416 PROVIDER INFORMATION

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EFFECTIVE DATE: May 13, 2016

REFERENCES: A.R.S. § 36-2901; 42 CFR 438.12; 42 CFR 438.100; 42 CFR 438.102

PURPOSE

This Policy establishes provider information requirements.

DEFINITIONS

1. "Americans With Disabilities Act" or "ADA" means the Americans with Disabilities Act of 1990, as amended, that prohibits discrimination on the basis of disability and ensures equal opportunity for individuals with disabilities in employment, State and local government services, public accommodations, commercial facilities transportation, and telecommunications as specified in 42 U.S.C. 126 and 47 U.S.C. 5.
2. "Early and Periodic Screening, Diagnostic, and Treatment" or "EPSDT" means a comprehensive child health program of prevention, treatment, correction, and improvement of physical

and behavioral health conditions for Members under the age of 21, to ensure the availability and accessibility of health care resources as well as to assist Medicaid recipients in effectively utilizing these resources.

a. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health conditions for AHCCCS members less than 21 years of age.

b EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services as specified in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and behavioral health illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan.

c. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

3. "Home and Community Based Services" or "HCBS" means Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.
4. "Member" means the same as "client" as defined in A.R.S. § 36-551.
5. "Primary Care Provider" or "PCP" means an individual who meets the requirements as specified in A.R.S. § 36-2901, and who is responsible for the management of the Member's health care.
    a. A PCP may be:
        i. A physician defined as an individual licensed as an allopathic or osteopathic physician as specified in A.R.S. Title 32, Chapter 13 or Chapter 17;
        ii. A practitioner defined as a physician assistant licensed as specified in A.R.S. Title 32, Chapter 25;
        iii. A certified nurse practitioner licensed as specified in A.R.S. Title 32, Chapter 15, or
        iv. A naturopathic physician for AHCCCS members under the age of 21 receiving EPSDT services.

b. The PCP shall be an individual, not a group or association of individuals, such as a clinic.

6. "Provider" means any person or entity that contracts with the Division to provide a covered service to Members in accordance with A.R.S. § 36-2901.

7. "Serious Mental Illness" or "SMI" means a designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

8. "Value-Based Purchasing" or "VBP" means a payment from a Contractor to a provider upon successful completion or expectation of successful completion of contracted goals and measures in accordance with the VBP strategy selected for the contract.

   a. VBP is a non-encounterable payment and does not reflect payment for a direct medical service to a member.

   b. VBP payment will typically occur after the completion of the contract period but could include quarterly or semiannual payments if contract terms specify such

payments in recognition of successful performance measurement.

POLICY

A. PROVIDER MANUAL

1. The Division shall develop, distribute, and maintain a provider manual, ensuring that each contracted provider is made aware of the provider manual available on the Division's website or, if requested, issued a hard copy of the provider manual. The Division shall make available a provider manual to any individual or group that submits claim and encounter data.
2. The Division shall ensure that all providers, whether contracted or not, meet the applicable AHCCCS requirements that relate to covered services and billing.
3. The Division shall ensure that the provider manual provides information regarding the following:
    a. The ability of a member's Primary Care Provider (PCP) to treat behavioral health conditions within the scope of their practice.

b. Introduction to the Division that explains the Division's organization and administrative structure.

c. Provider responsibility and the Division's expectation of the provider.

d. Division's provider service departments and functions including the expected response times for provider inquiries.

e. Listing and description of covered and non-covered services, requirements, and limitations, including behavioral health services.

f. Appropriate and inappropriate use of the emergency department.

g. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

    i. Screenings include a comprehensive history, developmental and behavioral health screening, comprehensive unclothed physical examination, appropriate vision testing, hearing testing, laboratory tests, dental screenings, and immunizations.

ii. EPSDT providers shall 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 and family planning services.

j. Criteria and process for referrals to specialists and other providers, including access to behavioral health services.

k. Process for referrals and provision of Augmentative and Alternative Communication (AAC) related services, including AAC device evaluations.

l. Grievance and appeal system process and procedures for providers and enrollees.

m. Billing and encounter submission information.

n. Policies and procedures relevant to the providers that contain:

i. Utilization management;

ii. Claims submission;

iii. Criteria for identifying provider locations that provide physical access, accessible equipment, and reasonable accommodations for Members with physical or cognitive disabilities; and

iv. PCP assignments, including how provider participation in Value-Based Purchasing (VBP) initiatives impacts member assignments to a PCP as specified in AMPM Policy 510.

o. Procedure for providers to request a PCP assignment roster, that the roster will be provided within 10 business days of receipt of the request, that contains:

i. Members' name,

ii. Members' date of birth,

iii. Members' AHCCCS ID,

iv. AHCCCS ID of the assigned PCP, and

v. Effective date of member assignment to the PCP.

p. Policies relevant to payment responsibilities that contain:

i. Description of the Change of Contractor policies as specified in ACOM Policy 401 and ACOM Policy 406, and

ii. Nursing Facility and Alternative Home and Community Based Service (HCBS) setting contract termination procedures as specified in ACOM Policy 421.

q. Reimbursement policies, including reimbursement for Members with other insurance as specified in ACOM Policy 434, and Medicare cost sharing as specified in ACOM Policy 201.

r. Cost sharing responsibility.

s. Explanation of remittance advice.

t. Criteria for the disclosure of member health information

u. Medical record standards.

v. Prior authorization and notification requirements, including a listing of services which most frequently used services which require authorization, and instructions on how to

obtain a complete listing of services that require authorization.

w. Requirements for out of state placement for members.

x. Claims medical review.

y. Concurrent review.

z. 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.

aa. Credentialing and re-credentialing activities.

bb. Fraud, waste, and abuse as specified in ACOM Policy 103.

cc. Information on the False Claims Act provisions of the Deficit Reduction Act as required in the Corporate Compliance paragraph of the contract.

dd. Minimum Required Prescription Drug List (MRPDL) information, including:

i. How to access the MRPDL, electronically or by hard copy upon request, and

ii. How and when updates are communicated.

ee. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications, including prior authorization and limits specified in AMPM Policy 310-V, the Contractor's monitoring process for prescribers in AMPM Policy 310-FF, and informed consent requirements in AMPM Policy 320-Q.

ff. AHCCCS appointment standards.

gg. Requirements pertaining to duty to warn and duty to report as specified in AMPM Policy 960.

hh. Submission requirements under the AHCCCS DUGless Portal Guide for behavioral health providers regarding their responsibilities for submitting to AHCCCS demographic information.

ii. Americans with Disabilities Act (ADA) and Title VI Of the Civil Rights Act of 1964 requirements, as applicable.

jj. Process providers use to notify the Division for changing an address, contact information, or other demographic information.

kk. Information on services available through the AHCCCS Provider Enrollment Portal and how to access the portal and how to update provider registration data including current population groups sets served.

ll. Eligibility verification.

mm. 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.

nn. Peer review and appeal process.

oo. Medication management services as described in the contract.

pp. A Member's rights as specified in 42 CFR 457.1220 and 42 CFR 438.100, including, to:

i. Be treated with dignity and respect.

ii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

iii. Participate in treatment decisions regarding his or her health care, including the right to refuse treatment.

iv. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

v. Request and receive a copy of the medical records, and to request that the medical records be amended or corrected, as specified in 45 CFR part 164 and applicable state law.

vi. Exercise his or her rights and the exercise of those rights shall not adversely affect service delivery to the Member.

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

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

ss. General and informed consent for treatment requirements.

tt. Advance directives.

uu. Transition of members.

vv. Encounter validation studies.

ww. Incidents, accidents, and deaths reporting requirements as specified in AMPM Policy 960.

xx. A pre-petition screening, court ordered evaluations, and court ordered treatment.

yy. Behavioral health assessment and service planning requirements:

i. As specified in AMPM Policy 320-O;

ii. Requirements for behavioral health providers to assist individuals as specified in the AMPM Policy 650;

iii. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to providers as specified in AMPM Policy 1040;

iv. Serious Mental Illness (SMI) eligibility determination process as specified in AMPM Policy 320-P;

v. Partnership requirements with families and family-run organizations in the children and adult behavioral health system; and

vi. Peer support and recovery training, certification, and clinical supervision requirements as specified in AMPM Policy 963.

4. The Division shall include the following information in the provider manual:

a. Housing criteria for individuals determined to have an SMI,

b. Seclusion, restraint, and emergency response reporting requirements, and

c. The SMI grievance and appeal process.

5. The Division shall include guidance in the Provider Manual on which services are the responsibility of DDD qualified vendors and which services are the responsibility of providers contracted with the DDD subcontracted health plans, and directions on how providers unsure of these responsibilities can obtain guidance.

B. REQUIRED NOTIFICATIONS

1. In addition to the updates required in this section, the Division shall require providers to disseminate information on behalf of the Division or AHCCCS. In these instances, the Division shall provide prior notification.
2. The Division shall provide written or electronic communication to contracted providers in the following instances:
    a. Exclusion from Network - Under Federal Regulation 42 CFR 438.12, the Division shall provide written notice of the reason for declining any written request for inclusion in the network.
    b. Material Changes - The Division shall notify providers in advance of any Material Change to the Provider Network or business operations as specified in ACOM policy 439.
    c. Division Policy and Procedure Changes – For any change in policy, process, or protocol including prior authorization, retrospective review, or performance and network standards that affects or can reasonably be foreseen to affect the Division’s ability to meet performance standards

of the Division contract with AHCCCS, the Division shall notify:

i. The designated operations compliance officer to which the Division is assigned, sixty calendar days before a proposed change, and

ii. Affected provider, thirty calendar days before the proposed change.

d. AHCCCS Guidelines, Policy, and Manual Changes - The Division shall notify its subcontractors when modifications are made to AHCCCS guidelines, policies, and manuals.

e. Division Provider Manual Changes - The Division shall notify its providers when modifications are made to the provider manual.

f. Subcontract Updates

i. If the AHCCCS Minimum Subcontract Provisions are modified, the Division shall issue a notification of the change to the subcontractors within 30 calendar days of the published change and ensure amendment of affected subcontracts.

ii. The Division shall amend the affected subcontracts on their regular renewal schedule or within six calendar months of the update, whichever comes first.

g. Termination of Contract – The Division shall provide, or require its subcontractors to provide, written notice to hospitals and provider groups at least 90 calendar days prior to any contract termination, other than contracts between subcontractors and individual practitioners, without cause.

h. Disease and Chronic Care Management – The Division shall disseminate information as required by the AHCCCS Medical Policy Manual (AMPM) Policy 1020.