the AdSS must identify new goals based on data, member/provider input, etc.

2. Targeted implementation and completion dates of work plan activities

3. Methodologies, strategies and specific measurable interventions to accomplish objectives

4. Measurable behavioral health goals and objectives

5. Assigned local staff positions responsible and accountable for meeting established goals and objectives.

B. The AdSS must review its work plan at least quarterly. If activities and interventions are not meeting the goals and objectives, the contractor must revise its work plan and develop new strategies aimed at achieving the goals.

QM/PI Program Evaluation

The annual QM/PI evaluation document must contain a summary of all QM/PI activities performed throughout the year and the following:

A. Title/name of each activity

B. Measurable goals and/or objective(s) related to each activity
C. AdSS departments or units and local staff positions involved in the QM/PI activities

D. Description of communication and feedback related to QM/PI data and activities

E. An evaluation of baseline data and outcomes utilizing qualitative and quantitative data which must include a statement describing of goals/objectives were met or not met

F. A description of how the sustained goal/objective is incorporated into the AdSS’s business practice (institutionalized)
   The AdSS is expected to develop new goals and objectives once a goal or objective has been sustained.

G. Actions to be taken for the improvement of Corrective Action Plan (CAP)

H. Documentation of continued monitoring to evaluate the effectiveness of the actions (interventions) and other follow up activities

I. Rationale for changes in the scope of the QM/PI program or documentation indicating if no changes were made

J. Necessary follow-up with targeted timelines for revisions made to the QM/PI Plan

K. Documentation of the QM/PI Committee review, evaluation, and approval of any changes to the QM/PI Plan

L. An evaluation of the previous year’s activities must be submitted as part of the QM/PI Plan after review by the AdSS’s governing or policy making body.

**QM/PI Plan and Evaluation**

See Section F3, Contractor Chart of Deliverables, for reporting timelines. For submission to the Division, the following by line of business, may be combined or written separately and paginated as long as required components are addressed and are easily located within the document(s) submitted:

A. QM/PI Plan

B. QM/PI Work Plan

C. QM/PI Evaluation

D. Maternity Care Plan and associated work plans and evaluations as described in the AHCCCS Medical Policy Manual (AMPM) Chapter 400, Exhibit 400-2A, as adopted by the Division

E. EPSDT Plan and associated work plans and evaluations as described in the AMPM Chapter 400, Exhibit 400-2B, as adopted by the Division

F. Oral Health Plan and associated work plans and evaluations as described in the AMPM Chapter 400, Exhibit 400-2C, as adopted by the Division
G. PIP Interim Report(s)

H. Quality Management Plan Checklist (AMPM, Exhibit 910-1, as adopted by the Division)

I. Submission of all referenced policies and procedures to implement the requirements of this Chapter.

**QM/PI Documentation**

The AdSS must maintain records that document Quality Management and Performance Improvement (QM/PI) activities. The data must be made available to the Division upon request. The required documentation must include, but is not limited to:

A. Policies and procedures

B. Studies and Performance Improvement Plans

C. Reports

D. Processes/desktop procedures

E. Standards

F. Worksheets

G. Meeting minutes

H. Corrective Action Plans (CAPs)

I. Other information and data appropriate to support changes made to the scope of the QM/PI Plan or Program.
920 QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT (QM/PI) PROGRAM SCOPE

EFFECTIVE DATE: October 1, 2019

REFERENCES: Division Medical Policy Manual 1600; Division contract, Division Medical Policy Manual 910; 42 CFR 438.208

DELIVERABLES: Service and Service Site Monitoring

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

QM/PI Program Components

The Quality Management/Performance Improvement (QM/PI) Program components must include:

A. A detailed, written set of specific measurable objectives that demonstrates how the QM/PI Program of the Administrative Services Subcontractor meets established goals and complies with all components of Chapter 900 of this Medical Policy Manual

B. A work plan, with timelines to support the objectives, that includes:
   1. A description of all planned goals and objectives for both clinical care and other covered services
   2. Targeted implementation and completion dates for quality management measurable objectives, activities, and performance improvement projects
   3. Methodologies and activities to accomplish measurable goals and objectives
   4. Measurable behavioral health goals and objectives
   5. Staff positions responsible and accountable for established goals and objectives
   6. Detailed policies and procedures implementing all components and requirements of this Chapter

C. A new-member health risk assessment or a “best effort” attempt to conduct an initial health risk assessment that includes follow up on unsuccessful attempts to contact a member within 90 days of the effective date of enrollment

   Note: Each attempt must be documented. The AdSS must develop processes to use the results of health assessments to identify individuals at risk for and/or with special health care needs and to coordinate care (42 CFR 438.208).

D. Requirements to ensure continuity of care and integration of services through:
   1. Policies and procedures allowing each member to have a choice to select, or the AdSS to assign, a Primary Care Provider (PCP) who is formally designated as having primary responsibility for coordinating the member’s overall health care, including coordination with the behavioral health medical professional
2. Policies and procedures specifying the circumstances under which services are coordinated by the AdSS, the methods for coordination, and specific documentation of these processes

3. Programs for care coordination of covered services with community and social services, generally available through contracted or non-contracted providers, in the AdSS’s service area

4. Policies and procedures specifying services coordinated by the AdSS’s Disease Management Unit

5. Policies and procedures for timely and confidential communication of clinical information amongst providers, as specified in Policy 940 of this Chapter

6. Development and implementation of procedures for members with special health care needs, as defined in the contract, for:
   a. Identifying members with special health care needs, including those who would benefit from disease management
   b. Ensuring an assessment by an appropriate health care professional of ongoing needs of each member identified as having special health care need(s) or condition(s)
   c. Identifying medical procedures (and/or behavioral health services, as applicable) to address and/or monitor the need(s) or condition(s)
   d. Ensuring adequate care coordination among providers, including but not limited to, other contractors/insurers and behavioral health providers, as necessary
   e. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member’s condition and identified special health care needs (e.g., a standing referral or an approved number of visits)

E. Implementation of measures to ensure members:
   1. Are informed of specific health care needs that require follow-up
   2. Receive training in self-care and other measures they may take to promote their own health, as appropriate
   3. Are informed of their responsibility to comply with ordered treatments or regimens

F. Maintenance of records and documentation as required under state and federal law.
QM/PI Program Monitoring and Evaluation Activities

The QM/PI Program scope of monitoring and evaluation must be comprehensive, incorporating the activities used by the AdSS, and it must demonstrate how these activities will improve the quality of services and the continuum of care in all services sites. These activities must be clearly documented in policies and procedures. The AdSS must:

A. Use information and data gleaned from QM monitoring and evaluation that shows trends in quality of care issues developing PI projects.
   
   Selection of specific monitoring and evaluation activities must be appropriate to each specific service or site.

B. Implement policies and procedures that require the individual and organizational providers to report to the proper authorities, as well as to the AdSS, incidents of abuse, neglect, injuries (e.g., falls and fractures), exploitation, healthcare acquired conditions, and or unexpected death as soon as the providers are aware of the incident.

C. Report all incidents of abuse, neglect, exploitation, and unexpected deaths to the Division’s Quality Management Unit as soon as the AdSS is aware of the incident.
   
   The AdSS must investigate and report case findings, including identification of organizational providers, individual providers, paid caregivers, or the specific individual rendering the service.

D. Report identified quality of care reportable incidents and/or service trends to the Division’s Clinical Quality Management Unit immediately upon identification of the trend; this reporting must include trend specifications such as providers, facilities, services, and allegation types.

E. Report Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC) to the Division’s Quality Management Unit through the Division’s Compliance Unit, using the template adopted by the Division in AHCCCS Medical Policy Manual, Exhibit 920-1.
   
   The AdSS must:
   1. Investigate and maintain case files that contain findings.
   2. Incorporate the ADHS licensure and certification reports and other publicly reported data in its monitoring process, as applicable.

F. Incorporate the AdSS quality of care trend reports into monitoring and evaluation activities. Policies and procedures must be adopted to explain how the process is routinely completed.
G. Ensure health and safety of members in placement settings or service sites that are found to have survey deficiencies that may impact the health and safety of members.

The AdSS must actively participate in individual and coordinated efforts to improve the quality of care in:

1. Placement settings, or service sites, that have been identified through the Licensure Survey process or other mechanisms as having an Immediate Jeopardy situation or has had more than one survey or complaint investigation resulting in a finding of non-compliance with licensure requirements

2. Facilities placement settings or service sites that have been identified by the Division as an Immediate Care Need.

Based on findings, the AdSS must:

1. Actively participate in meetings focused on ensuring health and safety of members.

2. Actively participate in meetings scheduled to develop work plans and Corrective Action Plans (CAPs) to ensure placement setting or service sites compliance with ADHS Licensure and/or Division or AHCCCS requirements.

3. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status or have serious identified deficiencies that may affect health and safety of members (Immediate Care Needs).

4. Assist in the identification of technical assistance resources focused on achieving and sustaining licensure compliance.

5. Monitor placement setting or service sites upon completion of the activities and interventions, to ensure that compliance is sustained.

H. At a minimum annually, AdSS Quality Management staff monitor services and services sites that include, but are not limited to, the following:
<table>
<thead>
<tr>
<th>SERVICES</th>
<th>SERVICE SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Therapeutic Home Care Services</td>
<td>Behavioral Health Outpatient Clinics</td>
</tr>
<tr>
<td>Behavioral Management</td>
<td>Behavioral Health Therapeutic Home (Adults and Children)</td>
</tr>
<tr>
<td>Behavioral Health Personal Assistance</td>
<td>Independent Clinic</td>
</tr>
<tr>
<td>Family Support</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Community Mental Health Center</td>
</tr>
<tr>
<td>Case Management Services</td>
<td>Community/Rural Health Clinic (or Center)</td>
</tr>
<tr>
<td>Emergency/Crisis Behavioral Health Services</td>
<td>Crisis Service Provider</td>
</tr>
<tr>
<td>Emergency Transportation</td>
<td>Community Service Agency</td>
</tr>
<tr>
<td>Evaluation and Screening (initial and ongoing assessment)</td>
<td>Hospital (if it includes a distinct behavioral health or detoxification unit)</td>
</tr>
<tr>
<td>Group Therapy and Counseling</td>
<td>Inpatient Behavioral Health Facility</td>
</tr>
<tr>
<td>Individual Therapy and Counseling</td>
<td>Behavioral Health Residential Facility</td>
</tr>
<tr>
<td>Family Therapy and Counseling</td>
<td>Residential Treatment Center</td>
</tr>
<tr>
<td>Marriage/Family Counseling</td>
<td>Psychiatric Hospital</td>
</tr>
<tr>
<td>Substance Use Treatment</td>
<td>Substance Use Transitional Center</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Unclassified Facility</td>
</tr>
<tr>
<td>Inpatient Psychiatric Facilities (resident treatment centers and sub-acute facilities)</td>
<td>Integrated Behavioral Health and Medical Facility</td>
</tr>
<tr>
<td>Institutions for Mental Diseases</td>
<td></td>
</tr>
<tr>
<td>Laboratory and Radiology Services</td>
<td></td>
</tr>
<tr>
<td>Non-emergency Transportation</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>Opioid Agonist Treatment</td>
<td></td>
</tr>
</tbody>
</table>
SERVICES

Partial Care (supervised day program, therapeutic day program and medical day program)

Psychosocial Rehabilitation (living skills training, health promotion and supported employment)

Psychotropic Medication

Psychotropic Medication Adjustment and Monitoring

I. At a minimum every three years, monitor services and service sites that include, but are not limited to, the following:

SERVICES

Ancillary

Dental

Emergency

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Family Planning

Obstetric

Pharmacy

Prevention and Wellness

Primary Care

Specialty Care

Other (e.g. Durable Medical Equipment (DME)/Medical Supplies, Home Health Services, Therapies, Transportation, etc.)

SERVICE SITES

Ambulatory Facilities

Hospitals

Nursing Facilities
J. At a minimum every three years (unless otherwise noted), monitor services and service sites that include, but are not limited to, the following:

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>SERVICE SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health Care*</td>
<td>Ambulatory Facilities</td>
</tr>
<tr>
<td>Ancillary</td>
<td>Behavioral Health Facilities</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Hospice*</td>
</tr>
<tr>
<td>Dental</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)/Medical Supplies</td>
<td>Institution for Mental Diseases*</td>
</tr>
<tr>
<td>Emergency</td>
<td>Nursing Facilities*</td>
</tr>
<tr>
<td>Emergency Alert</td>
<td>Residential Treatment Centers*</td>
</tr>
<tr>
<td>Early Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>Traumatic Brain Injury Facilities*</td>
</tr>
<tr>
<td>Family Planning</td>
<td></td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Medical/Acute Care</td>
<td></td>
</tr>
<tr>
<td>Obstetric</td>
<td></td>
</tr>
<tr>
<td>Prevention and Wellness</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td></td>
</tr>
<tr>
<td>Specialty Care</td>
<td></td>
</tr>
</tbody>
</table>

*These services must be reviewed annually.

K. Annually by December 15th, submit monitoring results to the Division’s Quality Management Unit. A standardized, agreed-upon tool must be used.

General Quality Monitoring of these services includes, but is not limited to, the review and verification of:

1. The written documentation of timeliness
2. The implementation of contingency plans
3. Customer/member satisfaction information
4. The effectiveness of service provision
5. Mandatory documents in the services or service site personnel file:
   a. CPR
   b. First aid
   c. Verification of skills or competencies to provide care

**Implementation of Actions to Improve Care**

A. The AdSS must develop a CAP for taking appropriate actions to improve care if problems are identified. The CAP should address the following:

1. Specified problem(s) requiring the corrective action. Examples include:
   a. Abuse, neglect, and exploitation
   b. Healthcare acquired conditions
   c. Unexpected death
   d. Isolated systemic issues
   e. Trends
   f. Health and safety issues, Immediate Jeopardy and Immediate Care Need situations
   g. Lack of coordination
   h. Inappropriate authorizations for specific ongoing care needs
   i. High profile/media events
2. Person(s) or body (e.g., Board) responsible for making the final determinations regarding quality issues (all determinations regarding quality issues that are referred for peer review will be made only by the Peer Review Committee chaired by the Chief Medical Officer). Note: See Division Medical Policy 910 for peer review requirements.

3. Type(s) of action(s) to be taken that include, but are not limited to:
   a. Education/training/technical assistance
   b. Follow-up monitoring and evaluation of improvement
   c. Changes in processes, organizational structures, and forms
   d. Informal counseling
   e. Termination of affiliation, suspension or limitation of the provider (if an adverse action is taken with a provider the AdSS must report the adverse action to the Division’s Quality Management Unit within one business day)
   f. Referrals to regulatory agencies

4. Documentation of assessment of the effectiveness of actions taken

5. Method(s) for internal dissemination of findings and resulting CAPs to appropriate staff and/or network providers

6. Method(s) for dissemination of pertinent information to the Division, AHCCCS Administration and/or regulatory boards and agencies (e.g., Arizona Department of Health Services, Arizona Medical Board, Arizona Board of Pharmacy, Arizona State Board of Nursing).

B. The AdSS must maintain documentation confirming implementation of corrective actions.
MEMBER RIGHTS AND RESPONSIBILITIES

EFFECTIVE DATE: October 1, 2019
REFERENCES: 9 A.A.C. 34; 42 CFR 438.6, 438.100, 493.3(a)(2); 45 CFR 164, 164.501, 164.524, 164.526; 5 U.S.C. 552(a)

Purpose: To establish guidelines for the Administrative Services Subcontractors (AdSS) to ensure compliance with applicable federal and state laws pertaining to member rights.

Policy: 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. The AdSS must have written policies and procedures that address, at a minimum, the following member rights and how these rights are disseminated to members and providers.

A. Each member has the right to:

1. Be treated with respect and with recognition of the member's dignity and need for privacy.
   a. The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.
   b. The AdSS must implement procedures to ensure the confidentiality of health, service and medical records, and of other member information.

2. Not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, gender, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or source of payment.

3. Have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds, and members with visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired, and written materials available in Braille for the blind or in different formats, as appropriate.

4. Have the opportunity to choose a Primary Care Provider (PCP), within the limits of the provider network, and choose other providers, as needed, from among those affiliated with the network. This also includes the right to refuse care from specified providers.

5. Participate in decision-making regarding his/her health care, including:
   a. The right to refuse treatment (42 CFR 438.100), and/or
   b. Have a representative facilitate care or treatment decisions when the member is unable to do so.

6. Be free from any form of restraint or seclusion used as a means of coercion,
7. Be provided with information about formulating Advance Directives (the AdSS must ensure involvement by the member or his/her representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment within the requirements of federal and state law with respect to Advance Directives [42 CFR 438.6]).

8. Complete an Advance Directive. For members in a behavioral health residential setting that have completed an Advance Directive, the document must be kept confidential but readily available (e.g., in a sealed envelope attached to the refrigerator).

9. Receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
   a. Provisions for after hours and emergency health care services. Information provided must notify members that they have the right to access emergency health care services from contracting or non-contracting providers without prior authorization, consistent with the member's determination of the need for such services as a prudent layperson.
   b. Information about available treatment options (including the option of no treatment) or alternative courses of care.
   c. Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance use services, or referrals for specialty services not furnished by the member's Primary Care Provider.
   d. Procedures for obtaining services outside the geographic service area of the AdSS.
   e. Provisions for obtaining Division covered services that are not offered or available through the AdSS and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider.
   f. A description of how the organization evaluates new technology for inclusion as a covered benefit.

10. Receive information regarding grievances, appeals, and requests for hearings.

11. Complain about the managed care organization.

12. Have access to review his/her medical records in accordance with applicable federal and state laws.

13. Request and receive annually, at no cost, a copy of his/her medical records as specified in 45 CFR 164.524.
a. The member’s right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:
   i. Psychotherapy notes,
   ii. Compiled for or in reasonable anticipation of a civil, criminal, or administrative action, or
   iii. Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2).

b. An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 CFR Part 164 if:
   i. The information meets the criteria stated in section M above.
   ii. The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 CFR 164.501.
   iii. The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research.
   iv. The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services.
   v. The denial of access meets the requirements of the Privacy Act, 5 USC 552a.
   vi. The information was obtained from someone other than a health care provider under the protection of confidentiality, and access would be reasonably likely to reveal the source of the information.

c. Except as provided in Section M above, a member must be informed of the right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:
   i. A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person, or
   ii. The protected health information makes reference to another person and access would reasonably be likely to cause substantial harm to the member or another person.

d. The AdSS must respond within 30 days to the member’s request for a copy of the records. The response may be a copy of the records, or if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in
14. Amend or correct his/her medical records as specified in 45 CFR 164.526:
   
a. The AdSS may require the request be made in writing but may not require a specific form be used.

b. If the AdSS agrees to amend information in the member’s medical record, in whole or in part, at a minimum the AdSS must:
   
   i. Identify the information in the member’s record that is affected and attach or link to the amended information.

   ii. Inform the member, in a timely manner, of the amendment.

   iii. Obtain the member’s agreement to allow the AdSS to notify relevant persons with whom the amendment needs to be shared.

   iv. The AdSS must make reasonable efforts to inform and provide the amendment, within a reasonable time, to:

      a) Persons identified by the member as having received protected health information and who need the amendment, and

      b) Persons, including business associates, that are known to the AdSS as having member information affected by the amendment and who have relied on or may in the future rely on the original information to the detriment of the member.

   c. The AdSS may deny the request for amendment or correction if the information:

      i. Would not be available for review (as stated above),

      ii. Was not created by the AdSS or one of its contracted providers, unless the individual provides a reasonable basis to believe that the originator of protected health information is no longer available to act on the requested amendment,

      iii. Is not a part of the member’s medical record, or

      iv. Is already accurate and complete.

   d. If the request is denied, in whole or in part, the AdSS must provide the member with a written denial within 60 days that includes:

      i. The basis for the denial;

      ii. The member’s right to submit a written statement disagreeing with the denial, and how to file the statement;
iii. A statement that, if the member does not submit a statement of disagreement, the member may request that the AdSS provide the member’s request for amendment and the denial with any future disclosures of the protected health information that is related to the amendment; and

iv. A description of how the member may seek review of the denial in accordance with 45 CFR 164.

e. The AdSS must ensure that each member is free to exercise his/her rights, and that the exercising of those rights will not adversely affect the treatment of the member by the AdSS or its contracted providers.

f. The Division has adopted the 12 Principles implemented by AHCCCS meant to maintain the integrity of the best practices and approaches to providing behavioral health services for children. AdSS are required to consider and integrate these principles in the provision of behavioral health services for members under the age of 18 years.

g. Each AdSS must have a written policy addressing member responsibilities. Member responsibilities include:

   i. Providing, to the extent possible, information needed by professional staff in caring for the member;

   ii. Following instructions and guidelines given by those providing health care;

   iii. Knowing the name of the assigned Primary Care Provider;

   iv. Scheduling appointments during office hours, whenever possible, instead of using urgent care facilities and/or emergency rooms;

   v. Arriving for appointments on time;

   vi. Notifying the provider in advance when it is not possible to keep an appointment; and

   vii. Bringing immunization records to every appointment for children 18 years of age or younger.

h. The AdSS must refer to the Division contract for requirements concerning member handbooks and notification of members regarding their rights and responsibilities. Member rights must be included in the member handbook.

i. The AdSS must refer to 9 A.A.C. 34 and the Division contract for information regarding requirements for the grievance system for members and providers.
940 MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

EFFECTIVE DATE: 10/1/2019
REFERENCES: 42 CFR 431.300 et seq

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

A. The AdSS must have policies and procedures in place for use of electronic medical (care management, physical and behavioral health) records, for use of a health information exchange (including electronic Early and Periodic Screening, Diagnosis and Treatment [EPSDT] tracking forms), and for use of digital (electronic) signatures (when electronic documents are used), that include processes for:

1. Signer authentication
2. Message authentication
3. Affirmative act
4. Efficiency
5. Record review.

B. The AdSS must implement appropriate policies and procedures to ensure that the organization and its providers have information required for:

1. Effective and continuous member care through accurate medical record documentation (including electronic health records) of each member’s health status, changes in health status, health care needs, and health care services provided
2. Quality review
3. Coordination of care
4. An ongoing program to monitor compliance with those policies and procedures.

If during the quality-of-care review process, or other processes, issues are identified with the quality or content of a provider’s medical record, the AdSS must conduct a focused review and implement corrective actions or other remedies until the provider’s medical records process meets standards specified in Division policy.

C. The AdSS must implement policies and procedures for initial and on-going monitoring of medical records for all contracted primary care physicians (PCPs), Obstetrician/Gynecologists (OB/GYNs), licensed behavioral health professionals, oral health providers, and high-volume specialists (50 or more referrals per contract year by AdSS).

1. The sample of files chosen for medical record review must reflect a
representative Statewide sample.

2. These requirements also apply to professionals employed by, or affiliated with, a contracted provider such as an Accountable Care Organization (ACO). Review of medical records must be conducted every three years.

D. The AdSS must:

1. Conduct medical record reviews, using a standardized tool that has been reviewed by AHCCCS.

2. Conduct medical record reviews at a minimum of every three years.

3. Use a collaborative approach that will result in only one AHCCCS Contractor conducting the “routine” medical record review for each provider.

4. Ensure results of the medical record review will be made available to all Contractors that contract with that provider.

5. Ensure samples are by provider, not by provider group.

6. Use a sample size of 30 records.
   a. If the first eight records reviewed are 100 percent in compliance, the review stops at the eight records.
   b. If deficiencies or variances are found in any of the first eight records reviewed, the full 30 records must be reviewed.

7. Ensure that identified deficiencies are shared with all AHCCCS Contractors contracted with the provider.

E. If the AdSS conducts the medical record review, the AdSS must be responsible for working with the provider on corrective actions. However, other AHCCCS Contractor input into those corrective actions may be necessary and appropriate.

1. If quality-of-care issues are identified during the medical record review process, it is expected that AHCCCS Contractors that contract with that provider be notified promptly of the results in order to conduct an independent on-site provider audit.

2. It is also expected that the AdSS will address noted areas of non-compliance, despite a provider obtaining an overall passing score, to include subsequent follow-up measures taken and/or a corrective action plan required to address the noted deficiency.

F. Each AdSS must implement policies and procedures that address paper and electronic health records, and the methodologies to be used by the organization to:

1. Ensure that contracted providers maintain a legible medical record (including electronic health record/medical record) for each enrolled member who has
been seen for medical or behavioral health appointments or procedures. The medical record must also contain clinical/behavioral health records from other providers who also provide care/services to the enrolled member.

2. Ensure providers, in multi-provider offices, have the treating provider sign his or her treatment notes after each appointment and/or procedure.

3. Ensure the medical record contains documentation of referrals to other providers, coordination of care activities, and transfer of care to behavioral health and other providers.

4. Make certain the medical record is legible, kept up to date, is well organized and comprehensive with sufficient detail to promote effective patient care, quality review, and identifies the treating or consulting provider. A member may have more than one medical record kept by various health care providers that have rendered services to the member. However, the PCP must maintain a comprehensive record that incorporates at least the following components:

   a. Behavioral health information when received from the behavioral health provider about an assigned member even if the provider has not yet seen the assigned member

      In lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member’s medical record as soon as one is established.

   b. Member identification information on each page of the medical record (i.e., name or AHCCCS identification number)

   c. Documentation of identifying demographics, including the member’s name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative

   d. Initial history for the member that includes family medical history, social history, and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member’s mother while pregnant with the member)

   e. Past medical history, for all members, that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received

   f. Immunization records (required for children; recommended for adult members if available)

   g. Dental history if available, and current dental needs and/or services

   h. Current problem list
i. Current medications

j. Documentation of review of the Controlled Substances Prescription Monitoring Program (CSPMP) database, prior to prescribing a controlled substance or another medication that is known to adversely interact with controlled substances

k. Current and complete EPSDT forms (required for all members age 0 through 20 years)

l. Developmental screening tools for children ages nine, 18 and 24 months

m. Documentation, initialed by the member's provider, to signify review of diagnostic information including:
   i. Laboratory tests and screenings
   ii. Radiology reports
   iii. Physical examination notes
   iv. Other pertinent data

n. Reports from referrals, consultations and specialists

o. Emergency/urgent care reports

p. Hospital discharge summaries

q. Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed

r. Behavioral health history and behavioral health information received from a behavioral health provider who is also treating the member

s. Documentation as to whether or not an adult member has completed advance directives and the location of the document

t. Documentation that the provider responds to behavioral health provider information requests within 10 business days of receiving the request

The response should include:

i. All pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last provider visit, and recent hospitalizations

ii. The provider's initials signifying review of member behavioral health information received from a behavioral health provider
who is also treating the member.

u. Documentation related to requests for release of information and subsequent releases

v. Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the provider including behavioral health providers, as appropriate to promote continuity of care and quality management of the member’s health care.

5. Ensure that obstetric providers complete a standardized, evidence-based risk assessment tool for obstetric members (i.e. Mutual Insurance Company of Arizona [MICA] obstetric risk assessment tool or American College of Obstetricians and Gynecologists [ACOG] risk assessment tool). Also, ensure that lab screenings for members requiring obstetric care conform to ACOG guidelines.

6. Ensure that PCPs used AHCCCS-approved developmental screening tools.

7. Ensure each organizational provider of services (e.g., hospitals, nursing facilities, rehabilitation clinics, transportation) maintains a record of the services provided to a member that includes:

   a. Physician or provider orders for the service

   b. Applicable diagnostic or evaluation documentation

   c. A plan of treatment

   d. Periodic summary of the member’s progress toward treatment goals

   e. The date and description of service modalities provided

   f. Signature/initials of the provider for each service.

8. Take into consideration professional and community standards and accepted and recognized evidence-based practice guidelines.

9. Ensure the provider has an implemented process to assess and improve the content, legibility, organization, and completeness of member health records when concerns are identified, and

10. Require documentation in the member’s record showing supervision by a licensed professional, who is authorized by the licensing authority to provide the supervision, whenever health care assistants or paraprofessionals provide services.

   a. Medical records may be documented on paper or in an electronic format.
b. If records are documented on paper, they must be written legibly in blue or black ink, signed, and dated for each entry. Electronic format records must also include the name of the provider who made the entry and the date for each entry.

c. If records are physically altered, the person altering the record must identify stricken information as an error, initial, and enter the date on which the change is made; correction fluid or tape is not allowed.

d. If information is kept in an electronic file, the provider must establish a method of indicating the initiator of information and a means to assure that information is not altered inadvertently.

e. If revisions to information are made, a system must be in place to track when, and by whom, they are made. In addition, a backup system including initial and revised information must be maintained.

f. Medical record requirements are applicable to both hard copy and electronic medical records. The AdSS may go on site to review the records electronically or use a secure process to review electronic files received from the provider when concerns are identified.

G. The AdSS must have written policies and procedures addressing appropriate and confidential exchange of member information among providers, including behavioral health providers, and must conduct reviews to verify that:

1. A provider making a referral transmits necessary information to the provider receiving the referral.

2. A provider furnishing a referral service reports appropriate information to the referring provider.

3. Providers request information from other treating providers as necessary to provide appropriate and timely care.

4. Information about services provided to a member by a non-network provider (e.g., emergency services) is transmitted to the member’s Primary Care Provider (PCP).

5. Member records are transferred to the new provider in a timely manner that ensures continuity of care when a member chooses a new PCP.

6. Member information is shared, when a member subsequently enrolls with a new AdSS, in a manner that maintains confidentiality while promoting continuity of care.

7. Member information is shared timely with behavioral health providers for members with ongoing care needs or changes in health status.

8. Information from, or copies of, records may be released only to authorized individuals, and the AdSS must implement a process to ensure that
Unauthorized individuals cannot gain access to, or alter, member records.

9. Original and/or copies of medical records must be released only in accordance with Federal or State laws, Division and AHCCCS policy and contracts. AdSS must comply with the Health Insurance Portability and Accountability Act (HIPAA) requirements and 42 CFR 431.300 et seq.

H. The AdSS must participate/cooperate in State of Arizona and Division and AHCCCS activities related to the development and implementation of electronic health records and e-prescribing. Electronic EPSDT tracking forms must include all elements of the EPSDT tracking forms approved by AHCCCS.

I. The AdSS may request approval to discontinue conducting medical record reviews. Prior to receiving approval to discontinue the medical record review process, the AdSS must:

1. Conduct a comprehensive review of its use of the medical record review process and how it is used to document compliance with AHCCCS requirements such as EPSDT, family planning, maternity and behavioral health services.

2. Document what processes will be used, in place of the medical record review process, to ensure compliance with requirements in this policy.

3. Submit the process that the AdSS will use to ensure provider compliance with medical record requirements set forth in this policy to the Division, prior to discontinuing the medical record review process.
950  CREDENTIALING AND RECREDENTIALING PROCESSES

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.A.C. R9-10-112, A.A.C. R9-10-114; 42 CFR 438.68(c)(1)(viii), 42 CFR 438.206 (c)(3), 42 CFR 438.214(b)(1); AHCCCS template, Exhibit 950-1; Section F3, Contractor Chart of Deliverables

DELIVERABLES: Credentialing and Re-credentialing Denials; Credentialing Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

This policy covers temporary/provisional credentialing, credentialing, and recredentialing policies for both individual and organizational providers. The credentialing and recredentialing policies must address all providers, including but not limited to acute, primary, behavioral, and substance use disorders [42 CFR 438.214(b)(1)]. The Administrative Services Subcontractors (AdSSs) must process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing the AdSS must follow the guidelines located in the Contract.

The AdSS must submit a Quarterly Credentialing Report, 30 days after the end of the quarter, using the AHCCCS template, Exhibit 950-1.

Credentialing Individual Providers

The AdSS must have a written process and a system in place for credentialing and recredentialing providers included in its contracted provider network. Providers who are not licensed or certified must be included in the credentialing process.

A. Credentialing and recredentialing must be conducted for all providers providing care and services to members eligible for the Division. The AdSS may choose to delegate credentialing to an organizational provider according to requirements outlined in Division Medical Policy Manual, Policy, 910. Credentialing and recredentialing must be completed for at least the following provider types:

1. Physicians (Medical Doctor [MD])
2. Doctor of Osteopathic Medicine [DO]
3. Doctor of Podiatric Medicine (DPM)
4. Nurse practitioners
5. Physician Assistants
6. Certified Nurse Midwives acting as primary care providers, including prenatal care/delivering providers
7. Dentists (Doctor of Dental Surgery [DDS] and Doctor of Medical Dentistry [DMD])
8. Affiliated Practice Dental Hygienists
9. Psychologists
10. Optometrist
11. Certified Registered Nurse Anesthetist
12. Occupational Therapist
13. Speech and Language Pathologist
14. Physical Therapists
15. Independent behavioral health professionals who contract directly with the AdSS and other non-licensed or certified providers that provide behavioral health services including, including:
   a. Licensed Clinical Social Worker (LCSW)
   b. Licensed Professional Counselor (LPC)
   c. Licensed Marriage/Family Therapist (LMFT)
   d. Licensed Independent Substance Abuse Counselor (LISAC)
16. Board Certified Behavioral Analysts (BCBAs)
17. Any non-contracted provider that is rendering services and sees 50 or more members served by the AdSS per contract year
18. Covering or substitute oral health providers that provide care and services to members while providing coverage or acting as a substitute during an absence of the contracted provider.

Covering or substitute oral health providers must indicate on the claim form that they are the rendering provider of the care of service.

B. The AdSS must ensure:
   1. Credentialing and recredentialing processes do not discriminate against a provider who serves high-risk populations or who specializes in the treatment of costly conditions.
   2. Compliance with federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid or that employ individuals or entities that are excluded from participation.

C. If the AdSS delegates to another entity any of the responsibilities of credentialing/recredentialing that are required by this Policy, it must retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of this Chapter regarding delegation.
Division of Developmental Disabilities  
Administrative Services Subcontractors  
Medical Policy Manual  
Chapter 900  
Quality Management and Performance Improvement Program

D. Written policies must reflect the scope, criteria, timeliness and process for credentialing and recredentialing providers. The policies and procedures must be reviewed and approved by the Contractor’s executive management, and

1. Reflect the direct responsibility of the local Medical Director, or in the absence of the local Medical Director, another local designated physician to:
   a. Act as the Chair of the Credentialing Committee
   b. Implement the decisions made by the Credentialing Committee
   c. Oversee the credentialing process.

2. Indicate the use of participating Arizona Medicaid network providers in making credentialing decisions.

3. Describe the methodology to be used by the AdSS staff and the local AdSS Medical Director to provide documentation that each credentialing or recredentialing file was completed and reviewed, prior to the presentation to the Credentialing Committee for evaluation.

E. The AdSS must maintain an individual electronic or hard copy credentialing/recredentialing file for each credentialed provider. Each file must include all of the following:

   a. The initial credentialing and all subsequent recredentialing applications, including attestation by the applicant of the correctness and completeness of the application as demonstrated by the signature on the application
   b. Information gained through credentialing and recredentialing queries
   c. Utilization data, quality of care concerns, grievances, performance measure rates, value based purchasing results and level of member satisfaction
   d. Any other pertinent information used in determining whether or not the provider met the AdSS’s credentialing and recredentialing standards.

F. Credentialed providers must be entered/loaded into the AdSS’s claims payment system with an effective date of no later than the date the provider was approved by the Credentialing Committee approval.

G. For Locum Tenens, the AdSS must verify the status of the physician with the Arizona Medical Board and national databases.
Initial Credentialing

The AdSS must use the Arizona Health Plan Association’s Credential Verification Organization (CVO) as part of the credentialing process. At a minimum, policies and procedures for the initial credentialing of providers, as required by the Policy must include:

A. Written application to be completed, signed and dated by the provider, that attests to the following elements:
   1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
   2. Lack of present illegal drug use
   3. History of loss of license and/or felony convictions
   4. History of loss or limitation of privileges or disciplinary action
   5. Current malpractice insurance coverage
   6. Attestation by the applicant of the correctness and completeness of the application (a copy of the signed attestation must be included in the provider’s credentialing file)
   7. Minimum five-year work history, or total work history if less than five years.

B. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification, if a prescriber.

C. Verification from primary sources of:
   1. Licensure or certification
   2. Board certification, if applicable, or highest level of credentials attained
   3. For credentialing of Independent Masters Level Behavioral Health Licensed Professionals, including:
      • Licensed Clinical Social Worker (LCSW)
      • Licensed Professional Counselor (LPC)
      • Licensed Marriage and Family Therapist (LMFT)
      • Licensed Independent Substance Abuse Counselor (LISAC).

      Primary source verification of:
      a. Licensure by Arizona Board of Behavioral Health Examiners (AZBBHE)
      b. A review of complaints received and disciplinary status through AZBBHE.
D. For credentialing of Licensed Board Certified Behavioral Health Analysts:

1. Licensure by the Arizona Board of Psychologist Examiners

2. A review of complaints received, board and disciplinary status through the Arizona Board of Psychologist Examiners.

3. Continuing Education requirements
   a. BCBAs credentialed under a 3-Year Cycle: 36 hours every 3 years (3 hours in ethics and professional behavior)
   b. BCBAs credentialed under a 2-Year Cycle: 32 hours every 2 years (4 hours in ethics for all certificates; 3 hours in supervision for supervisors)

4. Continuing Education courses (see table below)
   a. BCBAs providing supervision of individuals pursuing Behavior Analyst Certification Board (BACB) certification or the ongoing practice of Board Certified Assistant Behavior Analysts (BCaBAs) or Registered Behavior Technicians (RBTs) must obtain specific training in order to do so. These individuals must also obtain 3 Continuing Education Units (CEUs) on supervision in every certification cycle.
   b. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB’s Experience Standards (in particular, the “Nature of Supervision” section) and the BACB Supervisor Training Curriculum Outline.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>DESCRIPTION</th>
<th>LIMIT</th>
<th>CEUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>College or university coursework</td>
<td>None – all CE can come from this type</td>
<td>1 hour of instruction = 1 CEU</td>
</tr>
<tr>
<td>2</td>
<td>CE issued by approved continuing education (ACE) providers</td>
<td>None – all CE can come from this type</td>
<td>50 minutes of instruction = 1 CEU</td>
</tr>
<tr>
<td>3</td>
<td>Non-approved events</td>
<td>25% can come from this type*</td>
<td>1 hour = 1 CEU</td>
</tr>
<tr>
<td>4</td>
<td>Instruction of Type 1 or Type 2</td>
<td>50% can come from this type*</td>
<td>1 hour of instruction = 1 CEU</td>
</tr>
<tr>
<td>5</td>
<td>CE issued by the BACB directly</td>
<td>25% can come from this type*</td>
<td>Determined by BACB</td>
</tr>
<tr>
<td>TYPE</td>
<td>DESCRIPTION</td>
<td>LIMIT</td>
<td>CEUs</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>6</td>
<td>Take and pass the certification exam again</td>
<td>All CE will be fulfilled by this activity</td>
<td>Passing the exam equals 100% of your required CE, except for supervision</td>
</tr>
<tr>
<td>7</td>
<td>Scholarly Activities</td>
<td>25% can come from this type*</td>
<td>One publication = 8 CEUs One review = 1 CEU</td>
</tr>
</tbody>
</table>

*A maximum of 75% of the total required CE may come from categories 3, 4, 5 and 7. At least 25% must come from Type 1 or Type 2. Passing the examination (Type 6) meets all CE requirements except for supervision.

E. BCBAs providing supervision of individuals pursuing BACB certification or the ongoing practice of BCBAs or RBTs will be required to obtain specific training in order to supervise. These individuals will also be required to obtain three CEUs on supervision in every certification cycle. Acceptable supervision content is behavior-analytic in nature and covers effective supervision as defined in the BACB’s Experience Standards (in particular, the “Nature of Supervision” section) and the BACB Supervisor Training Curriculum Outline.

1. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training. A print out of license from the applicable Board’s official website denoting that the license is active with no restrictions is acceptable.

2. National Provider Databank (NPDB),

3. Verification of the following:
   a. Minimum five year history of professional liability claims resulting in a judgment or settlement
   b. Disciplinary status with regulatory Board or Agency
   c. Medicare/Medicaid sanctions, and exclusions, and terminations for cause
   d. State sanctions or limitations of licensure
4. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to AHCCCS/Office of the Inspector General (OIG) immediately in accordance with AdSS Operations Manual Policy 103.

   b. The System of Award Management (SAM) www.sam.gov formerly known as the General Services Administration (GSA)

F. Affiliated practice dental hygienists must provide documentation of the affiliation agreement with an AHCCCS registered dentist.

G. Initial site visits for Primary Care Providers (PCP) and Obstetrics/Gynecology (OB/GYN) applicants must include but are not limited to verification of compliance with the following:
   1. Vaccine and drug storage regulations
   2. Emergency and resuscitation equipment policy
   3. Americans with Disabilities Act requirements [42 CFR 438.3(f)(1); 42 CFR 438.100(d)]

H. The AdSS must ensure that network providers have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities [42 CFR 438.206(c)(2)(3)]. AdSS must also ensure that providers deliver services in a culturally competent manner, including to those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. [42 CFR 438.206(c)(2)].

I. The AdSS must conduct timely verification of information, as evidenced by approval (or denial) of a provider within 90 days of a receipt of complete application. The AdSS must send a notification to the provider and load all required information in to AdSS’s system within 30 days of Credentialing Committee approval in order to allow payment to the provider for services. The effective date should be no later than the date of the Credentialing Committee decision or the Contract effective date, whichever is later.

J. The AdSS must have written policies and procedures for notifying practitioners of their right to review information it has obtained to evaluate their credentialing application, attestation or Curriculum Vitae (CV).

K. AdSS providers including licensed or certified behavioral health providers may be subject to an initial site visit as part of the credentialing process.
Temporary/Provisional Credentialing

The AdSS must have policies and procedures to address temporary or provisional credentials, when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban. Providers working in a Federally Qualified Health Center (FQHC) and FQHC Look-Alike Center, as well as hospital employed physicians (when appropriate), are credentialed using the temporary or provisional credentialing process, even if the provider does not specifically request their application be processed as temporary or provisional.

The AdSS must follow the “Initial Credentialing” guidelines when granting temporary or provisional credentialing to:

- Providers in a Federally Qualified Health Center (FQHC)
- Providers in a FQHC Look-Alike organization
- Hospital employed physicians (when appropriate)
- Providers needed in medically underserved areas
- Providers joining an existing, contracted oral health provider group
- Covering or substitute providers providing services to members during a provider’s absence from the practice.

The AdSS has 14 calendar days from receipt of a completed application, accompanied by the minimum documents specified in the section, in which to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into the AdSS’s information system to allow payment to the provider effective the date the provisional credentialing is approved.

In situations where a covering or substitute provider must be used by a contracted provider and is approved through the temporary/provisional credentialing process, the AdSS must ensure that its system allows payments to the covering/substitute provider effective the date of the notification was received from the provider of the need for a covering or substitute provider. Covering or substitute providers must meet the following requirements:

A. Licensure: Provider and employees rendering services to members must be appropriately licensed in Arizona to render such services as required by state or federal law or regulatory agencies, and such licenses must be maintained in good standing.

B. Restriction of Licensure: Provider must notify the AdSS within two (2) business days of the loss or restriction of his/her DEA permit or license or any other action that limits or restricts the Provider’s ability to practice or provide services.
C. Professional Training: Provider and all employees rendering services to members must possess the education, skills, training, physical and mental health status, and other qualifications necessary to provide quality care and services to members.

D. Professional Standards: Provider and employees rendering services to members must provide care and services which meets or exceeds the standard of care and must comply with all standards of care established by state or federal law.

E. Continuing education: Provider and employees rendering care or services to members must comply with continuing education standards as required by state or federal law or regulatory agencies.

F. Regulatory compliance: Provider must meet the minimum requirements for participating in the Medicaid program as specified by the state.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that includes:

A. Reasons for any inability to perform the essential functions of the position, with or without accommodation

B. Lack of present illegal drug use

C. History of loss of license and/or felony convictions

D. History of loss or limitation of privileges or disciplinary action

E. Current malpractice insurance coverage

F. Attestation by the applicant of the correctness and completeness of the application. A copy of the most current signed attestation will be included in the provider’s credentialing file.

In addition, the applicant must furnish both of the following:

A. Work history for the past five years, or total work history if less than five years

B. Current Drug Enforcement Agency (DEA) or Controlled Drug System (CDS) certificate.

The AdSS must conduct primary verification of the following:

A. Licensure or certification; a printout of license from the applicable board’s official website denoting that the license is active with no restrictions is acceptable.

B. Board certification, if applicable, or the highest level of credential attained, and

C. National Provider Data Bank (NPDB) query, including:
   1. Minimum five-year history of professional liability claims resulting in a judgment or settlement
2. Disciplinary status with regulatory board or agency
3. State sanctions or limitations of licenses
4. Medicare/Medicaid sanctions, exclusions, and terminations for cause.

The local AdSS’s Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and Credentialing Committee review, as outlined in this policy, must be completed.

**Recredentialing Individual Providers**

The AdSS must use the Arizona Health Plan Association’s Credential Verification Organization as part of its credentialing process. At a minimum, the recredentialing policies for physicians and other licensed or certified health care providers must identify procedures that address the recredentialing process and include requirements for:

A. Recredentialing at least every three (3) years

B. An update of information obtained during the initial credentialing process as required in the Initial Credentialing section of this policy

C. Verification of continuing education requirements being met

D. A process for monitoring health care providers specific information, including, but not limited to:
   1. Member concerns, which include grievances (complaints)
   2. Utilization management information (e.g., emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)
   3. Performance improvement and monitoring (e.g., performance measure rates)
   4. Results of medical record review audits, if applicable
   5. Quality of care issues (including trend data)

   If an adverse action is taken with a provider, including non-renewal of a contract, the AdSS must report the adverse action and include the reason for the adverse action to the Division’s Quality Management Unit within one business day.

6. Pay for performance and value-driven health care data/outcomes, if applicable

7. Evidence that the provider’s policies and procedures meet Division requirements
8. **Timely approval (or denial) by the AdSS’s Credentialing Committee within three years from the previous credentialing approval date.** Primary Source Verification must also be current, within 180 days, for the Committee's decision.

### Initial Credentialing of Organizational Providers

A. **As a prerequisite to contracting with an organizational provider, the AdSS must ensure the organizational provider has established policies and procedures that meet AHCCCS and Division requirements, including policies and procedures for credentialing and recredentialing if delegated to the organization.** The requirements described in this section must be met for all organizational providers in its network, including, but not limited to:

1. Hospitals
2. Home health agencies
3. Nursing facilities
4. Dialysis centers
5. Dental and medical schools
6. Freestanding surgical centers
7. State or local public health clinics
8. Community/Rural Health Clinics (or Centers)
9. Air transportation
10. Non-emergency transportation vendor
11. Laboratories
12. Pharmacies
13. Behavioral health facilities, including but not limited to:
   
a. Independent Clinics  
b. FQHCs  
c. Community Mental Health Centers  
d. Level 1 Sub-Acute Facility  
e. Level 1 Sub-Acute Intermediate Care Facility  
f. Level 1 Residential Treatment Center (secure and non-secure)  
g. Community Service Agency  
h. Crisis Services Provider/Agency  
i. Behavioral Health Residential Facility  
j. Behavioral Health Outpatient Clinic  
k. Integrated Clinic  
l. Rural Substance Abuse Transitional Agency  
m. Behavioral Health Therapeutic Home  
n. Respite homes/providers  
o. Specialized Assisted Living Centers  
p. Specialized Assisted Living Homes.

B. Prior to contracting with an organizational provider, the AdSS must:

   1. Confirm the provider has met all the state and federal licensing and regulatory requirements (a copy of the license or letter from the regulatory agency will meet this requirement).

   2. Confirm the provider is reviewed and approved by an appropriate accrediting body as specified by the Centers for Medicare and Medicaid Services (CMS) (a copy of the accreditation report or letter from the accrediting body will meet this requirement). The AdSS must state in policy which accrediting bodies it accepts that are in compliance with federal requirements.
3. Conduct an onsite quality assessment if the provider is not accredited. The AdSS must develop a process and use assessment criteria, for each type of unaccredited organizational provider with which it contracts; that must include, but is not limited to, confirmation that the organizational provider has:

a. A process for ensuring that the organizational provider credentials its providers for all employed and contracted providers listed in this policy

b. Liability insurance

c. Business license

Centers for Medicare and Medicaid Services (CMS) certification or state licensure review/audit may be substituted for the required site visit if the site visit was within the past three years prior to the credentialing date. In this circumstance, the AdSS must obtain the review/audit documentation from CMS or the state licensing agency and verify that the review/audit was conducted and that the provider meets the AdSS’s standards. A letter from CMS that states the organizational provider was reviewed/audited and passed inspection is sufficient documentation when the AdSS has documented that they have reviewed and approved the CMS criteria and they meet the AdSS’s standards.

d. In addition, Community Service Agencies must also have:

i. A signed relationship agreement with the AdSS whose members they are serving

ii. An approved application with the AdSS

iii. A signed contract with the AdSS-contracted network provider or with contractor directly as applicable.

iv. A description of the services provided that matches the services approved on the Title XIX Certificate

v. Fire inspection reports

vi. Occupancy permits

vii. Tuberculosis testing

viii. CPR certification

ix. First Aid certification

x. Respite providers provide and maintain consistently a signed agreement with an Outpatient Treatment Center.
4. Review and approve the organizational provider through the AdSS’s Credentialing Committee.

5. For transportation vendors, review a maintenance schedule for vehicles used to transport members and the availability of age-appropriate car seats when transporting children.

**Reassessment of Organizational Providers**

The AdSS must reassess organizational providers at least every three years. The reassessment includes the following information, which must be current:

A. Confirmation the organizational providers remain in good standing with state and federal bodies, and, if applicable, are reviewed and approved by an accrediting body, by validating the organizational provider:

   1. Is licensed to operate in the state, and is in compliance with any other state or federal requirements as applicable
   2. Is reviewed and approved by an appropriate accrediting body.

   If an organizational provider is not accredited or surveyed and licensed by the state, an on-site review is conducted.

B. Review of:

   1. The most current review conducted by the Arizona Department of Health Services (ADHS) and/or summary of findings (date of ADHS review is documented) and, if applicable, review of the online “Hospital Compare” or “Nursing Home Compare”
   2. Record of on-site inspection of non-licensed organizational providers to ensure compliance with service specifications
   3. Supervision of staff and required documentation of direct supervision/clinical oversight as required in A.A.C. R9-10-114. This process must include a review of a valid sample of clinical charts
   4. Most recent audit results of the organizational provider
   5. Confirmation that the service delivery address is verified as correct
   6. Review of staff to verify credentials, and that staff meets the credentialing requirements.

C. Evaluation of organizational provider-specific information such as, but not limited to, the following:

   1. Member concerns which include grievances (complaints)
   2. Utilization management information
3. Performance improvement and monitoring

4. Quality of care issues

5. Onsite assessment.

If an adverse credentialing, recredentialing, or organizational credentialing decision is made, the AdSS must report the adverse action to the Division’s Quality Management Unit within one business day.

D. Review and approval by the AdSS’s Credentialing Committee with formal documentation that includes discussion, review of thresholds, and complaints or grievances.

E. The AdSS must review and monitor other types of organizational providers in accordance with their contract.

**Notification Requirements - Suspensions and Terminations**

A. The AdSS must have procedures for prompt reporting in writing to appropriate authorities including the Division’s Quality Management Unit, the provider’s regulatory board or agency, the Arizona Department of Health Services Licensure Division, and the Office of the Attorney General. The AdSS must report within one business day to the Division’s Quality Management Unit deficiencies that result in a provider’s suspension or termination from the AdSS’s network. If the issue is determined to have criminal implications, including allegations of abuse or neglect, the AdSS must promptly notify a law enforcement agency, and Adult Protective Services or the Department of Child Safety. The AdSS must have an implemented process to report providers to licensing and other regulatory entities all allegations of inappropriate or misuse of prescribing including allegations of adverse outcomes that may have been avoided should the provider have reviewed the CSPMP and coordinated care with other prescribers.

B. The AdSS must report to the Division’s Quality Management Unit all credentialing, provisional credentialing, recredentialing, and organizational credentialing denials that are based on quality-related issues or concerns.

C. The AdSS must indicate in its notification to the Division the reason or cause of the adverse/denial decision and when restrictions are placed on the provider’s contract, such as denials or restrictions that are the result of licensure issues, quality of care concerns, excluded providers, alleged fraud, and waste or abuse. The Division Quality Management Unit will refer cases, as appropriate, to the AHCCCS-OIG. The AHCCCS –OIG will conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation. The AdSS must:

1. Maintain documentation of implementation of the procedures

2. Have an appeal process for instances in which the AdSS places restrictions on the provider’s contract based on issues of quality of care and/or service
3. Inform the provider of the Quality Management (QM) dispute process through the QM Department

4. Notify the Division’s Quality Management (QM) within one business day for all reported events.

D. Have procedures for reporting to the AHCCCS Clinical Quality Management Unit in writing any final adverse action for any quality-related reason, taken against a health care provider, supplier/vendor, or practitioner. A “final adverse action” does not include an action with respect to a malpractice notice or settlements in which no findings or liability has been made.

E. Submit to the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB):

1. Within 30 calendar days from the date the final adverse action was taken or the date when the Contractor became aware of the final adverse action, or

2. By the close of the Contractor's next monthly reporting cycle, whichever is later.

F. A final adverse action includes:

1. Civil judgments in federal or state court related to the delivery of a health care item or service

2. Federal or state criminal convictions related to the delivery of a health care item or service

3. Actions by federal or state agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including:
   a. Formal or official actions, such as restriction, revocation or suspension of license (and the length of any such suspension), reprimand, censure or probation
   b. Any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise
   c. Any other negative action or finding by such federal or state agency that is publicly available information,
   d. Exclusion from participation in federal or state health care programs as specified in current statute
   e. Any other adjudicated actions or decisions that the Secretary must establish by regulation.
4. Any adverse credentialing, provisional credentialing, recredentialing, or organizational credentialing decision made based on quality-related issues/concerns or any adverse action from a quality or peer review process, that results in denial of a provider to participate in the AdSS network, provider termination, provider suspension or an action that limits or restricts a provider.

G. Notice of an AdSS’s final adverse action should be sent to the Division’s Quality Management Unit within one business day of the notice.

H. The AdSS, its subcontractors and providers are required to immediately notify the AHCCCS Office of Inspector General (AHCCCS-OIG) regarding any allegation of fraud, waste or abuse of the Medicaid Program. Notification to AHCCCS-OIG must be in accordance with AdSS Operations Manual Policy 103 and as specified in Section F3, Contractor Chart of Deliverables. This must include allegations of fraud, waste or abuse that were resolved internally but involved Medicaid funds. The AdSS must also report to the Division, as specified in Section F3, Contractor Chart of Deliverables, any credentialing denials issued by the Credential Verification Organization including, but not limited to those which are the result of licensure issues, quality of care concerns, excluded providers, and which are due to alleged fraud, waste or abuse. In accordance with 42 CFR 455.14, AHCCCS-OIG will then conduct a preliminary investigation to determine if there is sufficient basis to warrant a full investigation.

I. The AdSS must report, within one business day, the following:

1. The name and Tax Identification Number (TIN), as defined in section 7701(A)(41) of the Internal Revenue Code of 1986 (1121)

2. The name (if known) of any health care entity with which the health care provider, supplier, or practitioner is affiliated or associated

3. The nature of the final adverse action and whether such action is on appeal

4. A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information determined by regulation, for appropriate interpretation of information reported under this section

5. The date the final adverse action was taken, its effective date and duration of the action

6. Corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, and

7. Documentation that the following sites have been queried. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to AHCCCS/OIG immediately in accordance with AdSS Operations Manual, Policy 103:
a. The System of Award Management (SAM)/www.sam.gov, formerly known as the Excluded Parties List System (EPLS)
b. The Social Security Administration’s Death Master File
c. The National Plan and Provider Enumeration System (NPPES)
d. The List of Excluded Individuals (LEIE)
e. Any other databases directed by the Division, AHCCCS or CMS.

Teaching Physicians and Teaching Dentists

AHCCCS permits services to be provided by medical students or medical residents and dental students or dental residents under the direct supervision of a teaching physician or a teaching dentist. In limited circumstances when specific criteria are met, medical residents may provide low-level evaluation and management services to members in designated settings without the presence of the teaching physician.

The teaching physicians and teaching dentists must be an AHCCCS registered provider and must be credentialed by the AdSS in accordance with Division policy as set forth in this policy.

Credentialing Timeliness

The AdSS must process credentialing applications in a timely manner. To assess the timeliness of provisional and initial credentialing, the AdSS must divide the number of complete applications processed (approved/denied) during the time period per category by the number of complete applications that were received during the time period per category. The Division has adopted Exhibit 950-1 in the AHCCCS Medical Policy Manual to be used by the AdSS when submitting the Quarterly Credentialing Report to the Division’s Quality Management Unit through the Division’s Compliance Unit.

The standards for processing, are listed by category below.

<table>
<thead>
<tr>
<th>Type of Credentialing</th>
<th>Timeframe</th>
<th>Completion Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provisional</td>
<td>14 days</td>
<td>100%</td>
</tr>
<tr>
<td>Initial</td>
<td>90 days</td>
<td>100%</td>
</tr>
<tr>
<td>Organizational Credentialing</td>
<td>90 days</td>
<td>100%</td>
</tr>
<tr>
<td>Recredentialing</td>
<td>Every Three Years</td>
<td>100%</td>
</tr>
<tr>
<td>Load Times</td>
<td>30 Days</td>
<td>90%</td>
</tr>
</tbody>
</table>

(Time between Credentialing Committee approval and loading into claims system)
This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The AdSS must develop and implement policies and procedures to review, evaluate, and resolve quality of care and service issues raised by members, contracted providers, and stakeholders. The issues may be received from anywhere within the organization or externally from anywhere in the community. All issues must be addressed regardless of source (external or internal).

**Documentation Related to Quality of Care Concerns**

As a part of the AdSS’s process for reviewing and evaluating member and provider issues, there are written procedures regarding the receipt, initial and ongoing processing of these matters that include requirements that the AdSS perform the following:

A. Document each issue raised, when it was raised, from whom it was received, and the projected time frame for resolution.

B. Determine promptly whether one of the following processes will be used to resolve the issue:

1. Quality management process
2. Grievance and appeals process
3. Process for making initial determinations on coverage and payment issues
4. Process for resolving disputed initial determinations.

C. Acknowledge receipt of the issue and explain to the member/responsible person or provider the process that will be followed to resolve their issue through written correspondence.

D. For issues that are submitted to the Quality Management (QM) Unit but are determined to not be a Quality of Care (QOC) concern, inform the submitter of the process to be used to resolve the issue. QOC-related concerns must be addressed in the QM Unit.

E. Assist the member or provider as needed to complete forms or take other necessary actions to obtain resolution of the issue.

F. Ensure confidentiality of all member information.

G. Inform the member or provider of all applicable mechanisms for resolving the issue that are external to the AdSS processes.
H. Document all processes (including detailed steps used during the investigation and resolution stages) implemented to ensure complete resolution of each complaint, grievance or appeal, including but not limited to:

1. Corrective action plan(s) or action(s) taken to resolve the concern
2. Documentation that education/training was completed. This may include, but is not limited to, in-service attendance sheets and training objectives.
3. New policies and/or procedures
4. Follow-up with the member that includes, but is not limited to:
   a. Assistance as needed to ensure that the immediate health care needs are met
   b. Closure/resolution letter that provides sufficient detail to ensure all covered, medically necessary care needs are met, and a contact name/telephone number to call for assistance or to express any unresolved concerns.
5. Referral to the AdSS’s Corporate Compliance Units and/or AHCCCS Office of the Inspector General.

I. Refer to A.A.C. R9-34 and the Division Contract for information regarding requirements for the grievance and appeal system for members and providers.

**Process of Evaluation and Resolution of Quality of Care and Service Concerns**

The quality of care concerns process must include documentation of identification, research, evaluation, intervention, resolution, and trending of member and provider issues. Resolution include both member and system interventions when appropriate.

The quality of care/service concerns process must be a stand-alone process completed through the Quality Management Unit. The process must not be combined with other agency meetings or processes. Work units outside of the QM Unit will not have the authority to conduct quality of care investigations but may provide subject matter expertise throughout the investigative process.

A. The AdSS must develop and implement policies and procedures that address analysis of quality of care issues through:

1. Identification of the quality of care issues
2. Initial assessment of the severity of the quality of care issue
3. Prioritization of action(s) needed to resolve immediate care needs when appropriate
4. Review of trend reports obtained from the AdSS’s quality of care data system to determine possible trends related to the provider(s), including
organizational providers, involved in the allegation(s) including but not limited to types of allegation(s), severity, and substantiation

5. Research, including, but not limited to:
   a. A review of the log of the events
   b. Documentation of conversations
   c. Medical records review
   d. Mortality review

6. Quantitative and qualitative analysis of the research, which may include root cause analysis

7. Direct interviews of members, staff, and witnesses to a reportable event; when applicable and appropriate.

B. The AdSS’s Quality Management staff must conduct onsite visits in response to identified health and safety concerns, immediate jeopardy, serious incident situations, a request of the Division or AHCCCS.

Subject matter experts outside the QM Unit may participate in the onsite visit but may not take the place of Quality Management staff during reviews. SMEs may arrive on site first if they are closer to the site, however, a clinical QM staff member must be the lead for the review/investigation and participate in the onsite visits.

The AdSS may not delegate quality of care investigation processes or onsite quality of care visits. Quality investigations may not be delegated or performed by the staff of the provider agency/facility where the identified health and safety concerns, Immediate Jeopardy, or AHCCCS-requested reviews have occurred. Contractors must complete and submit to AHCCCS Attachment 960-C for each onsite review.

Based on findings, the AdSS must:

1. Actively participate in meetings focused on ensuring health and safety of members.

2. Actively participate in meetings scheduled to develop work plans and corrective action plans to ensure placement setting or service sites compliance with ADHS Licensure and/or AHCCCS requirements.

3. Participate in scheduled and unscheduled monitoring of placement setting or service sites that are in an Immediate Jeopardy status, have serious identified deficiencies that may affect health and safety of members or as directed by AHCCCS.

4. Assist in the identification of technical assistance resources focused on achieving and sustaining regulatory compliance.
5. Monitor placement setting or service sites upon completion of the activities and interventions to ensure that compliance is sustained.

C. The AdSS must develop a process to assure that action is taken when needed by:
   1. Developing an action plan to reduce/eliminate the likelihood of the issue reoccurring
   2. Determining, implementing, and documenting appropriate interventions
   3. Monitoring and documenting the success of the interventions
   4. Incorporating interventions into the organizations QM program if successful
   5. Implementing new interventions/approaches when necessary.

D. The AdSS must develop a process to ensure resolution of the issue. Member and system resolutions may occur independently from one another.

E. The AdSS must develop a process to determine the level of severity of the QOC issue.

F. The AdSS must develop a process to refer and/or report the issues to the appropriate regulatory agency(ies) identified below:
   1. The Department of Child Safety
   2. Adult Protective Services
   3. Arizona Department of Health Services (AZDHS)
   4. The Attorney General’s Office
   5. Law enforcement
   6. The Division or AHCCCS
   7. Other entities as necessary.

Initial reporting may be made verbally, but a verbal report must be followed by a written report within one business day.

G. The AdSS must have a process to refer the issue to the AdSS’s Peer Review Committee when appropriate. Referral to the Peer Review Committee is not a substitute for implementing interventions aimed at individual and systemic quality improvement.

H. If an adverse action is taken with a provider for any reason including those related to quality of care concern, the AdSS must report the adverse action to the Division’s QM Unit within 24 hours of the determination to take an adverse action and to the National Practitioner Data Bank when needed.
I. The AdSS must ensure a thoughtful process around member impact and care transition when acting on adverse actions. This is particularly important if a provider is being suspended or terminated. The Contractor must allow adequate time for identification of new providers, transition of members to those providers, impact to members (such as service plans, medications, etc.), and timely communication to members to prepare for the transition. While there may be instances where a move or transition must occur quickly, the MCO should work with AHCCCS to ensure member needs are met without potential gaps in care/services and or treatment disruption.

J. The AdSS must have a process to document the criteria and process for closure of the review or investigation. Required documentation includes, but is not limited to, the following:

1. A description of the problems, including new allegations identified during the investigation/review process, and the substantiation and severity level for each allegation and the case overall.
2. Written response from, or summary of, the documents received from referrals made to outside agencies such as accrediting bodies, or Medical Examiner.
3. Interventions imposed as part of the investigation (such as education, root/cause analysis, and ongoing monitoring).

K. The AdSS must document, in the QOC file, investigations that warrant ongoing monitoring or follow-up with the provider. All follow-up actions or monitoring activities as well as related observations or findings must be documented in the QOC file.

L. The AdSS must notify the Division’s QM Unit and take appropriate action with the provider, including suspension or corrective action plans and referrals to appropriate regulatory Boards including the Pharmacy Board, when an investigation identifies an adverse outcome, including mortalities, due to prescribing issues or failure of the provider to:

1. Check the CSPMP
2. Coordinate care with other prescribers
3. Refer for substance use treatment or pain management.

The case finding must be presented to the AdSS’s Peer Review Committee for discussion and review.
Requests for Copies of Death Certificates

As part of the quality of care investigative process, the AdSS will request copies of member death certificates from the ADHS Bureau of Vital Records.

A. Authorization of Requestors

The AdSS must:

1. Create a letter, on AdSS letterhead, providing one or two names of employees who are authorized to make a request for a copy of the death certificate. The requestor should be someone at a manager or supervisory level position with the AdSS.

Only those individual(s) listed on the letter are eligible to apply/request a copy of the death certificate.

2. Ensure the letter includes original ink signatures and is mailed to:

   Arizona Department of Health Records
   Bureau of Vital Records
   Office Chief
   P.O Box 3887
   Phoenix, Arizona 85030

3. Notify the AZDHS Office of Vital Statistics in writing of any termination of employment of those listed on the original letter. Include in the notification the name of the replacement managerial or supervisory staff person. Mail these changes to:

   Operations Section Manager
   Arizona Department of Health Services
   Bureau of Vital Records
   P.O Box 3887
   Phoenix, Arizona 85030

B. Requesting Copies of Death Certificates

When requesting a death certificate, the AdSS authorized requestor must:

1. Include the following in the request:

   a. The decedent’s (member’s) name
   b. Date of death
   c. Purpose of request (i.e. quality of care investigation process)
   d. Signature of the authorized employee (requests must be mailed with original ink signatures)
e. Documentation showing that the decedent was a member of the Division (copy of an eligibility screen with the Division’s name, members name and date of eligibility is acceptable)

f. A payment of $5.00 for each copy requested, in the form of a business check, money order, or credit card.

2. Send the request for a death certificate to:

   Arizona Department of Health Records
   Bureau of Vital Records
   Office Chief
   P.O Box 3887
   Phoenix, Arizona 85030

**Reporting to Independent Oversight Committee**

The AdSS must provide Incident, Accident and Death Reports concerning issues including, but not limited to, reports of possible abuse, neglect or denial of rights to the Division’s Independent Oversight Committee (IOC) as outlined in this policy. All incident, accident and death reports must have all personally identifiable information redacted in accordance with federal and state confidentiality laws.

A. When the Division or a IOC requests information regarding the outcome of a report of possible abuse, neglect or violation of rights, the AdSS must do one of the following:

1. Conduct an investigation of the incident if it has not already been conducted:

   a. For incidents in which a person currently or previously enrolled as seriously mentally ill is the possible victim, the investigation shall follow the requirements in A.A.C. R9-21-401 et seq.

   b. For incidents in which a currently or previously enrolled child or non-seriously mentally ill adult is the possible victim, the investigation shall be completed within 35 days of the request and shall determine: all information surrounding the incident, whether the incident constitutes abuse, neglect, or a violation of rights, and any corrective action needed as a result of the incident.

2. If an investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS must provide the final investigation decision to the Division and the IOC. The final investigation decision shall consist of, at a minimum, the following information:

   a. The accepted portion of the investigation report with respect to the facts found,

   b. A summary of the investigation findings, and
c. Conclusions and corrective action taken.

Personally identifiable information regarding any currently or previously enrolled person shall not be included in the final investigation decision provided to the IOC, unless otherwise allowed by law.

B. General Requirements

1. The AdSS must provide to IOC’s member information and records in accordance with A.R.S. §41-3804. The following items must be routinely provided to the IOC in redacted format:
   a. Seclusion and Restraint reports
   b. Incident/Accident/Death (IAD) reports, and/or
   c. Quality of Care (QOC) investigations as applicable.

Upon review of supplied information, the IOC may request documentation, supplemental information, or an investigation regarding alleged violation of rights.

2. The AdSS must provide Seclusion and Restraint Reports, and IAD Reports concerning issues including, but not limited to, reports of possible abuse, neglect or denial of rights to IOC’s as specified in Section F3, Contractor Chart of Deliverables. All Seclusion and Restraint Reports and IAD reports must have all information removed that personally identifies members, in accordance with federal and state confidentiality laws, and

3. If a QOC investigation has already been conducted by the AdSS and can be disclosed without violating any confidentiality provisions, the AdSS must provide the requested documentation to the IOC via the Secured Quality Management System Portal.

Requests for Protected Health Information (PHI) of a Currently Enrolled Member

A. When an IOC requests PHI concerning a currently or previously enrolled member, the IOC must first demonstrate that the information is necessary to perform a function that is related to the oversight of the behavioral health system or the IOC must have written authorization from the member to review PHI.

B. If it is determined that the IOC needs PHI and has obtained the member’s or representative’s written authorization, the AdSS must first review the requested information and determine if any of the following types of information are present: Communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program. If no such information is present, the AdSS must provide the information adhering to the requirements of this policy.

1. If communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program is found, the AdSS must:
a. Contact the member or representative if an adult, or the custodial parent or legal guardian if the member is a child, and ask if the member is willing to sign an authorization for the release of communicable disease related information, including confidential HIV information, and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program. The AdSS must provide the name and telephone number of a contact person with the IOC who can explain the Committee's purpose for requesting the protected information. If the member agrees to give authorization, the AdSS must obtain written authorization as required below and provide the requested information to the IOC,

b. Authorization for the disclosure of records of deceased members may be made by the executor, administrator, or other personal representative appointed by will or by a court to manage the deceased member’s estate. If no personal representative has been appointed, PHI may be disclosed to a family member, other relative, or a close personal friend of the deceased member, or any other person identified by the deceased, only to the extent that the PHI is directly relevant to such person’s involvement with the deceased members health care or payment related to the individual’s health care,

c. If the member does not authorize the release of the communicable disease-related information, including confidential HIV information and/or information concerning diagnosis, treatment or referral from an alcohol or drug use program, this information must not be included or must be redacted from any PHI that is authorized to be disclosed, and

d. Requested information that does not require the member or representative’s authorization must be provided within 15 working days of the request. If the authorization is required, requested information must be provided within five working days of receipt of the written authorization.

C. When PHI is sent, the AdSS must include a cover letter addressed to the IOC that states that the information is confidential, is for the official purposes of the Committee, and is not to be re-released under any circumstances.

D. If the Division denies the IOC’s request for PHI:

1. The Division notifies the IOC within five working days that the request is denied, the specific reason for the denial, and that the Committee may request, in writing, that the Division Director, or designee, review this decision. The Committee’s request to review the denial must be received by the Division Director, or designee, within 60 days of the first scheduled committee meeting after the denial decision is issued,

2. The Division Director, or designee, conducts the review within five business days after receiving the request for review,
3. The Division Director’s or designee’s decision is the final agency decision and is subject to judicial review pursuant to A.R.S. Title 12, Chapter 7, Article 6, and

4. No information or records can be released during the timeframe for filing a request for judicial review or when judicial review is pending.

Authorization Requirements

A written authorization for disclosure of information concerning diagnosis, treatment or referral from an alcohol or substance use program and/or communicable disease related information, including confidential HIV information, must include all of the following:

A. The specific name or general designation of the program or person permitted to make the disclosure

B. The name or title of the individual or the name of the organization to which the disclosure is to be made

C. The name of the currently or previously enrolled member

D. The purpose of the disclosure

E. How much and what kind of information is to be disclosed

F. The signature of the currently or previously enrolled member/legal guardian and, if the currently or previously enrolled member is a minor, the signature of a person authorized to give consent

G. The date on which the authorization is signed

H. A statement that the authorization is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it

I. The date, event, or condition upon which the authorization will expire if not revoked before. This date, event, or condition must ensure that the authorization will last no longer than reasonably necessary to serve the purpose for which it is given

J. A statement that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2) and state statute on confidentiality of HIV/AIDS and other communicable disease information (A.R.S. §36-664(H)) which prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the member to whom it pertains, or as otherwise permitted by 42 CFR Part 2 and A.R.S §36-664(H). A general authorization for the release of medical or other information is NOT sufficient for this purpose.

The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
**Problem Resolution**

If any problems with receipt of requested information as provided in this policy arise, the AdSS must notify the Division and the IOC in writing within the first 30 days. If the problem is not resolved, the IOC may then address the problem to the Division Director or designee.

**Duties and Liabilities of Behavioral Health Providers in Proving Behavioral Health Services**

A. The AdSS must develop and make available written policies and procedures that provide guidance regarding the provider’s duty to warn under A.R.S. § 36-517.02. This statute supplements other immunities of behavioral health providers or mental health treatment agencies that are specified in law.

With respect to the legal liability of a behavioral health provider, A.R.S. § 36-517.02 provides that no cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a patient unless both of the following occur:

1. The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat.

2. The mental health provider fails to take reasonable precautions.

B. A.R.S. § 36-517.02 provides that any duty of a behavioral health provider to take reasonable precautions to prevent harm threatened by a patient is discharged when the behavioral health provider:

1. Communicates when possible the threat to all identifiable victims,

2. Notifies a law enforcement agency in the vicinity where the patient or any potential victim resides,

3. Takes reasonable steps to initiate voluntary or involuntary hospitalization, if appropriate, or

4. Takes other precautions that a reasonable, prudent behavioral health provider would take under the circumstances.

C. This statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a patient under certain circumstances: The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a patient when a patient has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a patient is likely to cause harm, and the behavioral health provider discloses a confidential communication made by or relating to the patient to reduce the risk of harm.
All providers, regardless of their specialty or area of practice, have a duty to protect others against a member’s potential danger to self and/or danger to others. When a provider determines, or under applicable professional standards, reasonably should have determined, that a patient poses a serious danger to self or others, the provider must exercise care to protect others against imminent danger of a patient harming him/herself or others. The foreseeable victim need not be specifically identified by the member, but he/she may be someone who would be the most likely victim of the member’s dangerous conduct.

The responsibility of behavioral health provider to take reasonable precautions to prevent harm threatened by a member may include any of the following:

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 AMPM Policy 320-U, or
4. Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

Tracking and Trending of Quality of Care Issues

A. The AdSS must develop and implement a system to document, track, trend, and evaluate complaints and allegations received from members and providers or as requested by AHCCCS, inclusive of quality care, quality of service and immediate care need issues.

B. The data from the quality of care data system must be analyzed and evaluated to determine any trends related to the quality of care or service in the AdSS’s service delivery system or provider network. The AdSS must incorporate trending of quality of care issues in determining systemic interventions for quality improvement.

C. The Division documents quality tracking and trending information and documentation that the information was submitted, reviewed, and considered for action by the Division’s Quality Committee and Chief Medical Officer, as Chairman of the QM Committee.

D. The AdSS submits quality tracking and trending information from all closed quality of care issues within the reporting quarter to the Division’s QM Unit, utilizing the Quarterly Quality Management Report template provided by AHCCCS. The report is due 30 days after the end of each quarter, the Division line(s) of business must be reported separately and must include the following reporting elements:

1. Types and number/percentages of substantiated quality of care issues
2. Intervention implemented to resolve and prevent similar incidents
3. Resolution status of "substantiated," "unsubstantiated," and "unable to
substantiate” quality of care issues.

If significant negative trends are noted, the AdSS may consider developing performance improvement activities focused on the topic area to improve the issue resolution process itself, and to make improvements that address other system issues raised during the resolution process.

E. The AdSS submits to the Division all pertinent information regarding an incident of abuse, neglect exploitation, unexpected death (including all unexpected transplant deaths), and other serious incidents as determined by the Division or AHCCCS, via a written Incident Report to the Division no later than 24 hours after becoming aware of the incident. For more information regarding Incident Reporting see Section 6002 in the Division’s Operations Policy Manual. Pertinent information must not be limited to autopsy results and must include a broad review of all issues and possible areas of concern. Delays in receipt of autopsy results must not result in delays of the AdSS’s investigation of a quality of care concern. Delayed autopsy results must be used by the AdSS to confirm the resolution of the quality of care concern.

F. The AdSS must ensure member health records are available and accessible to authorized staff of its organization and to appropriate state and federal authorities, or their delegates, involved in accessing quality of care/service or investigating member or provider quality of care concerns, complaints, allegation of abuse, neglect exploitation, serious incidents, grievances, Provider Preventable Conditions and Healthcare Acquired Conditions (HCAC). Member record availability and accessibility must be in compliance with federal and state confidentiality laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) and CFR 431.300 et seq.

G. The AdSS must maintain information related to coverage and payment issues for at least five years following final resolution of the issue and must be made available to the member, provider, and/or Division or AHCCCS authorized staff upon request.

H. The AdSS must proactively provide care coordination for members who have multiple complaints regarding services.

**Provider-Preventable Conditions**

A. Payments are prohibited for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC).

If an HCAC or OPPC is identified, the AdSS must:

1. Conduct a quality of care investigation, and maintain case files containing findings..

2. Report the occurrence and results of the investigation to the Division’s QM Unit quarterly, as specified in the Contract.
B. The terms HCAC and OPPC are defined as follows:

1. Health Care Acquired Condition (HCAC) – means a Hospital Acquired Condition (HAC) under the Medicare program that occurs in any inpatient hospital setting and is not present on admission. (Refer to the current CMS list of Hospital-Acquired Conditions, located at www.cms.gov.)

2. Other Provider Preventable Conditions (OPPC) – means a condition occurring in the inpatient and outpatient health care setting which is limited to the following:
   a. Surgery on the wrong member
   b. Wrong surgery on a member
   c. Wrong site surgery.
970 PERFORMANCE MEASURES

EFFECTIVE DATE: October 1, 2019
REFERENCE: 42 CFR 438.330, 42 CFR 438.334(a) (1) and (2) and (3); AHCCCS Medical Policy Manual, Appendix A, EPSDT and Adult Quarterly Monitoring Report Instructions and Templates; Section F3, Contractor Chart of Deliverables

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

The Division of Development Disabilities (Division) uses AHCCCS’s performance metrics and measures, when monitoring the Administrative Services Subcontractors (AdSS) ability to meet contractual requirements related to the delivery of care and services to members.

**Triple Aim**

In the metric performance measure set, attention was paid to the goals coined by the Institute for Health Improvement (IHI) and adopted by the Centers for Medicare and Medicaid Services, which is called the “Triple Aim.” IHI defines the Triple Aim as a “framework for optimizing health system performance.” There are three components to the Triple Aim:

A. Improve the experience and outcomes of care.
B. Improve the health of populations.
C. Reduce the per capita costs of healthcare.

The components of the Triple Aim must be balanced in order to reach the overarching goal of optimizing the healthcare system. In order to achieve the Triple Aim, an accurate, reliable and valid health information system is necessary and required. The health information analytics system must be able to aggregate and analyze clinical, service, financial, and patient experience of care data in order to standardize best practices, implement targeted interventions and track improvement over time.

Examples of how the three components of the Triple Aim may be implemented include:

A. Improve the experience of care.

   Offer incentives and penalties to improve the experience of care, such as:
   1. Meeting the Value-Based Payment (VBP) patient satisfaction goals
   2. The Consumer Assessment of Healthcare Providers and Services (CAHPS)
B. Improve the health of populations.

1. Provide payment based on quality, such as:
   a. Achieving quality metrics
   b. Meeting pay-for-performance/quality or value based purchasing metrics.

2. Establish opportunities for clinically integrated care via:
   a. Implementation/use of the Health Information Exchange
   b. Increased use of electronic health records
   c. Creating disease registries
   d. Providing clinician and member portals
   e. Offering Patient Centered Medical Homes
   f. Using Accountable Care Organizations
   g. Providing population health initiatives that:
      i. Support and encourage patient engagement.
      ii. Incorporate mobile applications for patients achieving health goals.

C. Reduce the cost of health care reform delivery and payment systems to provide better care in a cost-efficient manner by:

1. Structuring payment based on quality
2. Rewarding increased access to care
3. Developing methods to use electronic health records for care coordination and quality improvement.

Core/Measure Sets Healthcare Effectiveness Data and Information Set

The Division uses delegated AHCCCS’s Performance Measures based on the Centers for Medicare and Medicaid Services (CMS) Core/Measure Sets Healthcare Effectiveness Data and Information Set (HEDIS-like) developed by the National Committee for Quality Assurance (NCQA), or other methodologies, as an integral component of its Quality Management/Performance Improvement (QM/PI) program. Each AdSS is expected to use the same performance measures.
The Division may also add additional performance measures. Examples of areas that may be measured include maternal and child health services, wellness and screening services, disease management processes, readmissions, emergency department, use of services, and non-clinical areas such as access to care, placement at appropriate level of care, supervision of providers, provider turnover, interpreter services, and cultural competency.

The measures will consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. The measures will support and align with an AdSS’s quality assessment and performance improvement program (42 CFR 438.330).

The performance measures are used to evaluate whether the AdSS is fulfilling key contractual obligations. Such performance measures established or adopted by AHCCCS are also an important element of the approach to transparency in health services and value-based purchasing. Performance is publicly reported on the AHCCCS website such as in its report cards and rating systems, and through other means, such as sharing of data with state agencies and other community organizations and stakeholders. The performance of the Division’s ADSS is compared to AHCCCS requirements and to national Medicaid and commercial health plan means as well as goal established by the Centers for Medicare and Medicaid Services.

CMS may, in consultation with states and other stakeholders, specify standardized performance measures and topics for performance improvement projects (PIPs) for inclusion alongside state- specified measures and topics in state contracts (42 CFR 438.330[a][2]). The AdSS is required to participate in performance measures and performance improvement projects that are mandated by CMS.

Performance Measures must be reported to the Division’s Quality Management Unit as specified in Section F3, Contractor Chart of Deliverables. Performance measures must be analyzed and reported separately, by line of business. In addition, the AdSS should evaluate performance based on sub-categories of populations when reasonable to do such.

**QUALITY RATING SYSTEM**

The Division has adopted AHCCCS’ quality rating system to provide additional oversight and guidance to AdSS. The quality rating system will measure and report on performance data collected from each contractor on a standardized set of measures that will be determined by CMS as well as state identified measures. The components of the rating system will be based on three summary indicators: (1) Clinical quality management, (2) Member experience, and (3) Plan efficiency, affordability, and management (42 CFR 438.334[a] [1] and [2] and [3]).
**Quality Management Performance Measure Requirements**

The AdSS must comply with Division and AHCCCS quality management requirements to improve performance in all Division and AHCCCS established performance measures. Descriptions of the AHCCCS Clinical Quality Performance Measures can be found in the most recently published reports of Acute Care Performance Measures located on the AHCCCS website. All performance measure descriptions, forms, and methodologies for specific measures, can also be found on the AHCCCS Performance Measures website. The AdSS is responsible for applying the correct performance measure methodologies including the CMS-416 methodology for its internal monitoring of performance measure results.

The AdSS must:

A. Achieve at least the Minimum Performance Standards (MPS) established by the Division or AHCCCS for each measure, based on the rate calculated by AHCCCS or,

B. Develop an evidence-based Corrective Action Plan (CAP) for each measure not meeting the MPS to bring performance up to at least the minimum level established by the Division or AHCCCS.

**Plan Do Study Act and Repeat Cycle**

1. **Plan:** Plan the change(s) or intervention(s), including a plan for collecting data. State the objective(s) of the intervention(s).

2. **Do:** Try out the intervention(s) and document any problems or unexpected results.

3. **Study:** Analyze the data and study the results. Compare the data to predictions and summarize what was learned.

4. **Act:** Refine the change(s)/intervention(s), based on what was learned, and prepare a plan for retesting the intervention(s).

5. **Repeat:** Continue the cycle as new data becomes available until improvement is achieved.

C. Receive Division approval prior to implementation. Each CAP must minimally require the actions described below.

1. Document the results of an evaluation of existing interventions to achieve Division and AHCCCS performance standards, including barriers to use of services and/or reasons why the interventions have not achieved the desired effect (Plan).

2. Identify new or enhanced interventions that will be implemented in order to bring performance up to at least the minimum level established by the Division and AHCCCS, including evidence-based practices that have been shown to be effective in the same/similar populations (Plan).
3. Demonstrate that the AdSS is allocating increased administrative resources to improving rates for a particular measure or service area (Do).

4. Identify staff positions responsible for implementing/overseeing interventions with specific timeframes for implementation (Do).

5. Provide a means for measuring the results of new/enhanced interventions on a frequent basis (Study).

6. Provide a means for refining interventions based on what is learned from testing different approached or activities (Act).

7. Describe a process for repeating the cycle until the desired effect – a rate that meets or exceeds the minimum level established by the Division and AHCCCS is achieved.

D. Monitor and report to the Division the status of and any discrepancies identified in encounters submitted to and received by the Division including paid, denied, and pended encounters for purposes of Performance Measure monitoring. The AdSS is responsible for monitoring encounter submissions by its subcontractors.

E. Shows demonstrable improvement from year to year, which is sustained over time, in order to meet goals for performance established by the Division and AHCCCS.

F. Comply with national performance measures and levels that may be identified and developed by the CMS in consultation with AHCCCS or relevant stakeholders.

1. The AdSS’s QM/PI Program must internally measure and report to the Division its performance for contractually mandated performance measures, using standardized methodology established or adopted by the Division or AHCCCS. These results should be reported to AHCCCS and the Division’s Compliance Unit using the Early Periodic Screening, Diagnosis and Treatment (EPSDT) and adult quarterly monitoring report as adopted by the Division. Refer to AHCCCS Medical Policy Manual Appendix A (EPSDT and Adult Quarterly Monitoring Report Instructions and Templates) for more details. The AdSS calculated and/or reported rates will be used strictly for monitoring the effectiveness of the AdSS actions/interventions and will not be used by the Division or AHCCCS for official reporting or for corrective action purposes.

2. The AdSS must use the results of the Division and AHCCCS performance measure in evaluating its quality assessment and performance improvement program.

3. The AdSS must shows demonstrable and sustained improvement toward meeting Division and AHCCCS Performance Standards. The Division may impose sanctions on an AdSS that does not show statistically significant improvement in a measure rate as calculated by the Division or AHCCCS. Sanctions may also be imposed for statistically significant declines of rates, even if they meet or exceed the MPS, for any rate that does not meet the Division or AHCCCS MPS, or at a rate, that has significant impact to the
aggregate rate for the State. The Division may require the AdSS to demonstrate that it is allocating increased administrative resources to improving rates for particular measure or service area. The Division may also require a CAP for measures that are below the MPS or that show a statistically significant decrease in its rate, even if it meets or exceeds the MPS.

G. The AdSS may be directed to collect all or some data used to measure performance as required by the Division or AHCCCS. In such cases, qualified personnel must be used to collect data and the AdSS must ensure inter-rater reliability if more than one person is collecting and entering data. The AdSS must submit specific documentation as requested by the Division, to verify that indicator criteria were met.

H. AdSS rates for each measure will be compared with the MPS specified in the contract in effect during the applicable measurement period.
980 PERFORMANCE IMPROVEMENT PROJECTS

EFFECTIVE DATE: October 1, 2019
REFERENCES: 42 CFR 438.330, Section F3, Contractor Chart of Deliverables
DELIVERABLES: Performance Improvement Project (PIP) Reports – Baseline, Intervention, or Re-measurement based on applicable reporting year; Performance Improvement Project (PIP) Reports – Final; Performance Improvement Project (PIP) Reports – as Requested

This policy applies to the Division’s Administrative Services Subcontractors (AdSS).

Overview

The Administrative Services Subcontractors (AdSS) of the Division of Developmental Disabilities (Division) must participate in Performance Improvement Projects (PIPs) selected by the Division and AHCCCS. The AdSS may also select and design, with Division approval, additional PIPs specific to needs identified through internal monitoring of trends and data. Topics take into account comprehensive aspects of member’s needs, care, and services for a broad spectrum of members or a focused subset of the population. When developing quality assessment and PIPs, the Division and its AdSS must consider all populations and services covered when selecting PIPs.

The Division may also mandate that a PIP be conducted by an AdSS according to standardized methodology.

The Centers for Medicare and Medicaid Services (CMS) in consultation with AHCCCS, states, and other stakeholders, specify standardized performance measures and topics for PIPs for inclusion with state-specified measures and topics in state contracts. The AdSS must participate in performance measures and PIPs that are mandated by CMS.

Performance Improvement Projects (PIPs) Design

A. PIPs are designed, through ongoing measurement and intervention, to achieve:
   1. Demonstrable improvement, sustained over time, in significant aspects of clinical care and nonclinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction
   2. Correction of significant systemic problems.

B. Clinical focus topics may include:
   1. Primary, secondary, and/or tertiary prevention of acute conditions
   2. Primary, secondary, and/or tertiary prevention of chronic conditions
   3. Care of acute conditions
   4. Care of chronic conditions
   5. High-risk services
6. Continuity and coordination of care.

C. Nonclinical focus topics may include:
   1. Availability, accessibility, and adequacy of the Division’s service delivery system
   2. Cultural competency of services
   3. Interpersonal aspects of care (e.g., quality of provider/member encounters)
   4. Appeals, grievances, and other complaints.

D. Behavioral health topics may include:
   1. A change in behavioral health status or functional status
   2. A change in member satisfaction.

E. PIP methodologies are developed according to 42 CFR 438.330, Quality Assessment and Performance Improvement Programs for Medicaid Managed Care Organizations. The Division has adopted AHCCCS’s protocol for developing and conducting PIPs, see Attachment 980-A in the AHCCCS Medical Policy Manual.

Data Collection Methodology

Assessment of the AdSS’s performance on the selected measures will be based on systematic, ongoing collection and analysis of the most accurate, valid and reliable data, as collected and analyzed by the Division and AHCCCS. The AdSS may be directed to collect all or some of the data used to measure performance. The AdSS must ensure inter-rater reliability if more than one person is collecting and entering data. The AdSS must submit specific documentation to verify that indicator criteria were met.

Measurement of Demonstrable Improvement

A. The AdSS must initiate interventions that result in significant demonstrable improvement, sustained over time, in its performance for the performance indicators being measured. Improvement must be evidenced in repeated measurements of the indicators specified for each PIP undertaken by the AdSS.

B. The AdSS must meet benchmark levels of performance defined in advance by the Division or AHCCCS.

C. The AdSS will have demonstrated improvement when:
   1. It meets or exceeds the Division or AHCCCS’ overall average for the baseline measurement if its baseline rate was below the average and the increase is statistically significant.
   2. It shows a statistically significant increase if its baseline rate was at or above the Division or AHCCCS overall average for the baseline measurement, or
3. It is the highest performing (benchmark) plan in any remeasurement and maintains or improves its rate in a successive measurement.

D. The AdSS will have demonstrated sustained improvement when:
   1. The AdSS maintains or increases the improvements in performance for at least one year after the improvement in performance is initially achieved.
   2. The AdSS must demonstrate how the improvement can be reasonably attributable to the interventions undertaken by the organization.

**Performance Improvement Projects (PIPs) Timeframes**

A. The AdSS must initiate mandated PIPs on the date established by the Division or AHCCCS. Baseline data will be collected and analyzed at the beginning of the PIP.

B. During the initial year of a mandated PIP, the AdSS will implement interventions to improve performance, based on an evaluation of barriers to care/use of services and evidence-based approaches to improving performance, as well as any unique factors such as its membership, provider network, or geographic area(s) served. The Division or AHCCCS may provide baseline data, and may provide additional data by race/ethnicity, and/or geographic area, which may assist the AdSS in refining interventions.

C. The AdSS should use a Plan-Do-Study-Act (PDSA) cycle to test changes (interventions) quickly and refine them as necessary. The rapid cycle improvement process is implemented in as short a time frame as practical based on the PIP topic. (See description of PDSA cycle in Policy 970 in this Chapter.)

D. The Division conducts annual measurements to evaluate the AdSS performance, and may conduct interim measurements, depending on the resources required to collect and analyze data.

E. The AdSS’s participation in the mandated PIP will continue until demonstration of significant improvement is sustained for at least one year.

**Performance Improvement Projects (PIPs) Reporting Requirements**

A. Annually, the AdSS must report to the Division its interventions, analysis of interventions and internal measurements, changes or refinements to interventions and actual or projected results from repeat measurements.

B. The Division has adopted AHCCCS’s Performance Improvement Project (PIP) Report, Exhibit 980-B in the AHCCCS Medical Policy Manual. This template must be used to submit the annual reports, as specified in Section F3, Contractor Chart of Deliverables, which are due with the AdSS’s annual Quality Management Plan and Evaluation.
1000 CHAPTER DELIVERABLES

Deliverables specific to individual Policies are identified in those individual Policies.

Deliverables related to this Chapter as a whole include:

1. HIV Specialty Provider List
2. Non-Transplant and Catastrophic Reinsurance
3. Outpatient Commitment COT Monitoring
4. Pregnant Women and Post-Partum
5. Prescription Drug Utilization Report
6. Transplant Log
1010 MEDICAL MANAGEMENT ADMINISTRATIVE REQUIREMENTS

EFFECTIVE DATE: October 1, 2019

REFERENCES: A.R.S. § 36-2907; A.A.C. R9-22-201 et seq.; 42 CFR 438.210(b)(3) and 406(a)(3); AMPM Appendix C Medical Management (MM) Plan Checklist and Appendix G Medical Management (MM) Work Plan Guide and Template; Section F3, Contractor Chart of Deliverables

DELIVERABLES: MM/UM Plan and Evaluation

The Division contracts with Administrative Services Subcontractors (AdSS) and delegates responsibility of implementation of this policy.

Medical Management Plan

A. The AdSS must develop a written Medical Management (MM) Plan that describes the methodology used to meet or exceed the standards and requirements of its contract with the Division and this Chapter.

B. The AdSS must submit the MM Plan, and any subsequent modifications, to the Division for review and approval prior to implementation. The AdSS must use AMPM Appendix C Medical Management (MM) Plan Checklist and Appendix G Medical Management (MM) Work Plan Guide and Template in the AHCCCS Medical Policy Manual, as adopted by the Division. Specific page numbers must be indicated on the checklist that specify where the required information can be found in the MM Plan narrative. The plan will not be accepted if the checklist is not included at the time of submission.

C. At a minimum, the MM Plan must describe, in detail, the MM program and how program activities assure appropriate management of medical care service delivery for enrolled members. MM Plan components must include:

1. A description of the AdSS’s administrative structure for oversight of its MM program as required by this policy, including the role and responsibilities of:
   a. The governing or policy-making body
   b. The MM committee
   c. The AdSS Executive Management
   d. MM program staff

2. An organizational chart that delineates the reporting channels for MM activities and the relationship to the AdSS Medical Director and Executive Management

3. Documentation that the governing or policy-making body has reviewed and approved the MM Plan

4. Documentation that appropriately qualified, trained and experienced personnel are employed to effectively carry out MM program functions and
meet qualification required by this policy

5. The AdSS’s specific MM goals and measurable objectives as required by Division’s Medical Policy Manual, Policy 1020.

6. Documentation of how the following processes are implemented and monitored to ensure quality and cost-effective care is provided to members in compliance with state and federal regulations:
   a. MM Utilization Data Analysis and Data Management
   b. Concurrent Review
   c. Discharge Planning
   d. Prior Authorization
   e. Inter-Rater Reliability
   f. Retrospective Review
   g. Clinical Practice Guidelines
   h. New Medical Technologies and New Uses of Existing Technologies
   i. Case Management/Care Coordination
   j. Disease/Chronic Care Management
   k. Drug Utilization Review

7. The AdSS’s method(s) for monitoring and evaluating its service delivery system and provider network that demonstrates compliance with Division’s Medical Policy Manual, Policy 1020

8. A description of how delegated activities are integrated into the overall MM program and the methodologies for oversight and accountability of all delegated functions, as required by this policy

9. Documentation of input into the medical coverage policies from the AdSS or affiliated providers and members

10. A summary of the changes made to the AdSS’s list of services requiring prior authorization and the rationale for those changes.
**MM Work Plan**

The AdSS is responsible for developing a work plan that identifies the goals, methodology for improvement, and monitoring efforts related to the MM program requirements outlined in Division’s Medical Policy Manual, Policy 1020 in this Manual. The work plan must:

A. Be submitted in an acceptable format on the template adopted by the Division and provided by AHCCCS

B. Support the MM Plan goals and objectives

C. Include goals that are quantifiable and reasonably attainable

D. Include specific actions for improvement

E. Incorporate a Plan, Do, Study, Act (PDSA) methodology for testing an action designed to result in a desired improvement in a specific area. Refer to Policy 970 of this Policy Manual for details related to PDSA methodologies.

**MM Evaluation**

A. An annual narrative evaluation of the effectiveness of the previous year’s MM strategies and activities must be submitted to the Division after being reviewed and approved by the AdSS’s governing or policy-making body. The narrative summary of the previous year’s work plan must include but is not limited to:

1. A summary of the MM activities performed throughout the year with:
   a. Title/name of each activity
   b. Desired goal and/or objective(s) related to each activity
   c. Staff positions involved in the activities
   d. Trends identified and the resulting actions implemented for improvement
   e. Rationale for actions taken or changes made
   f. Statement describing whether the goals/objectives were met.

2. Review, evaluation, and approval by the MM Committee of any changes to the MM Plan

3. Necessary follow-up with targeted timelines for revisions made to the MM Plan.

B. The MM Plan and MM Evaluation may be combined or written separately, as long as required components are addressed and easily located.

C. Refer to Section F3, Contractor Chart of Deliverables for reporting requirements and timelines.
**MM Administrative Oversight**

A. The AdSS MM program must be administered through a clear and appropriate administrative structure. The governing or policy-making body must oversee and be accountable for the MM Program. AdSS must ensure ongoing communication and collaboration between the MM program and the other functional areas of the AdSS’s organization (e.g., quality management, member and provider services).

B. The AdSS must have an identifiable and structured MM Committee that is responsible for MM functions and responsibilities, or if the MM Committee is combined with the Quality Management Committee, the agenda items and minutes reflect that MM issues and topics are presented, discussed, and acted upon.

C. At a minimum, the membership must include:
   1. The Medical Director, or appointed designee, as the chairperson of the MM Committee
   2. The MM Manager
   3. Representation from the functional areas within the AdSS’s organization
   4. AdSS staff with experience with Developmental Disabilities, Behavior Health, and medically fragile physical health conditions.
   5. Representation of contracted or affiliated providers.

D. The Medical Director, as chairperson for the MM Committee, or his/her designee, is responsible for the implementation of the MM Plan and must have substantial involvement in the assessment and improvement of MM activities.

E. The MM Committee must ensure that each of its members is aware of the requirements related to confidentiality and conflicts of interest (e.g., a signed statement on file or MM Committee sign-in sheets with requirements noted).

F. The frequency of MM Committee meetings must be sufficient to demonstrate that the MM Committee monitors all findings and required actions. At a minimum, the MM Committee must meet quarterly.

G. MM Committee meeting minutes must include the data reported to the MM Committee, and analysis and recommendations made by the MM Committee. Data, including utilization data, may be attached to the MM Committee meeting minutes as separate documents if the documents are noted in the MM Committee meeting minutes. Recommendations made by the MM Committee must be discussed at subsequent MM Committee meetings. The MM Committee must review the MM program objectives and policies annually and updates them as necessary to ensure:
   1. The MM responsibilities are clearly documented for each MM function/activity.
   2. The AdSS and their providers are informed of the most current MM requirements, policies and procedures in a timely fashion in order to allow for
implementation that does not adversely impact the members or provider community.

3. The AdSS and their providers are informed of information related to their performance (e.g., provider profiling data).

4. The MM policies and procedures, and any subsequent modifications to them, are available upon request by the Division.

H. The MM Program must be staffed with a sufficient number of appropriately qualified personnel to carry out the functions and responsibilities specified in this Chapter.

I. Staff qualifications for education, experience, and training must be developed for each MM position.

J. The grievance process must be part of the new hire and annual staff training, which includes:
   1. What constitutes a grievance
   2. How to report a grievance
   3. The role of the AdSS’s quality management staff in grievance resolution.

K. A current organizational chart is maintained to show reporting channels and responsibilities for the MM program.

L. The AdSS must maintain records that document MM activities, and it must make the information available to the Division upon request. The required documentation includes, but is not limited to:
   1. Policies and procedures
   2. Reports
   3. Practice guidelines
   4. Standards for authorization decisions
   5. Documentation resulting from clinical reviews (e.g. notes related to concurrent review, retrospective review, and prior authorization)
   6. Meeting minutes including analyses, conclusions, and actions required with completion dates
   7. Corrective Action Plans (CAPs) resulting from the evaluation of any component of the MM program such as inter-rater reliability
   8. Other information and data deemed appropriate to support changes made to the scope of the MM Plan.
M. The AdSS must have written policies and procedures pertaining to:

1. Verification that information/data received from providers is accurate, timely, and complete
2. Review of reported data for accuracy, completeness, logic, and consistency, (review and evaluation processes used must be clearly documented)
3. Security and confidentiality of all member and provider information protected by federal and state law
4. Informing of appropriate parties of the MM requirements and updates, utilization data reports, and profiling results.
5. Identification of provider trends and subsequent necessary corrective action regarding over/under utilization of services
6. Quarterly evaluations and trending of internal appeal overturn rates
7. Quarterly evaluations of the timeliness of service request decisions
8. Annual review of prior authorization requirements that encompasses the analysis of prior authorization decision outcomes, including but not limited to, the rationale for requiring prior authorization for types of services such as high dollar, high risk, or case finding for care management.

N. The AdSS must have processes that ensure:

1. Per 42 CFR 438.210(b)(3), qualified health care professionals, with appropriate clinical expertise in treating the enrollee’s condition or disease, render decisions to:
   a. Deny an authorization request based on medical necessity.
   b. Authorize a request in an amount, duration, or scope that is less than requested.
   c. Make a decision involving excluded or limited services under Arizona Revised Statute A.R.S. § 36-2907(B) and A.A.C. R9-22-201 et seq., as specified in this policy.

2. Per 42 CFR 438.406(a)(3), qualified health care professionals, with appropriate clinical expertise in treating the members’ condition or disease, and who have not been involved in any previous level of decision making, will render decisions regarding:
   a. Appeals involving denials based on medical necessity
   b. Grievances regarding denial of expedited resolution of an appeal
   c. Grievances and appeals involving clinical issues.
3. Prompt notifications to the requesting provider and the member or member’s authorized representative or Medical Power of Attorney, as applicable, of any decision to deny, limit, or discontinue authorization of services. The notice includes information as specified in the Division’s AdSS Operations Manual.

4. For purposes of this section, the following qualified health care professionals have the appropriate clinical expertise to render decisions based on previously established Division contractor standards and clinical criteria for skilled and non-skilled services within their scope of practice:
   a. Physician
   b. Podiatrist
   c. Optometrist
   d. Chiropractor
   e. Psychologist
   f. Dentist
   g. Physician assistant
   h. Physical or occupational therapist
   i. Speech-language pathologist
   j. Audiologist
   k. Registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist and certified nurse midwife)
   l. Licensed social worker
   m. Registered respiratory therapist
   n. Licensed marriage and family therapist
   o. Licensed professional counselor.

5. Decision-making includes determinations involving excluded or limited services under A.R.S. § 36-2907 and A.A.C. R9-22-201 et seq.

6. Consistent application of standards and clinical criteria, and ensure consistent decisions that include inter-rater reliability criteria and monitoring of all staff involved in this process. A plan of action must be developed and implemented for staff who fail to meet the inter-rater reliability standards.
O. The AdSS must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its MM Program. Data elements must include but are not limited to:

1. Member demographics
2. Provider characteristics
3. Services provided to members
4. Other information necessary to guide the selection of, and meet the data collection requirements for, improvement activities.

P. The AdSS must oversee and maintain accountability for all functions or responsibilities described in this Chapter that are delegated to other entities. Documentation must be kept on file, for Division review, and the documentation must demonstrate and confirm the following requirements have been met for all delegated functions:

1. A written agreement must be executed that specifies the delegated activities and reporting responsibilities of the entity to the AdSS and include provisions for revocation of the delegation or imposition of sanctions for inadequate performance.
2. The AdSS must evaluate the entity’s ability to perform the delegated activities prior to executing a written agreement for delegation. The delegated agreement must be submitted the contractor review checklist adopted by the Division and located in the AHCCCS Contractor Operations Manual.
3. The performance of the entity and the quality of services provided are monitored on an ongoing basis and formally reviewed

Q. The AdSS must ensure:

1. Compensation to persons or organizations conducting prior or prospective authorization, and concurrent or retrospective review activities are not structured so as to provide inappropriate incentives for selection, denial, limitation or discontinuation or authorization of services.
2. Providers are not prohibited from advocating on behalf of members within the service provision process.
MEDICAL MANAGEMENT (MM) SCOPE AND COMPONENTS

EFFECTIVE DATE: October 1, 2019
DELIVERABLES: Adult and Child Emergency Department (ED) Wait Times; Diabetic Diagnosis Report; Emergency Department Diversion Summary; Inappropriate Emergency Department (ED) Utilization Report; Inpatient Hospital Showings Report; Members in Need of Care Manager; Notification of All Hospital Admissions; Pressure Ulcer Report; Psychiatric Security Review Board (PSRB)/Guilty Except Insane (GEI) Conditional Release Report

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). This policy outlines requirements for the AdSS to develop an integrated process or system that is designed to assure appropriate use of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care from prevention to hospice, including Advanced Care Planning at any age or stage of illness.

Definitions

A. **Advance Care Planning** - Advance care planning is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:

1. Educate the member/guardian/designated representative about the member’s illness and the health care options that are available to them.

2. Develop a written plan of care that identifies the member’s choices for treatment.

3. Share the member’s wishes with family, friends, and his or her physicians.

B. **Arizona State Hospital (AZSH)** - Provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

C. **Autism Spectrum Disorder** - Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication and behavioral challenges.

D. **Conditional Release Plan (CRP)** - If the psychiatric security review board finds that the person still suffers from a mental disease or defect or that the mental disease or defect is in stable remission but the person is no longer dangerous, the board must order the person's conditional release. The person must remain under the board's jurisdiction. The board in conjunction with the state mental health facility and behavioral health community providers must specify the conditions of the person's release. The board must continue to monitor and supervise a person who is released conditionally. Before the conditional release of a person, a supervised treatment plan must be in place, including the necessary funding to implement the plan as outlined in A.R.S. § 13.3994.
E. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

F. End-of-Life Care - A concept of care, for the duration of the member’s life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.

G. Health Care Acquired Condition (HCAC) - A Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.

H. Lennox-Gastaut Syndrome - A progressive disorder that includes refractory seizures, cognitive decline, and functional and behavioral deterioration.

I. Medication Assisted Treatment (MAT) - The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery.

J. Other Provider-Preventable Condition (OPPC) - A condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong member
2. Wrong surgery on a member
3. Wrong site surgery.

K. Practical Support - Non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to; housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.

L. Psychiatric Security Review Board (PSRB) - The psychiatric security review board is established consisting of the following members who are appointed by the governor pursuant to A.R.S. § 38-211 as outlined in A.R.S. § 31-501 experienced in the criminal justice system:

1. One psychiatrist
2. One psychologist

3. One person who is experienced in parole, community supervision or probation procedures

4. One person who is from the general public

5. One person who is either a psychologist or a psychiatrist.

M. **Vivitrol** - An opioid antagonist that blocks opioid receptors in the brain for one month at a time, helping patients to prevent relapse to opioid dependence, following detoxification, while they focus on counseling and treatment.

**Utilization Data Analysis and Data Management**

The AdSS must have in effect mechanisms to review utilization and detect both underutilization and overutilization of services [42 CFR 438.240(b)(3)]. The AdSS must develop and implement processes to collect, validate, analyze, monitor, and report the utilization data. On an ongoing basis, the AdSS’s Medical Management (MM) Committee must review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified. Evaluation must include a review of the impact to both service quality and outcome. The MM Committee must determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address overutilization and underutilization of services must be integrated throughout the organization. All such strategies must have measurable outcomes that are reported in AdSS MM Committee minutes.

For ASD: This measure is used to assess the combined number of child and adolescent psychiatrists, neurodevelopmental pediatricians, and developmental-behavioral pediatricians who have provided any outpatient care to at least one enrolled child, per 1,000 eligible children.

The quarterly deliverable will be a rate that will be expressed in terms of 1,000 eligible children (number of providers/1,000 enrolled children). The eligible population includes children younger than 18 years of age who have been enrolled in a Medicaid program or health plan that includes outpatient specialty care for at least one 90-day period (or 3 consecutive months) within the measurement year and classified to counties of Arizona. Taxonomy codes identify specialists: Child and Adolescent Psychiatrist (2084P0804X), Neurodevelopmental Pediatricians (2080P0008X) and Developmental-Behavioral Pediatricians (2080P0006X). The deliverable will be used to identify critical gaps for effective recognition and treatment for these specific providers.

For Lennox-Gastaut Syndrome: This deliverable is used to collect data on seizure type/syndrome classification which is salient for quality treatment through early identification for those with epilepsy. Infantile spasms are at higher risk to developing Lennox-Gastaut syndrome connected with intellectual disability.

Reportable data to be reported quarterly will be obtained from the population which includes children younger than 18 years of age who have been enrolled in a Medicaid program or health plan that includes outpatient specialty care for at least one 90-day period (or 3 consecutive months) within the measurement year and classified to counties of Arizona.
consecutive months) within the measurement year and classified to counties of Arizona. Members meeting this criterion will be identified by the ICD-10 codes for Infantile Spasms (G40.822) and Lennox-Gastaut Syndrome (G40.812).

**Concurrent Review**

The AdSS must have policies, procedures, processes, and criteria in place that govern the use of services in institutional settings. The AdSS must have procedures for review of medical necessity before a planned institutional admission (precertification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

A. Policies and procedures for the concurrent review process must:

1. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information may include but is not limited to symptoms, diagnostic test results, diagnoses, and required services.

2. Specify timeframes and frequency for conducting concurrent review and decisions:
   a. Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed
   b. Admission reviews must be conducted within one business day after notification is provided to the AdSS by the hospital or institution (this does not apply to pre-certifications) (42 CFR 456.125)

3. Provide a process for review that includes but is not limited to:
   a. Necessity of admission and appropriateness of the service setting
   b. Quality of care
   c. Length of stay
   d. Whether services meet the member needs
   e. Discharge needs
   f. Utilization pattern analysis.

4. Establish a method for the AdSS’s participation in the proactive discharge planning of all members in institutional settings.

B. Criteria for decisions on coverage and medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

1. Medical criteria must be approved by the AdSS’s MM Committee. Criteria must be adopted from national standards. When providing concurrent review, the AdSS must compare the member’s medical information against medical necessity criteria that describes the condition or service.
2. Initial institutional stays are based on the AdSS’s adopted criteria, the member’s specific condition, and the projected discharge date.

3. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay will be assigned a review date each time the review occurs. The AdSS ensures that each continued stay review date is recorded in the member’s record.

4. The AdSS concurrent review staff must coordinate with the inpatient facility’s Utilization Review Department and Business Office, when there is any change to the CRS authorization status or level of care required for CRS members.

5. The AdSS concurrent review staff must notify the AIHP, or DDD concurrent review staff when they become aware that a member who receives CRS is admitted to the hospital.

6. Conversely, the Division’s concurrent review staff will notify the AdSS’s concurrent review staff when they become aware that a member eligible for CRS services is admitted to the hospital.

7. Coordination will include proactive discharge planning between all potential payment and care sources upon completion of the CRS related service, and

8. AdSS must submit the “Contractor Quarterly Showing Report for Inpatient Hospital Services” as specified in Contract. Confirming there were methods and procedures in place as required.

**Discharge Planning**

The AdSS must have policies and procedures in place that govern the process for proactive discharge planning and coordinating services the ADSS furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

The intent of the discharge planning policy and procedure is to increase the management of inpatient admissions, improve the coordination of post discharge services, reduce unnecessary hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge. The AdSS must develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member in order to arrange necessary services and resources for appropriate and timely discharge from a facility. A proactive assessment of discharge needs must be conducted before admission when feasible. Discharge planning must be performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continued post discharge to ensure a timely, effective, safe and appropriate discharge.

The AdSS staff participating in the discharge planning process must ensure the member/guardian/ designated representative, as applicable:

A. Is involved and participates in the discharge planning process
B. Understands the written discharge plan, instructions and recommendations provided by the facility

C. Is provided resources, referrals and possible interventions to meet the member’s assessed and anticipated needs after discharge.

Discharge planning, coordination and management of care must include:

A. Follow-up appointment with the PCP and/or specialist within 7 days

B. Safe and clinically appropriate placement, and community support services

C. Communication of the member’s treatment plan and medical history across the various outpatient providers, including the member’s outpatient clinical team, TRBHA and other contractor when appropriate

D. Prescription medications

E. Medical Equipment

F. Nursing Services

G. End of Life Care related services such as Advance Care Planning

H. Practical supports

I. Hospice

J. Therapies (There are limits for outpatient physical therapy visits for members 21 years of age and older. See Policy 310-X in this Policy Manual.)

K. Referral to appropriate community resources

L. Referral to AdSS’s Disease Management or Care Management (if needed)

M. A post discharge follow-up call to the member within three days of discharge to confirm the member’s well-being and the progress of the discharge plan according to the member’s assessed clinical, behavioral, physical health, and social needs

N. Additional follow-up actions as needed based on the member’s needs

O. Proactive discharge planning when the AdSS is not the primary payer.

**Prior Authorization and Service Authorization**

The AdSS must have an Arizona-licensed prior authorization staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training, to apply the AdSS’s medical criteria or make medical decisions.

Prior authorization is required in certain circumstances.
The AdSS must develop and implement a system that includes at least two modes of delivery for providers to submit prior authorization requests such as telephone, fax, or electronically through a portal on the AdSS’s website.

The AdSS must ensure providers who request authorization for a service are notified that they have the option to request a peer to peer discussion with the AdSS Medical Director when additional information is requested by the AdSS or when the prior authorization request is denied. The AdSS must coordinate the discussion with the requesting provider when appropriate.

The AdSS must develop and implement policies and procedures, coverage criteria and processes for approval of covered services, which include required time frames for authorization determination.

A. Policies and procedures for approval of specified services must:

1. Identify and communicate, to providers, TRBHAs and members, those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization must also be identified. Methods of communication with members include newsletters, AdSS website, and/or member handbook. Methods of communication with providers and TRBHAs include newsletters, AdSS website, and/or provider manual. Changes in the coverage criteria must be communicated to members, TRBHAs and providers 30 days before implementation of the change.

2. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria must be made available to providers and TRBHAs through the provider manual and AdSS website. Criteria must be available to members upon request.

3. Authorize services in a sufficient amount, duration, or scope to achieve the purpose for which the services are furnished.

4. Ensure consistent application of review criteria.


6. Provide decisions and notice as expeditiously as the member’s health condition requires and no later than 72-hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i).

7. Provide for consultation with the requesting provider when appropriate.

8. Review all prior authorization requirements for services, items, or medications annually. The review will be reported through the MM Committee and will include the rationale for changes made to prior authorization requirements. A summary of the prior authorization requirement changes and the rationale for
B. AdSS must develop and implement policies for processing and making determinations for prior authorization requests for medications. The AdSS must ensure the following:

1. A decision to a submitted prior authorization request for a medication is provided by telephone, fax, electronically or other telecommunication device within 24 hours of receipt of the submitted request for prior authorization,

2. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication device within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision must be rendered within seven business days from the initial date of the request,

3. At least a 4-day supply of a covered outpatient prescription drug is provided to the member in an emergent situation. [42 CFR 438.3(s)(6)].

C. The AdSS Criteria for decisions on coverage and medical necessity for both physical and behavioral services must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals.

1. The AdSS may not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the setting, diagnosis, type of illness or condition of the member.

2. The AdSS may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome.

3. The AdSS must have criteria in place to make decisions on coverage when the AdSS receives a request for service involving Medicare or other party payers. The fact that the AdSS is the secondary payer does not negate the AdSS’s obligation to render a determination regarding coverage within the timeframes established in this policy.

Inter-rater Reliability

The AdSS must have in place a process to ensure consistent application of review criteria in making medical necessity decisions which include prior authorization, concurrent review, and retrospective review. Inter-rater reliability testing of all staff involved in these processes must be done at least annually. A corrective action plan must be included for staff that do not meet the minimum compliance goal of 90%.
Retrospective Review

The AdSS must conduct a retrospective review, which is guided by the following.

A. Policies and procedures
   1. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews.
   2. Describe services requiring retrospective review.
   3. Specify time frame(s) for completion of the review.

B. Criteria for decisions on medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

C. A process for consistent application of review criteria

D. Guidelines for Provider-Preventable Conditions

   Title 42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a Health Care-Acquired Condition (HCAC) or an Other Provider-Preventable Condition (OPPC). These terms are defined as follows:

   A member’s health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a “complication.” If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

   If it is determined that the HCAC or OPPC was a result of a mistake or an error by a hospital or medical professional, the AdSS must conduct a quality of care investigation and report the occurrence and results of the investigation to the Division’s Quality Management Unit and the AHCCCS’ Clinical Quality Management Unit.

Clinical Practice Guidelines

A. The AdSS must develop or adopt and disseminate practice guidelines for physical and behavioral health services that:
   1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field
   2. Consider the needs of the AdSS’s members
   3. Are either:
      a. Adopted in consultation with contracting health care professionals and National Practice Standards, or
b. Developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical journals published in the United States when national practice guidelines are not available. Published peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

4. Are disseminated by the AdSS to all affected providers and, upon the request, to members and potential members

5. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply (42 CFR 438.236).

B. The AdSS must annually evaluate the practice guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards.

C. The AdSS must document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines.

New Medical Technologies and New Uses of Existing Technologies

A. The AdSS must develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology. The policies and procedures must include the process and timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an urgent request must be made as expeditiously as the member’s condition warrants and not later than 72 hours from receipt of request.

B. The AdSS must include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.

C. The AdSS must evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.
D. The AdSS must establish:

1. Coverage rules, practice guidelines, payment policies, policies and procedures, utilization management, and oversight that allows for the individual member’s medical needs to be met.

2. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received.

3. A process for documenting the coverage determinations and rationale in the Medical Management Committee meeting minutes.

Care Coordination

The AdSS must establish a process to ensure coordination of member physical and behavioral health care needs across the continuum based on early identification of health risk factors or special care needs, as defined by the AdSS. Coordination must ensure the provision of appropriate services in acute, home, chronic, and alternative care settings that meet the member’s needs in the most cost-effective manner available.

AdSS care managers are expected to have direct contact with members for the purpose of providing information and coordinating care, but they are not performing the day-to-day duties of the assigned Support Coordinator. AdSS care management must occur at the MCO level or TRBHA level and cannot be delegated down to the provider level. AdSS care management is an administrative function.

Care managers identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. AdSS care managers work closely with assigned Support Coordinator to ensure the most appropriate plan and services for members.

The AdSS must develop a plan outlining short- and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs. In addition, the AdSS must develop an outcome measurement plan to track the progress of the strategies. The plan outlining the strategies for improving care coordination and the outcome measurement must be reported in the annual MM Plan, Evaluation and Work Plan submitted to the Division as specified in contract.

A. AdSS must establish policies and procedures that reflect integration of services to ensure continuity of care by:

1. Ensuring that, in the process of coordinating care, each member’s privacy is protected in accordance with the privacy requirements including, but not limited to, [45 CFR Parts 160 and 164, Subparts A and E], Arizona statutes and regulations, and to the extent that they are applicable [42 CFR 438.208 (b)(2) and (b)(4) and 438.224]

2. Allowing each member to select a Primary Care Provider (PCP) who is formally designated as having primary responsibility for coordinating the member’s
overall health care, and a behavioral health provider, if appropriate

3. Ensuring each member has an ongoing source of care appropriate to his or her needs 438.208(b)(1)

4. Ensuring each member receiving care coordination has a person or entity that is formally designated as primarily responsible for coordinating services for the member, such as the assigned Support Coordinator

The member must be provided information on how to contact their designated person or entity [438.208(b)(1)].

5. Specifying under what circumstance services are coordinated by the AdSS, including the methods for coordination and specific documentation of these processes

6. Coordinating the services for members between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays [42 CFR 438.208(b)(2)(i)]

7. Coordinating covered services with the services the member receives from another contractor and/or FFS [42 CFR 438.208(b)(2)(ii) and (iii)]

8. Coordinating covered services with community and social services that are generally available through contracting or non-contracting providers, in the AdSS’s service area

9. Ensuring members receive End of Life Care and Advance Care Planning as specified in Policy 310-HH in this Policy Manual

10. Establishing timely and confidential communication of clinical information among providers, as specified in this Policy Manual

This includes the coordination of member care between the PCP, AdSS, and Tribal Regional Behavioral Health Authority (TRBHA) providers. At a minimum, the PCP must communicate all known primary diagnoses, comorbidities, and changes in condition to the AdSS or TRBHA providers when the PCP becomes aware of the AdSS or TRBHA provider’s involvement in care.

11. Ensuring the AdSS are providing pertinent diagnoses and changes in condition to the PCP in a timely manner

The AdSS must facilitate this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs as follows:

a. “Urgent” – Requests for intervention, information, or response within 24 hours

b. “Routine” – Requests for intervention, information, or response within 10 days.
12. Educating and communicating with PCPs who treat any member with diagnoses of depression, anxiety or Attention Deficit Hyperactivity Disorder (ADHD) that care requirements include but are not limited to:
   a. Expectations described in “4” of this section
   b. Monitoring the member’s condition to ensure timely return to the PCP’s care for ongoing treatment, when appropriate, following stabilization by an AdSS.

13. Ensuring that behavioral health providers provide consultation to a member’s inpatient and outpatient treatment team and/or directly engage the member as part of the AdSS care management program.

14. Ensuring policies reflect care coordination for members presenting for care outside of the AdSS’s provider network.

15. Monitoring controlled and non-controlled medication. The AdSS must restrict members to an exclusive pharmacy or prescriber as specified in Policy 310-FF in the Policy Manual.

16. Meeting regularly with the AdSS to coordinate care for members with high behavioral and physical health needs and/or high costs.

High level AdSS meetings must occur at least every other month or more frequently if needed to discuss barriers and outcomes. Care coordination meetings and staffing meetings must occur at least monthly, or more as often as necessary, to affect change. The AdSS must implement the following:
   a. Identification of High Need/High Cost members as required in contract
   b. Plan interventions for addressing appropriate and timely care for these identified members
   c. Report of outcome summaries to the Division, as specified in Section F3, Contractor Chart of Deliverables.

B. The AdSS must develop policies and implement procedures specific to members who are eligible for the Division, including:

1. Identifying members with special health care needs
2. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member identified as having special health care needs or conditions
3. Ensuring adequate care coordination among providers
4. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member’s condition and identified special health care needs (e.g., a standing referral or an approved number of visits).
C. The AdSS must implement measures to ensure that members receiving care Management:

1. Are informed of particular health care conditions that require follow-up
2. Receive, as appropriate, training in self-care and other measures they may take to promote their own health
3. Are informed of their responsibility to comply with prescribed treatments or regimens.

D. The AdSS must have in place a care management process whose primary purpose is the application of clinical knowledge to coordinate care needs for members who are medically, physically and/or behaviorally complex and require intensive medical and psychosocial support.

The AdSS must develop member selection criteria for care management model to determine the availability of services, and work with the member’s provider(s) or TRBHA. The care manager works with the assigned Support Coordinator, and TRBHA, PCP and/or specialist to coordinate and address member needs in a timely manner. The care manager must continuously document interventions and changes in the plan of care.

E. The AdSS care management individualized care plan will focus on achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The AdSS care manager must also assist the member in identifying appropriate providers, TRBHAs, and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the member and the AdSS.

The AdSS must provide oversight and monitoring of AdSS care management that is subcontracted or inclusive in a providers’ contractual agreement. The AdSS care management role must comply with all Division and AHCCCS requirements.

F. In addition to care coordination as specified in their contract with the Division, the AdSS must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes members who do not meet the AdSS criteria for care management, as well as, members who contact governmental entities for assistance, including the Division and AHCCCS.

The AdSS must identify and coordinate care for members with Opioid Use Disorders and ensure access to appropriate services such as MAT and Peer Support Services.

G. The AdSS must develop and implement policies and procedures to provide high touch care management or other behavioral health and related services to members on Conditional Release from the Arizona State Hospital (AzSH) consistent with the Conditional Release Plan (CRP) issued by the Psychiatric Security Review Board PSRB, including but not limited to assignment to a AdSS care manager. The AdSS may not delegate the care management functions to a subcontracted provider.
The AdSS care manager is responsible for at minimum the following:

1. Coordination with AzSH for discharge planning,
2. Participating in the development and implementation of Conditional Release Plans,
3. Participation in the modification of an existing or the development of a new Individual Service Plan (ISP) that complies with the Conditional Release Plan (CRP),
4. Member outreach and engagement to assist the PSRB in evaluating compliance with the approved CRP,
5. Attendance in outpatient staffing at least once per month, and
6. Care coordination of care with the member’s treatment team, assigned Support Coordinator, TRBHA, and providers of both physical and behavioral health services to implement the ISP and the CRP,
7. Routine delivery of comprehensive status reporting to the PSRB,
8. Attendance in a monthly conference call with Division Health Care Services,
9. If a member violates any term of his or her CRP, the AdSS must immediately notify the PSRB and provide a copy to the Division and AzSH, and
10. The AdSS further agrees and understands it must follow all obligations, including those stated above, applicable to it as set forth in A.R.S. § 13-3994.

Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medications not prescribed to the member must be reported to the PSRB and the AzSH immediately.

The AdSS must submit a monthly comprehensive status report for members on Conditional Release to the PSRB and Division Health Care Services, as specified in Contract using AHCCCS Medical Policy Manual (AMPM) Attachment 1020-A. The AdSS must provide additional documentation at the request of the Division’s Health Care Services. If a member’s mental status renders him/her incapable or unwilling to manage his/her medical condition and the member has a skilled medical need, the AdSS must arrange ongoing medically necessary nursing services in a timely manner.

H. The AdSS must identify and track members who use Emergency Department (ED) services inappropriately four or more times within a six-month period. Interventions must be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service.

AdSS care management interventions to educate members should include, but are not limited to:
1. Outreach phone calls/visits
2. Educational Letters
3. Behavioral Health referrals
4. High Need/High Cost Program referrals
5. Disease Management referrals

The AdSS must submit the bi-annual ED Diversion Report to the Division as specified in Contract. The report must identify the number of times the AdSS intervenes with members.

I. The AdSS must monitor the length of time adults and children wait to be discharged from the Emergency Department (ED) while awaiting behavioral health placement or wrap around services. Immediately upon notification that a member who needs behavioral health placement or wrap around services is in the ED, the AdSS must coordinate care with the ED and the member’s treatment team including the assigned Support Coordinator to discharge the member to the most appropriate placement or wrap around services. Additionally, the AdSS must submit the Adult and Child ED Wait Times Report using AMPM Attachment 1020-B as required in the AdSS Contract, Section F3, Contractor Chart of Deliverables.

J. The Division will lead reach-in care coordination efforts due to the low volume of members with justice system involvement. However, the Contractor is required to assist the Division in justice system “reach-in” care coordination efforts as directed by the Division. Reach-in care coordination activities are conducted for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. The Division initiates reach-in care coordination activities, with the assistance of the Contractor, when notified of a member’s anticipated release date. The Contractor’s care management protocols for members involved in reach-in care coordination shall be consistent with the Division’s Medical Policy Manual, Chapter 500.

The Contractor must notify the Division upon becoming aware that a member may be an inmate of a public institution when the member’s enrollment has not been suspended. The Division adjusts eligibility dates based upon AHCCCS’ notification of incarceration in AHCCCS’ 834 files sent to the Division, and capitation is adjusted as specified in Contract. In addition to the care coordination requirements, the Contractor shall also utilize the renewal date information to identify incarcerated members that may have missed their eligibility redetermination date while incarcerated causing a discontinuance of benefits and provide assistance with reapplication for AHCCCS Medical Assistance upon release.

K. The AdSS must develop policies and processes to collaborate with the Arizona Department of Corrections (ADC) in Maricopa County to provide care management to members enrolled in the Governor’s Vivitrol Treatment Program, as required by Executive Order 2017-01. The Vivitrol treatment program will only be initiated for
individuals being released from prison to Maricopa County. Individuals who have been determined eligible for Vivitrol treatment will receive a monthly injection of Vivitrol for up to 12 months to treat opioid dependence. Vivitrol will not be prescribed to pregnant or breast feeding women.

The AdSS must designate a care manager to provide care management to members enrolled in the Vivitrol treatment program.

Upon notification from the ADC Reentry Planner that a member is enrolled in the program and will be released in 30 days, the designated AdSS care manager will collaborate with the Reentry Planner and the ADC provider to determine the member’s appropriateness for participation in the Vivitrol treatment program. To qualify for entry into the program individuals must be eligible for Medicaid, commit to participate in the program both pre and post release and sign necessary releases of information and consent to participate, as well as:

1. Have a history of opioid dependence.
2. Be identified as a potential candidate for the program at least 30 days before release.
3. Commit to participate in substance use counseling pre and post release and Medication Assisted Treatment (MAT).
5. Pass urinalysis tests.
6. Pass the Naloxone challenge test (to be done three to seven days before first injection).
7. Be screened for physical and/or behavioral health comorbidities that may make the member ineligible for Vivitrol.
8. Be free from any medical conditions which contraindicate participation.
9. Be administered the Vivitrol two to three days before release.
10. Be released to the community under either county or ADC community supervision
11. Be released to Maricopa County.

The AdSS care manager must also:

1. Confirm that the member received pre-release counseling and is scheduled for post release counseling and MAT related to Vivitrol treatment from the ADC provider.
2. Coordinate the referral with the MAT specialist who has agreed to prescribe and administer the post-release Vivitrol.
3. Provide accessibility to Naloxone and substance use treatment. Naloxone will be provided to whoever supports the member. If the member has no formal or informal support, the Naloxone will be provided directly to the member with instructions for the purpose and use by the provider within 72 hours following release from incarceration.

4. Act as a liaison between the ADC provider responsible for administering the first injection of Vivitrol and the MAT specialist.

5. Schedule a post release appointment with the MAT specialist within seven days of administration of last injection.

6. Schedule counseling and other needed behavioral health services as applicable.

7. Support the MAT specialist in identifying an alternate treatment if Vivitrol is not the appropriate course of treatment.

The AdSS must submit a semi-annual Vivitrol Treatment Program Report to the Division as specified in Contract. The report must identify:

1. The name of the member participating in the program
2. The member’s ADC # and AHCCCS ID
3. The date of the member’s first injection
4. The date the member was released from prison
5. The name of the post release prescriber
6. First appointment and then track monthly appointment (Received second shot and engaged in treatment in the first month)
7. Length of stay in treatment (e.g., end date)
8. Vivitrol end date and reason
9. If member decides to change medication
10. Compliance with treatment (e.g., regular drug screens)
11. Report on data monthly
12. Member satisfaction
13. Overdose/death and reason
14. Successfully completed their term of supervision
15. Recidivism
16. Positive drug screen
17. Emergency department
18. Hospital admission.

**AdSS Disease/Chronic Care Management**

The AdSS must implement a Disease/Chronic Care Management Program that focuses on members with high risk and/or chronic conditions that have the potential to benefit from a concerted intervention plan. The goal of the Disease/Chronic Care Management Program is to increase member self-management and improve practice patterns of providers, thereby improving healthcare outcomes for members.

A. The AdSS’s MM Committee must focus on selected disease conditions (e.g., Diabetes, Pneumonia admissions/ER visits, or constipation admissions/ER visits) based on use of services, needs and trends, at risk population groups, and high volume/high cost conditions to develop the Disease Management Program.

B. The Disease Management Program must include, but is not limited to:

1. Members at risk or already experiencing poor health outcomes due to their disease burden

2. Health education that addresses the following:
   a. Appropriate use of health care services
   b. Health risk-reduction and healthy lifestyle choices including tobacco cessation
   c. Screening for tobacco use with the Ask, Advise, and Refer model and refer to the Arizona Smokers Helpline using the proactive referral process
   d. Self-care and management of health conditions, including wellness coaching
   e. Self-help programs or other community resources that are designed to improve health and wellness
   f. EPSDT services for members including education and health promotion for dental/oral health services
   g. Maternity care programs and services for pregnant women including family planning

3. Interventions with specific programs that are founded on evidence based guidelines

4. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified members’ ability to self-manage their
disease and measurable outcomes

5. Methods for supporting both the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and an understanding of and adherence to the plan of care.

6. Components for providers include, but are not limited to:
   a. Education regarding the specific evidenced based guidelines and desired outcomes that drive the program
   b. Involvement in the implementation of the program
   c. Methodology for monitoring provider compliance with the guidelines
   d. Implementation of actions designed to bring the providers into compliance with the practice guidelines.

**Drug Utilization Review**

Drug Utilization Review (DUR) is a systematic, ongoing review of the prescribing, dispensing and use of medications. The purpose of DUR is to assure efficacious, clinically appropriate, safe, and cost-effective drug therapy to improve member health status and quality of care.

The AdSS must develop and implement a system, including policies and procedures, coverage criteria and processes for their DUR programs.

A. Criteria for decisions on coverage and medical necessity must be clearly documented and based on the scientific evidence and standards of practice that include, but are not limited to, peer-reviewed medical literature, outcomes research data, official compendia, or published practice guidelines developed by an evidence-based process.

B. AdSS must manage a DUR program that includes, but is not limited to:

1. Prospective review process for:
   a. All drugs before dispensing. This review process may be accomplished at the pharmacy using a computerized DUR system. The DUR system, at minimum, must be able to identify potential adverse drug interactions, drug-pregnancy conflicts, therapeutic duplication and drug-age conflicts
   b. All non-formulary drug requests.

2. Concurrent drug therapy of selected members to assure positive health outcomes

3. Retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse
The review process serves as a means of identifying and developing prospective standards and targeted interventions.

4. Pattern analyses that evaluates clinical appropriateness, over and underutilization, therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products and mail order medications.

5. Provision for education of prescribers and AdSS professionals on drug therapy problems based on utilization patterns with the aim of improving safety, prescribing practices and therapeutic outcomes. The program must include a summary of the educational interventions used and an assessment of the effect of these educational interventions on the quality of care.
| Health Plan | AHCCCS ID | Consume Name | DOB | PCP First Name | PCP Last Name | PCP Address | PCP City | PCP State | PCP Zip | PCP Phone Number | New ICD 10 Code | Note | Most Recent Hb A1c Result | Most Recent Hb A1c Date | Diabetes Medication 1 | Diabetes Medication 2 | Diabetes Medication 3 | Insulin Pen | Insulin Pump | Comments |
|-------------|------------|--------------|-----|----------------|---------------|-------------|--------|----------|--------|------------|----------------|------|---------------------|---------------------|---------------------|---------------------|---------------------|-----------------|-------------|-----------|-----------|
|             |            |              |     |                |               |             |        |          |        |            |                |      |                     |                     |                     |                   |                 |                |            |            |           |
# Emergency Department (ER) Diversion Reporting Tool

**Reporting Period:**
**Contractor Name:**
**Date Submitted:**

| Total Number of Members Utilizing ED Inappropriately 4 x in 6 months | Case Management Interventions |
|---|---|---|---|---|---|
| | Outreach Calls/Visits | Educational Letters | Referral to Behavioral Health | Referral to High Need/High Cost Program | Assignment to Exclusive Pharmacy | Disease Management |

**INSTRUCTIONS**

In accordance with SB 1034, please report total numbers in each category. This is not a member specific report. It is expected that each member will have more than one intervention. The interventions listed above are not listed in order of occurrence or priority. This report must be submitted bi-annually on October 15th and April 15th.
### Notification Of All Hospital Admissions

<table>
<thead>
<tr>
<th>Member Last Name</th>
<th>Member First Name</th>
<th>AHCCCS ID #</th>
<th>DOB</th>
<th>Health Plan</th>
<th>Inpatient Facility Name</th>
<th>Level of Care (Type)</th>
<th>Admit Date</th>
<th>Discharge Date</th>
<th>Diagnosis 1</th>
<th>Diagnosis Code 1</th>
<th>Diagnosis 2</th>
<th>Diagnosis Code 2</th>
<th>Inpatient Days per Admission</th>
<th>Current Total Days</th>
<th>Medicare Y/N</th>
<th>TPL Y/N</th>
<th>HCS Nurse</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member ID</td>
<td>Last Name</td>
<td>First Name</td>
<td>County</td>
<td>Diagnosis 1</td>
<td>Dx 1 Desc</td>
<td>Service Type 1</td>
<td>Service Type 2</td>
<td>Month</td>
<td>LOB</td>
<td>LOB Desc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
<td>------------</td>
<td>--------</td>
<td>-------------</td>
<td>-----------</td>
<td>----------------</td>
<td>----------------</td>
<td>-------</td>
<td>-----</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1050 COORDINATION OF CARE WITH OTHER GOVERNMENT ENTITIES FOR
BEHAVIORAL HEALTH SERVICES

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Service Subcontractors (AdSSs). All coordination referenced in this policy applies to members eligible for the Division and ALTCS.

The Division requires the AdSS to coordinate services and communicate with other government entities, to ensure that members have proper access to care, optimal quality of service and coordination of care. This policy outlines requirements for the AdSS to establish and maintain collaborative relationships with these entities and to develop and implement policies and procedures in accordance with this policy.

AdSS Behavioral Health Providers must coordinate member care with Division of Developmental Disabilities (Division) by performing all of the following:

A. Inviting Division staff (e.g., Support Coordinator) to participate in the development of the behavioral health service plan and all subsequent planning meetings as representatives of the member’s clinical team (see Division Medical Policy 320-O)

B. Incorporating information and recommendations in the Planning Document (e.g., Individual or Family Support Plan (ISP)) developed by the Planning Team, when appropriate

C. Ensuring that the goals of the Planning Document, of a member diagnosed with developmental disabilities who is receiving psychotropic medications, includes reducing behavioral health symptoms and achieving optimal functioning, not merely the management and control of challenging behavior

D. Actively participating in Division team meetings

E. For members diagnosed with Autism Spectrum Disorder and Developmental Disabilities, sharing all relevant information from the initial assessment and Planning Document with Division to ensure coordination of services.

For Division members with a co-occurring behavioral health condition or physical health condition who demonstrate inappropriate sexual behaviors and/or aggressive behaviors, a Community Collaborative Care Team (CCCT) may be developed. For additional information regarding the roles and responsibilities of the CCCT and coordination of care expectations, see Division Medical Policy 570.

The AdSS must develop and make available to providers policies and procedures that include information on Division-specific protocols or agreements.

Courts and Corrections

The AdSS must collaborate and coordinate care and ensure that behavioral health providers collaborate and coordinate care for members with 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).

The AdSS must collaborate with courts and/or correctional agencies to coordinate member care by performing all of the following:

A. Working in collaboration with the appropriate staff involved with the member,
B. Inviting probation or parole representatives to participate in the development of the ISP and all subsequent planning meetings for the Adult Recovery Team (ART) with the member’s approval,
C. Actively considering information and recommendations contained in probation or parole case plans when developing required plans
D. Ensuring that the behavioral health provider evaluates and participates in transition planning prior to the release of eligible members and arranges and coordinates enrolled member care upon the member’s release (see Division Medical Policy 580).

Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA)

The AdSS must coordinate member care (in collaboration with the assigned Support Coordinator) with ADES/RSA by:

A. Working in collaboration with the vocational rehabilitation counselors or employment specialists in the development and monitoring of the member’s employment goals
B. Ensuring that all related vocational activities are documented in the comprehensive clinical record (see Division Medical Policy 940)
C. Inviting ADES/RSA staff to be involved in planning for employment programming to ensure that there is coordination and consistency with the delivery of vocational services
D. Participating and cooperating with ADES/RSA in the development and implementation of a Regional Vocational Service Plan inclusive of ADES/RSA services available to adolescents
E. Allocating space and other resources for vocational rehabilitation counselors or employment specialists working with enrolled members who have been determined to have a Serious Mental Illness.
1060 TRAINING REQUIREMENTS FOR BEHAVIORAL HEALTH PROVIDERS

EFFECTIVE DATE: October 1, 2019

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). To meet the requirements of the Division and Arizona Health Care Cost Containment System (AHCCCS), the AdSS must participate in the development, implementation and support of trainings for behavioral health contractors and subcontractors to ensure appropriate training, education, technical assistance, and workforce development opportunities. AdSS are required specifically to:

A. Promote a consistent practice philosophy, provide voice and empowerment to staff and members.
B. Ensure a qualified, knowledgeable and culturally competent workforce.
C. Provide timely information regarding initiatives and best practices.
D. Ensure that services are delivered in a manner that results in achievement of the Arizona System Principles, which include the Adult Service Delivery System- Nine Guiding Principles as outlined in Contract and Arizona Vision-Twelve Principles for Children Service Delivery as outlined in Division Medical Policy Manual, Policy 430.

The purpose of this policy is to provide information to behavioral health providers regarding:

- The scope of required training topics
- How training needs are identified for behavioral health providers
- How behavioral health providers may request specific technical assistance from the AdSS.
- Trainings required to be provided by behavioral health providers.

Required Training for Behavioral Health Providers

A. The AdSS must monitor and implement training activities and requirements outlined in this policy. The AdSS must annually evaluate the impact of the training requirements and activities in order to develop a qualified, knowledgeable and culturally competent workforce.

1. The AdSS and its providers must ensure that, before providing services to members, each licensed and unlicensed staff person is qualified, knowledgeable, and capable to provide services as required by Division policy and, as relevant to their job duties and responsibilities, consistent with the approved training content specified in this policy under Sections One, Section Two, and Section Three (below).

2. Licensed and unlicensed personnel attend and complete all pre-service,
ongoing and or annual in-service training programs described and required by specific Division policies:

3. Section One
   a. Fraud and program abuse recognition and reporting requirements and protocols
   b. Managed care concepts, including information on the behavioral health provider, and the public behavioral health system
   c. Screening for eligibility, enrollment for covered behavioral health services (when eligible), and referral when indicated
   d. Overview of Arizona behavioral health system policies and procedures in the Arizona Vision and 12 Principles (AMPM Policy 430) in the children's system
   e. Overview of Arizona's behavioral health system policies and procedures in the 9 Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems Adult Service Delivery System-Nine Guiding Principles
   f. Overview of Developmental Disabilities, including partnership with Department of Economic Security/Division of Developmental Disabilities and training specific to the needs of individuals with Developmental Disabilities
   g. Overview of partnership with Department of Economic Services/Rehabilitative Services Administration (DES/RSA)
   h. Cultural competency; including cultural diversity in persons with Developmental Disabilities
   i. Interpretation and translation services
   j. AHCCCS Demographic Data Set, including required timeframes for data submission and valid values
   k. Identification and reporting of quality of care concerns and the quality of care concerns investigation process

4. Section Two
   a. Use of assessment and other screening tools (e.g., substance-related, crisis/risk, developmental, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program), including the Birth-to-Five Assessment adopted by the Division on the AHCCCS website depending upon population(s) served
   b. Use of effective interview and observational techniques that support
engagement and are strengths-based, recovery-oriented, and culturally sensitive

c. Application of diagnostic classification systems and methods depending upon population(s) served

d. Best practices in the treatment and prevention of behavioral health disorders

e. Behavioral health service planning and implementation which includes family vision and voice, developed in collaborations with the individual/family needs as identified through initial and ongoing assessment practices

f. Covered behavioral health services (including information on how to assist persons in accessing all medically necessary covered behavioral health services regardless of a person's behavioral health category assignment or involvement with any one type of service provider)

g. Overview of Substance Abuse Block Grant (SABG): priority placement criteria, interim service provision, consumer wait list reporting, and expenditure restrictions of the SABG in accordance with requirements in Division Operations Policy Manual 417, Division Medical Policy Manual 320-T, and 45 CFR Part 96

h. AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements

Behavioral health providers must receive training on the AHCCCS National Practice Guidelines and Clinical Guidance Documents with required elements before providing services, but must receive training within six months of the staff person's hire date (protocol training is only required if pertinent to populations served).

i. Clinical training as it relates to specialty populations including but limited to conditions based on identified need

j. Information regarding the appropriate clinical approaches when delivering services to individuals with developmental disabilities

k. Information regarding the appropriate clinical approaches when delivering services to children in the care and custody of the Arizona Department of Child Safety (DCS)

l. Understanding behavioral and environmental risk factors, nonphysical interventions, the safe use of seclusion or restraint, and responding to emergency situations in accordance with this Policy Manual Chapter 960, Tracking and Trending of Member and Provider Issues

5. Section Three
a. Behavioral health record documentation requirements (see this Policy Manual Chapter 940)

b. Confidentiality/Health Information Portability and Accountability Act (HIPAA)

c. Sharing of treatment/medical information

d. Coordination of service delivery for persons with complex needs (e.g., persons at risk of harm to self and others, court ordered to receive treatment)

e. Rights and responsibilities of eligible and enrolled members, including rights for persons determined to have Serious Mental Illness (SMI)

f. Grievance and Appeal System including SMI grievances, and requests for investigations

g. Customer service

h. Coordination of care requirements with Primary Care Providers (PCPs) (see this Policy Manual Chapter 500)

i. Third party liability and coordination of benefits (see the Division’s Operations Policy Manual and 201)

j. Other involved agencies and government entities (see this Policy Manual Chapter 1050)

k. Claims/encounters submission process (see the Division’s Operations Policy Manual 203)

l. Advance Directives (see this Policy Manual Chapter 640)

m. Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring involvement of persons providing Special Assistance (see this Policy Manual Chapter 320-R)

n. Providers delivering services through distinct programs (e.g., Assertive Community Treatment teams, Dialectical Behavioral Therapy, Multi-Systemic Therapy, developmental disabilities, trauma, substance abuse, children age birth to five, and Behavioral Health Inpatient Facilities)

o. Member benefit options trainings: such as Medicare Modernization Act (MMA), DES/RSA and SABG.

B. Specific situations may require additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that affect the public behavioral health system (e.g., the Balanced
Budget Act (BBA), MMA, the Affordable Care Act (ACA) and Deficit Reduction Act (DRA). Additional trainings may be required, as determined by geographic service area identified needs.

C. The AdSS must develop and make available to providers any policies and procedures regarding additional training information.

**Annual and Ongoing Training Requirements**

A. In addition to training required within the first 90 days of hire, all Behavioral Health providers are required to undergo and provide ongoing training for the following content areas:

1. AHCCCS Demographic Data Set, including required timeframes for data submission, valid values and as changes occur
2. Trainings concerning procedures for submissions of encounters as determined by AHCCCS
3. Annual cultural competency and linguistically appropriate training updates for staff at all levels and across all disciplines respective to underrepresented/underserved populations
4. Identification and reporting of Quality of Care Concerns and the Quality of Care Concerns investigations process when determined to be needed by the Division
5. American Society of Addition Medicine Patient Placement Criteria (ASAM PPC-2R)
6. Child and Adolescent Service Intensity Instrument (CASII)
7. Ticket to Work/Disability Benefits 101
8. Peer, family member, peer-run, family-run and parent-support training and coaching
9. Identification and reporting of persons in need of Special Assistance for individuals who have been determined to have a SMI and ensuring involvement of persons providing Special Assistance (see this Policy Manual Chapter 320-R)
10. Workforce Development trainings specific to hiring, support, continuing education and professional development.

B. Specific situations may require additional trainings. For example, quality improvement initiatives that may require focused training efforts and/or new regulations that impact the public behavioral health system (e.g., the BBA, MMA, ACA, and DRA). Additional trainings may be required, as determined by geographic service area identified needs.
C. The AdSS must develop and make available to providers any policies and procedures regarding specific ongoing training requirements. ADHS Public Health Licensing required training must be completed and documented in accordance with Public Health Licensing requirements (see applicable provisions of A.A.C. Title 9, Chapter 10. and the ADHS Public Health Licensing website).

**Required Training Specific to Professional Foster Homes Providing HCTC Services**

**A. Children**

Medicaid reimbursable HCTC services for children are provided in professional foster homes, licensed by the DES/Office of Licensing, Certification and Regulation, which must comply with training requirements as listed in A.A.C. R6-5-5850. All agencies that recruit and license professional foster home providers must provide and credibly document the following training to each contracted provider:

1. CPR and First Aid Training and
2. 18 hours of pre-service training using the HCTC to Client Service Curriculum.

The provider delivering HCTC services must complete the above training before delivering services. In addition, the provider delivering HCTC services for children must complete and credibly document annual training as outlined in A.A.C. R6-5-5850, Special Provisions for a Professional Foster Home.

**B. Adults**

Medicaid reimbursable HCTC services for adults are provided in Adult Therapeutic Foster Homes licensed by ADHS Public Health Licensing, and must comply with training requirements as listed in applicable sections of A.A.C. Title 9, Chapter 10. Training must cover:

1. Protecting the person's rights
2. Providing behavioral health services that the adult therapeutic foster home is authorized to provide and the provider delivering HCTC services is qualified to provide
3. Protecting and maintaining the confidentiality of clinical records
4. Recognizing and respecting cultural differences
5. Recognizing, preventing or responding to any of the following situations in which a person:
   a. May be a danger to self or a danger to others
   b. Behaves in an aggressive or destructive manner
   c. May be experiencing a crisis
d. May be experiencing a medical emergency.

6. Reading and implementing a person's treatment plan, and

7. Recognizing and responding to a fire, disaster, hazard or medical emergency.

In addition, providers delivering HCTC services to adults must complete and credibly document annual training as required by A.A.C. Title 9, Chapter 10.

**Required Training Specific to Community Service Agencies**

Community Service Agencies (CSAs) must submit documentation as part of the initial and annual CSA application indicating that all direct service staff and volunteers have completed training specific to CSAs before providing services to members. For a complete description of all required training specific to CSAs, see AMPM 961, *Peer, Family and CSA Training, Credentialing and Oversight Requirements*.

**Training Expectations for AHCCCS Clinical and Recovery Practice Protocols**

A. Under the direction of the Division’s Chief Medical Officer and the AHCCCS Chief Medical Officer national practice guidelines and clinical guidance documents are published to assist behavioral health providers.

B. Behavioral health providers providing services to children and families involved with DCS will be required to attend "Unique Needs of Children Involved with DCS" training that must be offered by each AdSS Behavioral Health Providers on a regular basis (See AHCCCS Practice Protocol, The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS).

C. Training on Child and Family Team (CFT) practice, depending on the population(s) served (See AHCCCS Practice Protocol Child and Family Team).

D. Training curriculums may be tailored to specific professional levels (e.g., BHMP, BHT, BHPP) and or job functions (e.g., Coach, Family Support Partner, Supervisor) so long as curriculums are consistent with the CFT Practice Protocol. Curriculums and certification processes must be submitted for approval to the Division.

**Training Requests**

The AdSS must make available to providers any policies, procedures, and contact information that identify how providers can access additional training and/or technical assistance specific to the trainings required by this policy and/or other types of applicable training resources.

**Workforce Development**

A. The AdSS must develop and make available to providers any additional policies and procedures regarding specific workforce development requirements.

B. Training Expert – The AdSS must employ a training expert/contact as key personnel and point of contact to implement and oversee compliance with the
training requirements, training plan, and this policy.

C. Training Development Plan - The AdSS must develop, implement and submit an Annual Training Plan that provides information and documentation of all trainings. The training plan and training curriculums will be submitted annually, 45 days after fiscal year end as specified in Section F3, Contractor Chart of Deliverables.

D. Training Quarterly Updates - The AdSS must submit a Workforce Development Quarterly Update which includes information specific to initiatives and activities specific to training. Quarterly updates are to be submitted 30 days after quarter end as specified in Section F3, Contractor Chart of Deliverables.

**Provision of Training Related to Behavior Health Plans**

The AdSS must ensure that any Behavioral Health entity/provider, that develops a Behavior Plan for a member, trains family members and all staff to implement the plan with fidelity.
1210 INSTITUTIONAL SERVICES AND SETTINGS

EFFECTIVE DATE: October 1, 2019

This policy applies to AdSS and its contractors. The Division of Developmental Disabilities (Division) covers medically necessary institutional services provided in an Arizona Health Care Cost Containment System (AHCCCS) registered long term care facility for members who are eligible for the Arizona Long Term Care System (ALTCS). Institutional settings include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), Inpatient Behavioral Health Residential Treatment Facilities and Nursing Facility (NF) Services.

AdSS Contractors are responsible for ensuring that providers delivering institutional services to members must meet the requirements as specified in this Manual. For purposes of this Service Specification, the term “Contractor” refers to the facility.

Prior to a denial of NF services, the AdSS must contact the Division for a second level review.

Nursing Facility

See Chapter 310-R of this manual regarding acute NF Services for members who are ALTCS eligible and members in the ALTCS transitional program.

Service Description and Goals

This service provides habilitative skilled nursing care, residential care, and supervision to persons who need nursing services on a 24-hour basis, but who do not require hospital care or direct daily care from a physician.

The goal of this service is to provide care that meets and enhances the medical, physical, and emotional needs of members residing in Nursing Facilities (NF).

Service Settings

NFs must be Medicare and Medicaid certified and licensed by the Arizona Department of Health Services in accordance with 42 CFR 440.155 and 42 CFR 483.75 to provide inpatient room, board, and nursing services to members who require these services on a continuous basis. For the purposes of reimbursement by ALTCS funding, the facility must be Medicare/Medicaid certified.

Contractor Requirements

The Contractor must:

A. Be licensed and certified by the appropriate Arizona state agencies.

B. Comply with all applicable federal and state laws relating to professional conditions, standards, and NF requirements, including the conditions set forth in the 42 CFR 483 et seq.
C. Comply with all health, safety, and physical plant requirements established by federal and state laws.

D. The portion of the facility in which the member will be placed must be registered with AHCCCS.

E. Provide all services in a culturally relevant and linguistically appropriate manner for the population to be served.

F. Provide services to members who meet the eligibility requirements for such services as determined by the AdSS and who have been evaluated and placed by the AdSS in coordination with the Division.

G. Provide a healthy, safe, and clean environment that meets the medical, physical, and emotional needs of the member.

H. Provide services, equipment, and supplies as specified in A.A.C. R9-28-204(B), as may be amended.

I. Responsible for coordinating the delivery of the auxiliary services specified in A.A.C. R9-28-204(C), as may be amended.

J. Maintain a complete file for each member that includes physician's orders, care plans, treatment records, medication records, evaluations and assessments, progress reports and any other needed documentation. The member’s file must be made available to the AdSS immediately, or as specified by the Division.

K. Ensure that a PASRR Level I assessment is completed on members prior to admission and whenever a significant change in the physical or mental status of the member occurs.

1. Failure to have the proper PASRR screening on file, prior to placement of a member in a Skilled Nursing Facility may result in federal financial participation (FFP) withheld from AHCCCS. If withholding of FFP occurs, the Division will recoup the withheld amount from the AdSS’s subsequent capitation payment. The AdSS may, at its option, recoup the withholding from the Contractor that admitted the member without the proper PASRR.

2. Ensure that the completed PASRR Level I is maintained in the member’s file, and appropriate referrals made, as needed.

3. If there are indications that a member may have a cognitive/intellectual disability or a related diagnosis, forward the completed PASRR Level I and all supporting documentation, including Minimum Data Set (MDS), health and progress notes, assessments, or other supporting documentation to the AdSS, who is responsible to forward the submitted documents to the Division’s Health Care Services Representative (i.e., the PASRR Coordinator). The Division is responsible for completing PASRR Level II reviews.

L. PASRR Level II reviews must occur for each member whose expected stay in the Skilled Nursing Facility will exceed 90 days.
1. If the results of a PASRR Level II review indicate there is a change in the member’s condition, ensure:
   a. Recommendations are followed,
   b. Appropriate referrals are made, as needed, and
   c. The Division’s Health Care Services representative (e.g., the PASRR Coordinator) is contacted for prior approval before billing a different level of care.
   d. Ensure that any subsequent documentation (e.g., PASRR Level II) is maintained in the member’s file.

M. Complete a quarterly review of the member to assess key indicators or resident status and revise the plan of care as necessary.

N. Conduct a reassessment within one year or whenever there is a significant change in the member’s status.

O. Provide medical, physical, and emotional care and supervision as follows:
   1. Provide nursing care treatment as indicated in the prescribed care plan. The care plan must be specific to the member and be available immediately or as specified by the AdSS.
   2. Provide dietary management, including the preparation and administration of special diets and adaptive mealtime equipment.
   3. Provide access to dental care and treatment, in accordance with Chapter 300 of the Division’s Medical Policy Manual.
   4. Provide access to podiatric care and treatment, in accordance with Chapter 300 of the Division’s Medical Policy Manual.
   5. Provide activities (e.g., therapeutic, vocational), recreational services, and spiritual services in accordance with the member’s preference.
   6. Provide coordination of services to the member from various agencies, as appropriate. Maintain records of interactions with other agencies or service providers relative to the member.
   7. Participate in the development and review of the member’s planning document (e.g., Individual Support Plan, Individualized Family Services Plan).
   8. Participate in discharge planning following the process specified in the Division’s Policy Manuals, as may be amended.
   9. Provide an outcome measurement system whereby the member/member’s representative can provide feedback regarding satisfaction with the performance of the Contractor. The outcome measurement system must be made available to the AdSS upon request.
P. Provide Progress Reports on the member’s planning document (e.g., ISP) objectives every thirty (30) days to the designated Support Coordinator

Contractor Qualifications

A. Skilled Nursing Facility(s) must be licensed by the Arizona Department of Health Services (ADHS) and Medicare/Medicaid certified in accordance with 42 C.F.R. § 483, as may be amended.

B. Skilled Nursing Facility(s) must be licensed, certified, and monitored in accordance with A.R.S. Title 6, Chapter 4, as may be amended.

C. Skilled Nursing Facility(s) must be registered with AHCCCS to provide this service for that portion of the facility subject to Title XIX (Medicaid) reimbursement.

D. Comply with all applicable federal and state laws relating to professional conditions, standards and requirements for nursing facilities, and all health, safety and physical plant requirements established by federal and state laws.

E. Have procedures that ensure temporary nursing care registry personnel, including Nurses’ Aides, are properly certified and licensed before caring for members, in accordance with 42 C.F.R. § 483.75(e)3 and (g)2 and fingerprinted as required by A.R.S. § 36-411, as may be amended.

F. Maintain on-site files that document appropriate licenses and inspections. Files must be made available to the AdSS immediately upon request or as specified by the AdSS.

Admission Criteria (Nursing Facility)

A. The NF service may be considered appropriate for a member if the member is in need of skilled nursing care on a 24-hour basis but does not require hospital care or direct daily care from a physician and is ordered by, and provided under, the direction of a physician, pursuant to 42 CFR 440.40 and a less restrictive level of care is not available in a home and community case service setting as determined by the member’s planning team.

B. The AdSS must contact the Division by Day 45 of a member’s acute NF placement to discuss long term placement alternatives and coordinate discharge planning with the Division. Prior to consideration of long term NF placement as outlined in this chapter, the AdSS must obtain approval from the Division. The Division will use an acuity tool to determine the level of institutional placement prior to placement. If the Primary Care Provider (PCP) or the Division advises that the NF cannot meet the member’s needs, the member shall be offered a choice of available alternatives, including less restrictive settings and/or Home and Community Based Services (HCBS), as medically necessary.

C. Pursuant to 42 CFR 409.31-35 and 440.155, the member requires:

1. The skills of technical or professional personnel such as registered nurses, licensed practical nurses, or therapists
2. Daily skilled services that can only be provided in an NF, on an inpatient basis
3. Skilled services because of special medical complications
4. Services that are above the level of room and board.

Reassessment for Continued Placement

A. Members residing in an NF must be reassessed by the AdSS for appropriateness (medical necessity) of placement, whenever a significant change in the physical or mental status of the member occurs (see PASARR section of this policy manual).

B. Physicians must order the continued need for NF placement not less than annually in accordance with 42 CFR 483.114.

C. The member must continue to meet the criteria in the Admission Criteria (Nursing Facility) section of this Policy.

Service Closure (Nursing Facility)

As determined by the PASRR, medical documentation, and the current needs of the member, NF services will be terminated by the AdSS when the criteria in the Admission Criteria (Nursing Facility) section of this Policy are no longer met and alternative placement has been identified. The discharge shall occur as follows:

A. Ten days prior to anticipated discharge, a Planning Team Meeting must occur to allow the support coordinator to update the current Planning Document to include:
   1. The member’s health and abilities
   2. Current medication
   3. Identification of needed Durable Medical Equipment (DME)
   4. An updated Service Plan
   5. A completed Cost Effectiveness Study (CES) based on anticipated service needs
   6. Needed follow up medical appointments.

B. The Planning Team includes the member and/or responsible person, the Division’s Health Care Service (HCS) nurse, the Support Coordinator, and representatives from the NF. The Planning Team may also include other representatives as needed per Division’s Operations Manual, Policy 2001 Planning Team Members.

C. In the event the member’s previous living arrangement needs to change, the Support Coordinator makes a request for residential services by completing a Placement Profile and submitting it to the Division’s District Network Unit.

D. The member or responsible person, the PCP, attending Physician, and the Division’s Medical Director shall resolve disagreements regarding discharge planning.
E. The Division’s Chief Medical Officer has the final authority as delegated by the Assistant Director.

NF Contract Termination

If the AdSS places an NF on termination status:

A. No new members will be admitted to the NF.

B. Members currently residing, or on leave from, the NF may remain or return to the facility and will have a special planning meeting scheduled. The planning meeting must include the Division’s support coordinator and must identify contracted residential alternatives that are available to the member.

Behavioral Health

Institutional settings also include Behavioral Health Inpatient facilities, Institutions for Mental Disease (IMD), and Inpatient Behavioral Health Residential Treatment Facilities.

Behavioral Health Inpatient Facility

A Behavioral Health Inpatient Facility is a behavioral health service facility licensed by ADHS, as defined in A.A.C. R9-10-101, to provide a structured treatment setting with 24-hour supervision, on-site medical services, and an intensive behavioral health treatment program. These facilities are the highest level of inpatient behavioral health services. Some Behavioral Health Inpatient Facilities are IMDs.

Institution for Mental Disease (IMD)

Services provided to members eligible for Title XIX (including members who receive behavioral health services through an Integrated/Tribal/Regional Behavioral Health Authority (IRBHA, RBHA, TRBHA) may be reimbursed in any behavioral health setting, regardless of age, as per AHCCCS Medical Policy Manual, Policy 1210.

An IMD is a Medicare-certified hospital, special hospital for psychiatric care, behavioral health facility, or nursing care institution which has more than 16 treatment beds and provides diagnosis, care, and specialized treatment services for mental illness or substance abuse for more than 50% of the members is considered an IMD. ADHS Office of Behavioral Health Licensure-licensed Inpatient facilities with more than 16 beds are considered IMDs.

Inpatient Psychiatric Residential Treatment Center (available to Title XIX members under 21 years of age)

An Inpatient Psychiatric Residential Treatment Center is a behavioral health service facility licensed by ADHS. Services must be provided under the direction of a physician and include active treatment implemented as a result of the service plan developed. The service plan must include an integrated program of therapies, activities, and experiences designed to meet the treatment objectives for the member. A member who turns age 21 and is Tribal ALTCS Title XIX while receiving services in an inpatient psychiatric facility considered to be an IMD may continue to receive services until the point in time in which services are no longer required or the member turns age 22, whichever comes first.
In addition, the following services must be available to members residing in a behavioral health institutional setting, but are not included in the service unit:

A. Speech, physical, and occupational therapies unless required as a part of the per diem for the service unit

B. Medical/acute care services as specified in this Policy Manual.
1240-D EMERGENCY ALERT SYSTEM

EFFECTIVE DATE: October 1, 2019

Description

An Emergency Alert System is a monitoring device/system for members who are unable to access assistance in an emergency situation.

Emergency Alert System may include:

A. A one emergency alert system unless a second is medically necessary

B. Medically necessary accessories for operation

C. Replacement of equipment in cases of loss, irreparable damage, or wear not caused by carelessness or abuse.

Considerations

The following factors will be considered when assessing the need for this service:

A. The member lives alone or is alone for eight or more hours without contact with a service provider, family member, or other support system and cannot call 911 by using a standard phone, portable phone, or cell phone.

B. The member’s community does not have reliable/available emergency assistance on a 24-hour basis.

C. The assessment of the member’s medical and/or functional level documents an acute or chronic medical condition, which is not improving.

D. The primary care provider has prescribed the system.

Settings

An Emergency Alert System may only be provided in the member’s own or family home.

Exclusions

An Emergency Alert System will not be provided:

A. To members living in Group Homes or Child/Adult Developmental Homes

B. When the member no longer meets the target population/service considerations (e.g., the member moves to a Group Home or the member is no longer alone for eight hours or more). When this occurs, the system and all components must be returned to the Division.
1250-E THERAPIES (REHABILITATIVE/HABILITATIVE)

EFFECTIVE DATE: October 1, 2019
REFERENCES: AHCCCS AMPM 310-X, Attachment A

This policy applies to the Division’s Administrative Services Subcontractors (AdSS). The Division covers occupational, physical, respiratory and speech therapy services that are ordered by a Primary Care Provider (PCP), approved by the Division or AdSS, and provided by or under the direct supervision of a licensed therapist as noted and applicable in this policy. The AdSS is responsible for providing rehabilitative therapy and habilitative physical therapy services for members Age 21 and older.

Members residing in their own home, and HCB approved alternative residential setting or an institutional setting may receive physical, occupational and speech therapies through a licensed Medicare-certified Home Health Agency (HHA) or by a qualified licensed physical, occupational, or speech therapist in independent practice, as applicable.

Services require a PCP or attending physician’s order and must be included in the member’s record. The record must be reviewed at least every 62 days (bi-monthly) by the member’s PCP or attending physician.

Therapy services must be prescribed by the member’s PCP or attending physician as a medically necessary treatment to develop, improve or restore functions/skills which have not been attained, are underdeveloped or have been impaired, reduced or permanently lost due to illness or injury. Therapy services related to activities for the general good and welfare of members, activities to provide diversion or general motivation do not constitute therapy services for Medicaid purposes and are not covered.

The therapy must relate directly and specifically to an active written treatment regimen or care plan established by the member’s physician for reasonable and necessary treatment of a member’s illness or injury, habilitation or rehabilitation. If necessary, the physician should consult with a qualified therapist.

For purposes of the Policy, reasonable and necessary means:

A. The services must be considered under accepted standards of medical practice to be specific and effective treatment for the member’s condition.

B. Based on the amount, frequency, and duration of the services must be reasonable.

Developmental/Restorativesthe Therapy

A therapy service must be reasonable and necessary to the functional development, and/or treatment of the member’s illness or injury. If the member’s expected potential for improving or restoring functional level is insignificant in relationship to the type and number of therapy services required to achieve such potential the therapy would not be covered for other than a maintenance program as described below. If at any point in the development of skills, or the treatment of an illness or injury, it is determined that the therapy expectations will not materialize, the services will no longer be considered reasonable and necessary.
Maintenance Program

If the developmental or restorative potential is evaluated as insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified therapist may be required to assess and establish the maintenance program to achieve the treatment goals of the ordering PCP or attending physician. After the member’s condition has been assessed, and the member’s caregiver has been instructed/trained in the established maintenance program components, the services of the qualified therapist are no longer covered except for reassessments and treatment plan revisions. Refer to Division Medical Manual Chapter 300 for additional information regarding therapy services.

Habilitative Therapy

Habilitation therapy directs the member’s participation in selected activities to facilitate and/or improve functional skills. Additionally, habilitative therapy is described in terms of everyday routines and activities related to achieving the goals/outcomes described in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents) and is based on needs identified in these respective documents. Habilitative therapy is available through the Division and some Health Plans through Early and Periodic Screening, Diagnosis, and Treatment Medicaid program. Habilitative therapy also provides for direct treatment by a licensed therapist.

Habilitation therapy may use direct treatment by a licensed therapist and is time limited and outcome driven. All therapy is consultative in nature.

Occupational, Physical and Speech Therapy

Therapy Descriptions (Occupational, Physical and Speech)

A. Physical Therapy

The Division covers inpatient and outpatient Physical Therapy (PT) services to members eligible for the Division and ALTCS. Services provide treatment to develop, restore, maintain or improve muscle tone and joint mobility and to develop or improve the physical/functional capabilities of members. Physical therapy may address the movement of the body related to walking, standing, balance, transferring, reaching, sitting, and other movements.

B. Occupational Therapy

The Division covers inpatient and outpatient occupational therapy for members eligible for the Division and ALTCS to achieve their highest level of functioning, maximize independence, prevent disability and maintain health. Occupational therapy may address the use of the body for daily activities such as, dressing, sensory and oral motor development, movement, and eating.

Services may be provided to members who are functionally limited due to physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, or the aging process.
C. Speech Therapy

The Division covers inpatient and outpatient speech therapy services including evaluation, program recommendation for treatment and/or training in receptive and expressive language, voice, articulation, fluency and aural habilitation and rehabilitation, and medical issues dealing with swallowing.

Barring exclusions noted in this section, Therapy includes the following:

A. Evaluation of skills
B. Development of home programs and consultative oversight with the member, family and other providers
C. Assisting members to acquire knowledge and skills, increase or maintain independence, promote health and safety
D. Modeling/teaching/coaching parents and/or caregivers specific techniques and approaches to everyday activities, within a member’s routine, in meeting their priorities and outcomes
E. Collaboration with all team members/professionals involved in the member’s life.

Responsible Person’s Participation (Occupational, Physical and Speech)

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, parents/family or other caregivers (paid/unpaid) are required to:

A. Be present and actively participate in all therapy sessions.
B. Carry out the home program.

Considerations (Occupational, Physical and Speech)

The following will be considered when approving this service:

A. Developmental/functional skills
B. Medical conditions
C. Member’s network of support (e.g., family/caregivers, friends, providers)
D. Age
E. Therapies provided by the school.
Settings (Occupational, Physical and Speech)

Therapy must be provided in settings that support outcomes developed by the team. This includes:

A. The member’s home
B. Community settings
C. Division funded settings such as day programs and residential settings for the purpose of training staff
D. Daycare
E. A clinic/office setting.

Exclusions (Occupational, Physical and Speech)

Exclusions to the authorization of Therapy services may include, but are not limited to, the following:

A. Limits as specified in AHCCCS AMPM 310-X, Attachment A – AHCCCS Adult Member (Persons Age 21 and Older) Therapy Benefit Table
B. Therapy for educational purposes.

Respiratory Therapy

The Division covers respiratory care services prescribed by a PCP or attending physician to restore, maintain or improve respiratory functioning. Services include administration of pharmacological, diagnostic and therapeutic agents related to respiratory and inhalation care procedures; observing and monitoring signs and symptoms, general behavioral and general physical response to respiratory care; diagnostic testing and treatment; and implementing appropriate reporting and referral protocols.

Service Description and Goals (Respiratory Therapy)

This service provides treatment to restore, maintain or improve respiration.

The goals of this service are to:

A. Provide treatment to restore, maintain or improve respiratory functions.
B. Improve the functional capabilities and physical well-being of the member.

Service Settings (Respiratory Therapy)

The Division does not authorize rates for respiratory therapy as a stand-alone service that is separate from other services provided in a particular setting. Although, respiratory therapy may be provided to the member in any setting, it is part of the established rate for Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) and Nursing Facilities (NF).
Service Requirements (Respiratory Therapy)

Before Respiratory Therapy can be authorized, the following requirements must be met:

A. The service must be prescribed by a qualified, licensed physician as part of a written plan of care that must include the frequency, duration, and scope of the therapy.

B. The provider must be licensed by the Arizona Board of Respiratory Care Examiners and be a graduate of an accredited respiratory care education program. This program must be accredited/approved by the American Medical Association’s Committee on Allied Health Education and in collaboration with the Joint Review Committee for Respiratory Therapy Education.

C. The provider must be designated for members who are eligible for ALTCS services and registered with the AHCCCS.

D. Tasks may include:
   1. Conducting an assessment and/or review previous assessments, including the need for special equipment
   2. Developing treatment plans after discussing assessments with the Primary Care Provider, Nurse and the Planning Team
   3. Implementing respiratory therapy treatment as indicated by the assessment(s) and the member’s treatment plan
   4. Monitoring and reassessing the member’s needs on a regular basis
   5. Providing written reports to the AdSS staff, as requested
   6. Attending Planning Meetings (Individual Support Plan/Individualized Family Services Plan/Person Centered Plan meetings) if requested by the member and Division staff
   7. Developing and teaching therapy objectives and/or techniques to be implemented by the member, caregivers and/or other appropriate individuals
   8. Consulting with members, families, Support Coordinators, medical supply representatives, and other professional, and paraprofessional staff on the features and design of special equipment
   9. Giving instruction on the use and care of special equipment to the member and care providers.

Target Population (Respiratory Therapy)

This service is indicated for members who have a health condition that require respiratory therapy, as ordered by a physician, which is documented in the Individual Support Plan/Individualized Family Services Plan/Person Centered Plan (Planning Documents).
Exclusions (Respiratory Therapy)

Respiratory Therapy is prohibited without Physicians orders and prescriptions for certain medical procedures. This requirement does not apply to private or state-operated Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID).

Service Provision Guidelines (Respiratory Therapy)

Respiratory Therapy must not exceed eight (8) fifteen (15) minute sessions per day.

Provider Types and Requirements (Respiratory Therapy)

Designated District staff will ensure all contractual requirements related to Respiratory Therapy providers are met before the service is approved. Additionally, all providers of ALTCS must be registered with the AHCCCS prior to service initiation.

Service Evaluation (Respiratory Therapy)

A. The Primary Care Provider (PCP) must review the plan of care at least every 60 days and prescribe continuation of service.

B. If provided through a Medicare certified home health agency, the supervisor must review the plan of care at least every 60 days.

C. The provider must submit progress notes on the plan of care on a monthly basis to the Division Support Coordinator.

Service Closure (Respiratory Therapy)

Service closure should occur in any of the following situations:

A. The physician determines that the service is no longer needed as documented on the “Plan of Care.”

B. The member/responsible person declines the service.

C. The member moves out of state.

D. The member requires other services, such as home nursing.

E. The member/responsible person has adequate resources or other support to provide the service.

The Division supports and encourages continuity of care among all therapy resources such as hospitals, outpatient rehabilitation clinics, and schools. The Division contracted therapists must collaborate with other service providers and agencies involved with the member.
1250-F CUSTOMIZED DURABLE MEDICAL EQUIPMENT, AND APPLIANCES

EFFECTIVE DATE: October 1, 2019

Adaptive Aids (Acute Care Services)

Certain medically necessary adaptive aids qualify as a covered service if prescribed by a specialist physician, practitioner, or dentist upon referral by a Primary Care Provider (PCP).

Documentation from therapists who have treated the member may be required. That documentation must establish the need for equipment and a comprehensive explanation of how the member will benefit from the equipment. It is important to remember that this service is based on “assessed need” and not a person’s or the family’s stated desires regarding specific services.

Covered adaptive aids are limited to:

A. Traction equipment
B. Feeding aids (including trays for wheelchairs)
C. Helmets
D. Standers, prone, and upright
E. Toileting aids
F. Wedges (positioning)
G. Transfer aids
H. Augmentative communication devices
I. Medically necessary car seats
J. Other items as determined medically necessary by joint consultation of the Medical Directors of the health plan and the Division.