416 PROVIDER MANUAL AND REQUIRED NOTIFICATIONS

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

PURPOSE

This Policy establishes guidelines for Provider information requirements and other Provider notification 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. "Closed-Loop Referral System" or "CLRS" means the AHCCCS-approved statewide technology platform for screening

and referring Members to address their health-related social needs.

3. "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. EPSDT services include:
   a. Screening services,
   b. Vision services,
   c. Dental services,
   d. Hearing services, and
   e. All other medically necessary mandatory and optional services listed in Federal Law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

4. "Electronic Visit Verification" or "EVV" means a computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.
5. "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.
6. "Member" means a person receiving developmental disabilities services from the Division.
7. "Primary Care Provider" or "PCP" means an individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the Member's health care. PCPs include:
    a. A person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17,
    b. A practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or
    c. A certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15.

d. The PCP must be an individual, not a group or association of persons, such as a clinic.

8. "Provider" means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services, as specified in 42 CFR 457.10 and 42 CFR 438.2.

9. "Serious Emotional Disturbance" or "SED" means a designation for individuals from birth until the age of 18 who currently meet or at any time during the past year have had a diagnosable mental or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders that resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

10. "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.

11. "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.

2. The Division shall make available a Provider manual to any individual or group that submits claim and encounter data.
3. The Division shall ensure that all Providers, whether contracted or not, meet the applicable AHCCCS requirements that relate to covered services and billing.
4. The Division shall ensure that the Provider manual provides information regarding the following:
    a. The ability of a Member's 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. Overview of the Division's Provider service departments and its functions;
    e. Expected response times for Provider inquiries, including the expected response times for Provider calls;

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

g. Appropriate and inappropriate use of the emergency department;

h. EPSDT Services, specifically:

i. Screenings which include a

a) Comprehensive history,

b) Developmental and behavioral health screening,

c) Comprehensive unclothed physical examination,

d) Appropriate vision testing,

e) Hearing testing,

f) Laboratory tests,

g) Dental screenings, and

h) Immunizations.

ii. Document immunizations into Arizona State Immunization Information System (ASIIS); and

iii. Enroll every year in the Vaccine for Children program.

i. Description of dental services coverage and limitations.

j. Description of maternity and family planning services as specified in AHCCCS Medical Policy Manual (AMPM) Policy 410 and AMPM Policy 420;

k. Criteria and process for referrals to specialists and other Providers, including access to behavioral health services;

l. Information on the CLRS and how Providers can use it to refer Members to community-based services;

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

n. Grievance and appeal system process and procedures for Providers and Members;

o. Billing and encounter submission information;

p. Policies and procedures relevant to the Providers that contain:

i. Utilization management;

ii. Claims submission;

iii. EVV;

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

v. PCP assignments, including how Provider participation in Value-Based Purchasing (VBP) initiatives impacts Member assignments to a PCP as specified in AdSS Medical Policy 510.

q. 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.

r. Policies relevant to Providers including:

i. Payment responsibilities as outlined in ACOM 432;

ii. Description of the Change of Contractor policies as specified in AdSS Operations Policy 401 and 406; and

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

s. 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;

t. A link, or directions on how to find all required policies, protocols, and procedures required under AMPM Policy 541 that describe how Member care will be coordinated with governmental and tribal agencies and entities;

u. Cost sharing responsibility;

v. Explanation of remittance advice;

w. Criteria for the disclosure of member health information

x. Medical record standards;

y. Prior authorization (PA) 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;

z. Requirements for out of state placement for Members;

aa. Claims medical review;

bb. Concurrent review;

cc. Coordination of Care requirements;

dd. Credentialing and re-credentialing activities;

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

ff. The AHCCCS Drug List information including:

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

ii. How and when updates to these lists are communicated.

gg. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications,

including (PA) requirements 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;

hh. Division and AHCCCS appointment standards;

ii. Requirements pertaining to duty to warn and duty to report as specified in AdSS Medical Policy 960;

jj. Submission requirements under the AHCCCS DUGless Portal Guide for behavioral health Providers regarding their responsibilities for submitting to AHCCCS demographic information;

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

ll. Process Providers use to notify the Division for changing an address, contact information, or other demographic information;

mm. Information on the 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;

nn. Responsibility of Providers required by AHCCCS to identify demographic data regarding their population group sets served to report and update any changes to these group sets within 10 days of the change, as outlined in AMPM Policy 610;

oo. Eligibility verification.

pp. 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, as specified in ACOM Policy 405;

qq. Peer review and the Provider's ability to dispute the process;

rr. Medication management services as described in the contract;

ss. A Member's rights as specified in 42 CFR 457.1220 and 42 CFR 438.100, including the right 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; and

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

tt. Notification that the Division has no policies that prevent the Provider from advocating on behalf of the Member as specified in 42 CFR 457.1222 and 42 CFR 438.102;

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

vv. General and informed consent for treatment requirements;

ww. Advance directives;

xx. Transition of Members;

yy. Encounter validation studies;

zz. Incidents, accidents, and deaths reporting requirements as specified in AMPM Policy 961;

aaa. Information on pre-petition screening, court ordered evaluations, and court ordered treatment;

bbb. Behavioral health assessment and service planning requirements as specified in AdSS Medical Policy 320-O;

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

ii. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to Providers as specified in AdSS Medical Policy 1040;

iii. Serious Emotional Disturbance (SED) eligibility determination process as specified in AdSS Medical Policy 320-P;

iv. Serious Mental Illness (SMI) eligibility determination process as specified in AdSS Medical 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 AdSS Medical Policy 963.

ggg. Housing criteria for individuals determined to have a SMI;

hhh. Seclusion, restraint, and emergency response reporting requirements;

iii. The SMI grievance and appeal process;

jjj. Requirements for grant funded services provided to Special Populations;

kkk. Behavioral health crisis intervention service requirements; and

lll. Explanation of the process for members not eligible for Title XIX/XXI services to file a complaint, grievance, or request for hearing when not determined SMI.

5. The Division shall include guidance in the Provider Manual on:

a. Which services are the responsibility of DDD qualified vendors,

b. Which services are the responsibility of Providers contracted with the DDD subcontracted health plans, and

c. Directions on how Providers can obtain guidance when they are unsure of these responsibilities.

B. REQUIRED NOTIFICATIONS

1. The Division shall provide written or electronic communication to contracted Providers in the following instances:

a. Exclusion from Network - provide written notice of the reason for declining any written request for inclusion in the network;

b. Material Changes - notify Providers in advance of any Material Change to the Provider Network or Business Operations as specified in AdSS Operations policy 439;

c. AHCCCS Guidelines, Policy, and Manual Changes - notify its subcontractors when modifications
are made to AHCCCS guidelines, policies, and manuals within 30 days of the published change and ensure amendment of any affected subcontracts on their regular renewal schedule or within six months of the update, whichever comes first:

d. Division Provider Manual Changes - notify its Providers when modifications are made to the Provider manual;

e. Subcontract Updates:

i. When a modification to the AHCCCS Minimum Subcontract Provisions are modified, issue a notification of the change to the Subcontractors

within 30 calendar days of the published change and ensure amendment of affected subcontracts; and

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

f. Termination of €Subcontract – notify hospitals and Provider groups at least 90 calendar days prior to any subcontract termination, other than contracts between subcontractors and individual practitioners, without cause;

g. Disease and Chronic Care Management – disseminate information as required by AdSS Medical Policy 1020.

2. The Division shall distribute other communication to the AdSS upon request of AHCCCS and the Division. In these instances, AHCCCS or the Division shall provide prior notification.