

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