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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.

Chapter #	AIHP/FFS	QV/QVA	Acute/AdSS	State-Contracted Developmental Home	Individual Independent Provider
1	x	x	x	x	x
2		x		x	x
3	x	x	x	x	x
4	x		x		
5	x		x		
6	x		x		
7	x		x		
8	x		x		
9	x		x		
10	x		x		
11	x	x	x	x	x
12	x	x	x	x	
13	x	x	x		x
16	x	x	x	x	x
17	x	x	x		x
18	x	x	x	x	x
19	x		x		
20	x	x	x	x	x
21	x	x	x	x	x
22	x		x		
23	x	x	x		
24	x	x	x	x	x
25			x		

Chapter #	AIHP/FFS	QV/QVA	Acute/AdSS	State-Contracted Developmental Home	Individual Independent Provider
26	x	x	x	x	x
27			x		
28	x	x	x	x	x
29	x	x	x	x	x
30	x	x	x	x	x
31			x		
32		x			
33		x			
34		x	x		
35		x		x	x
36		x			
37		x			
38		x			
40		x			
41		x			
42		x		x	
43		x			
44		x			
45		x			
46		x			
47	x	x	x	x	x
48		x			
49		x		x	
57-A		x	x		
57-B		x	x		
57-C		x	x		
57-D		x	x		
57-E		x	x		
57		x	x		
58	x		x		
59	x	x	x	x	x
60		x	x		

Chapter #	AIHP/FFS	QV/QVA	Acute/AdSS	State-Contracted Developmental Home	Individual Independent Provider
61	x	x	x	x	x

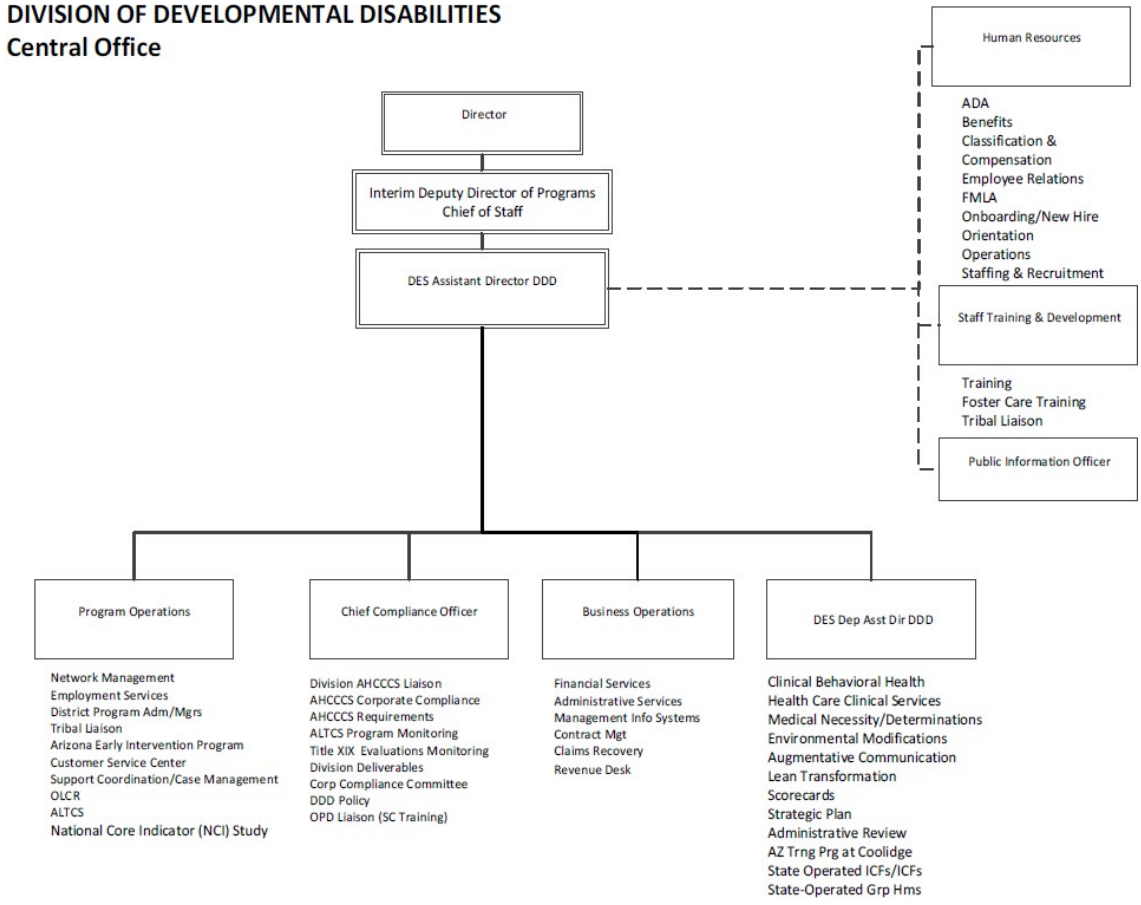
CHAPTER 1 - INTRODUCTION TO THE DIVISION OF DEVELOPMENTAL DISABILITIES

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

45 CFR 164.306 Security standards: General rules.

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.

CHAPTER 3 PROVIDER SERVICE DEPARTMENT

REVISION DATE: 5/16/2018, 2/14/2018, 5/5/2017, 5/27/2016, 1/29/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013

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

REVISION DATE: 6/9/2017, 10/14/2016, 5/27/2016, 4/1/2015, 8/1/2014, 4/16/2014
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
14. Attendant care services.

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.

CHAPTER 6 - EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

REVISION DATE: 3/7/2018, 5/26/2017, 5/27/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: AMPM, A.A.C. R9-22-205, R9-22-213.

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

REVISIONDATE: 8/22/2018, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: AMPM 410, AMPM 420

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.

Chapter 10 REFERRALS TO SPECIALISTS

REVISION DATE: 10/1/2019, 5/5/2017, 4/16/2014
EFFECTIVE DATE: March 29, 2013

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

REVISION DATE: 8/28/2019, 6/23/2017, 11/10/2016, 4/16/2014
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 or 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

REVISION DATE: 9/11/2019, 6/17/2016, 4/16/2014 EFECTIVE DATE: March 29, 2013
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

   - 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 <u>all</u> 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		
Billing For	**Documents Required**	**Comments**
Surgical procedures	History and physical, operative report, and emergency room report	
Missed abortion/ Incomplete abortion Procedures (all CPT codes)	History and physical, ultrasound report, operative report, and pathology report	Information must substantiate fetal demise.
Emergency room visits	**Complete** emergency room record.	The billing physician's signature must be on ER record
Anesthesia	Anesthesia records	Include "begin and end" time
Pathology	Pathology reports	
E&M services	Progress notes, history and physical, office records, discharge summary, & consult reports	Documentation should be specific to code(s) billed
Radiology	X-ray/Scan reports	
Medical procedures	Procedure report, history and physical	Examples: Cardiac catheterizations, Doppler studies, etc.
UB-04 Claims		
Billing for	**Documents Required**	**Comments**
Observation	Refer to AHCCCS FFS Chapter 11 Hospital Services for required documentation.	If labor and delivery, send labor and delivery records
Missed abortion/Incomplete abortion	All documents required by statute, ultrasound report, operative report, and pathology report.	Information must substantiate fetal demise.
Outlier	Refer to AHCCCS FFS Chapter 11, Hospital Services, and to Exhibit 11-4, the Outlier Record Request, for information on the required documentation.	

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

REVISION DATE: 07/31/2019, 6/27/2018, 5/30/2018, 5/31/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013
REFERENCES: 42 CFR § 435.1103, A.R.S. § 36-2903, A.R.S. § 36-2904; A.A.C. R9-22-703, A.A.C. R9-29-301; ALTCS DES/DDD Contract YH6-0014 (Amendment 69), AHCCCS Fee-For-Service (FFS) Provider Billing Manual

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-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 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 AHCCCCS 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 Medicaid application date 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	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST PAY:** *(Subject to the limits outlined in this Policy)*
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid (See Examples Below)	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.

FIGURE 1 – QMB DUAL COST SHARING - EXAMPLES **Services are covered by both Medicare and Medicaid** *Subject to the limits outlined in this Policy*			
	EXAMPLE 1 (b. In Table 1 above)	**EXAMPLE 2** (b. In Table 1 above)	**EXAMPLE 3** (b. In Table 1 above)
Provider charges	$125	$125	$125
Medicare rate for service	$100	$100	$100

Medicaid rate for Medicare service (The Division's contracted rate)	$100	$90	$90
Medicare deductible	$0	$0	$40
Medicare paid amount (80% of Medicare rate less deductible)	$80	$80	$40
Medicare coinsurance (20% of Medicare rate)	$20	$20	$20
THE DIVISION PAYS	**$20**	**$10**	**$50**

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 2: NON-QMB DUALS (IN NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST <u>NOT</u> PAY:**
Medicare Only	Medicare copay, coinsurance or deductible
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION MUST PAY:** *Subject to the limits outlined in this Policy*
Medicaid Only	The provider in accordance with the contract

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 3 NON-QMB DUALS (OUT OF NETWORK)	
WHEN THE SERVICE IS COVERED BY:	**THE DIVISION** *Subject to the limits outlined in this Policy*
Medicare Only	Has no responsibility for payment.
Medicaid only and the Division **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
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	Must pay in accordance with A.A.C. R9-22-705.
By both Medicare and Medicaid and the Division **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
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

REVISION DATE: 5/26/2017, 6/17/2016, 4/16/2014
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

REVISION DATE: 10/1/2019, 4/18/2018, 5/26/2017, 6/17/2016, 4/16/2014
EFECTIVE 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.

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 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.
2. Report the incident by completing the on-line referral form:

   https://des.az.gov/how-do-i/report-suspected-fraud/developmental-disabilities-fraud

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.

Chapter 22 FORMULARY INFORMATION

REVISION DATE: 3/7/2018, 5/26/2017, 6/17/2016, 4/16/2014
EFFECTIVE DATE: March 29, 2013

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:

1. https://www.care1st.com/az/providers/formulary.asp
2. https://www.mercycareplan.com/assets/pdf/MCP_Formulary_508.pdf
3. http://www.uhccommunityplan.com/health-professionals/az/pharmacy-program.html

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 RELIABLITY

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

REVISION DATE: 5/26/2017, 3/25/2016, 4/16/2014

EFFECTIVE DATE: March 29, 2013

REFERENCES: 42 CFR 438.3(j)(3), 42 CFR 438.100, 45 CFR 164.524 and 526; A.R.S § 36-551.01, A.R.S. § 36-3205.C.1; Division Operations Manual Policy 1001-A; Qualified Vendor Contract

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

   2. A provider directory as described in the AHCCCS Contractor Operations Manual, Policy 404.

      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

REVISION DATE: May 8, 2019, 5/27/2016, 4/16/2014
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. Qualifed 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. Qualifed 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

REVISION DATE: 6/26/2019, 9/15/2017, 9/1/2014
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).

Position	Parameter	Description	Size	Example
1	YYYY	4-digit Year	4	2019
2	MM	2-digit Month	2	02
3	PBS	4 Character PBS Vendor Code	4	ABCD
4	ASSISTID	10 Digit Client ASSIST ID	10	1234567890
5	SVC	Service Code: • 3 Character DDD Code • 4 Character REV Code • 5 Character HCPCS Code	3, 4, or 5	OTA 0111 A9901
6	SQN	3-digit Sequence Number	3	000-999
7	EXT	File Extension	(Varies)	.pdf, .xlsx, .docx

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.

9. Transition to Employment.

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

- Habilitation, Vendor Supported Developmental Home (Child and Adult).

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:

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/Impairmant 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:

https://des.az.gov/sites/default/files/qv2014.section_6_standard_terms_and_conditions.pdf

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 Manger 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 7of the Arizona Administrative Code (A.A.C.). 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

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

REVISION 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.

Division Provider Policy Manual *Appendix B DDD Agency with Choice User Guide – FOCUS Vendor* instructions, provides guidance for billing as an AWC vendor.

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. 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 Manuel 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):

      a. Document the staffing schedule on Habilitation IDLA Staffing Schedule (DDD-1951A).

      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

4. Home closure.

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

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
REFERENCES: 42 CFR 433.138, 42 CFR 433.139, Deficit Reduction Act ("DRA") of 2005, A.R.S. § 36-2923, A.A.C. R9-22-1002, A.A.C. R9-22-1003, A.A.C. R9-22-1001, A.R.S. § 36-596, A.A.C. R6-6-1303, A.R.S. § 36 Chapter 5.1

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.

	Field	Explanation
1	Provider Name	Name of the billing agency
2	Provider ID Number	Tax ID or FEI Number, 9 digits
3	Four Digit Code	Four-letter alpha code assigned to the provider agency by the Division
4	Fax Number	Fax number of the agency
5	E-Mail Address	E-mail address of the assigned individual on behalf of the agency
6	Signature	Signature of the assigned individual on behalf of the agency
7	Date	Date of completion of the Waiver form
8	Member's Name	Legal name of the member
9	ASSIST ID	Unique 10 digit number
10	Insurance name/ MCID	Name of the Insurance Company in reference to EOB along with the Master Carrier ID (MCID)
11	Service Code	The Division-assigned service code for the approved services based on the ISP
12	Start Date	Start date of the service
13	End Date	End date of the service
14	Comments	Any comments that might be helpful in understanding the submitted documentation

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):

	Error Description	What it Means	What Should the Qualified Vendor Do
1	*Waiver not found and reason code not supplied*	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.	Review Focus and ensure a waiver is on file for each active policy. Submit *COBV Waiver Request* form to TPLWaiver@azdes.gov. Submit eligibility information to DDD Claims for an insurance update, if a policy is no longer active.
2	*Number of insurances does not match number of active insurances*	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.	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 TPLbenefits@azdes.gov for an insurance update. If there are two policies in Focus for the same insurance, the Qualified Vendor should email: TPLbenefits@azdes.gov for a review.

	Error Description	What it Means	What Should the Provider Do
3	*Invalid Insurance Company*	The Master Carrier ID (MCID) reported on the claim line of the Uniform Billing Document does not match Focus records.	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 TPLbenefits@azdes.gov for an insurance review/update.
4	*TPL amount greater than zero, no insurance on file*	The claim line reports a TPL payment; members record shows no insurance on file	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 TPLbenefits@azdes.gov for an insurance review/update.
5	*Pay amount plus TPL amount does not equal rate times unit*	This is an indication of the mathematical error. Rate times units minus TPL amount does not match the total amount due.	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")

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/ (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:

	Scenarios	Required Information
1	New Insurance	• Insurance Card or • Member Eligibility Page or • Explanation of Benefits (EOB)
2	Termed Insurance (Policy expired)	• Member Eligibility Page or • EOB and • 4 Alpha Vendor Code and • Service Codes for Billed Services
3	Duplicate Insurance More than one policy reflected in the system with similar: • Insurance company name • Effective/end dates • Policy number	• 4 Alpha Vendor Code and • Service Codes for Billed Services and • Details about the policy requested for removal (Policy number plus Master Carrier ID [MCID])
4	Invalid Insurance (Insurance policy does not exist)	• EOB with denial/rejection indicating member not enrolled (e.g., "member not found") or • The following information from the insurance company contacted: o Phone number of the insurance company o Name of the representative spoken to o Reference/confirmation number associated with the call
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

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

   Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
50.00	90655	$50.00	$0.00

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

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$60.00	$0.00

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.

Insurance Paid Amount = $30.00
Division Contracted Rate = $50.00
Payment To Provider = $20.00

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

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

   Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$30.00	$20.00

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 in column "T," of the Uniform Billing Template as shown below.

Legend - Uniform Billing Template

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
M	Deductible Code 01
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode2	Total Amt Due
$50.00	90655	01	$50.00

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

Column Name	**Explanation**
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$50.00	$0.00

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.

Insurance Paid Amount = $30.00
Division Contracted Rate = $50.00
Payment To Provider = $20.00

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

Column Name	Explanation
J	Division rate for specific service
K	MCID number
L	Amount paid by insurance company
T	Total amount due

Sample Row - Uniform Billing Template

J	K	L	T
Rate	TplCode1	TplAmt1	Total Amt Due
$50.00	90655	$30.00	$20.00

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

Column Name	Explanation
J	Division rate for specific service
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode1	Total Amt Due
$50.00			$50.00

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

Column Name	**Explanation**
J	Division rate for specific service
T	Total amount due

Sample Row - Uniform Billing Template

J	K	M	T
Rate	TplCode1	TplReCode1	Total Amt Due
$50.00			$50.00

CHAPTER 57-J RECOMMENDATIONS FOR WORKING WITH INSURANCE COMPANIES

EFFECTIVE DATE: August 5, 2016
REFERENCES: A.R.S § 20-3101, A.R.S § 20-3102

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.

J	K	L	N	P	T
Rate	TplCode1	TplAmt1	TplCode2	TplReCode2	TotalAmtDue
$50.00	90655	$30.00	94940	01	20.00

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

REFERENCES: A.R.S. §§36-2904 and 2905.01; A.A.C. R9-22 A.A.C. R9-28 42 A.A.C. R9-22-1003; 42 CFR 433.135, 42 CFR 438.114; ACOM 432 Attachment A

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/notification 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

Manual Chapter 16 Remittance Advice, Reimbursement, and Cost Sharing. [42 CFR 433 Subpart D, 42 CFR 447.20].

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

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).

3. Submit Gap in Critical Service Logs to the District Gap Lead.

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

Column Number	Instruction	Explanation
0.	**Contractor ID #**	Contractor fills in column with identification number 110306, 110049, etc.
1.	**Provider Registration Number**	Provider's AHCCCS Identification numbers. Column to be filled in by provider or contractor. Ensure that this column is completed.
2.	**Date Called In**	The date the agency was notified of the gap in critical service. Use the following format **00/00/00**.
3.	**Time Called In**	The time the agency was notified. **Use military time** i.e., 08:00, 13:30, etc. Round to the nearest 15-minute increment.
4.	**Gap Date**	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**.
5.	**Time Service Scheduled to Begin**	Insert the time the service was regularly scheduled to begin. **Use military time** i.e., 08:00, 13:30, etc. Round to the nearest 15-minute increment.
6.	**County Code**	The county of **residence** code from the following chart.

County	Code
Apache	01
Cochise	03
Coconino	05
Gila	07
Graham	09
Greenlee	11
La Paz	29
Maricopa	13

County	Code
Mohave	15
Navajo	17
Pima	19
Pinal	21
Santa Cruz	23
Yavapai	25
Yuma	27

Column Number	Instruction	Explanation
7.	**Member's Name**	List member's name, last name, first name and middle initial – Jones, Mary J.
8.	**Member's Zip Code**	Member's Zip Code – this column can be filled in either by the contractor or the provider.
9.	**Member's AHCCCS ID**	List member's AHCCCS Identification Number – A12345678.
10.	**Select from the following authorized critical service type**	Select what critical service the member was to receive and list the corresponding alphabetical bullet in Column 10. A member may be receiving more than one critical service i.e., personal care and homemaker. List member's name twice and use a separate line to record the second critical service.

Log #1 ATC, HSK, RSP

Service Type	
Attendant Care	A
Homemaker	B
Personal Care	C
Respite	D

Log#2 IDLA, Nursing

Service Type	
IDLA	A
Nursing	B
N/A	
N/A	

Note: **Vendor must use two <u>SEPERATE</u> Gaps in Critical Services Logs:**

- **Log #1 report gaps in ATC, HSK, and RSP Services**
- **Log #2 report gaps in IDLA and Nursing.**

Column Number	Instruction	Explanation
11.	**Member Critical Service Preference Level at the time of notice (Agency)**	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.

Member Critical Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

Column Number	Instruction	Explanation
12.	**Member Critical Service Preference Level (Contractor)**	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.

Member Critical Service Preference Level	
Needs services within 2 hours	1
Needs services today	2
Needs services within 48 hours	3
Can wait until next scheduled day	4

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.

Reason for Critical Service Gap	
Caregiver Cancelled	1
Caregiver Did Not Show	2
Caregiver Left Early	3
Replacement Caregiver Not Available	4
Reserved	5
Other	6

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.

Log # 1		Log #2	
Explain how critical service gap was resolved (ATC, HSK & RSP)		**Explain how critical service gap was resolved (IDLA & NURSING)**	
Attendant Care	A	IDLA	A
Homemaker	B	Nursing	B
Personal Care	C	N/A	C
Respite	D	N/A	D
Unpaid Caregiver	E	N/A	E
Unpaid Community Organization	F	Unpaid Community Organization	F
Other	G	Other	G
Unpaid/Paid Caregivers	H	Unpaid/Paid Caregivers	H

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.**

Column Number	Instruction	Explanation
15.	**Original Critical Hours Authorized**	Enter the amount of critical hours authorized by the Support Coordinator for the date of the gap in critical service.
16.	**Number of Critical Hours Not Replaced**	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.
17.	**Unpaid hours provided to resolve gap in critical services on the day of the gap**	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.
18.	**Paid hours provided to resolve gap in critical services on the day of the gap**	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.

Column Number	Instruction	Explanation
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.**

Column Number	Instruction	Explanation
21.	**If Member Critical Service Preference Level Timeline Not Met**	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.

If Member Critical Service Preference Timelines are not met, explain why.	
Reserved	1
Member Choice	2
Unable to find replacement	3
Not alerted of critical service gap	4
Other	5

Column Number	Instruction	Explanation
22.	**If total Authorized Critical Hours not replaced explain why**	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.

If total critical hours were not replaced, explain why.	
Full replacement hours not needed	1
Member Choice	2
Unable to find replacement	3
Not alerted of critical service gap	4
Other	5

Column Number	Instruction	Explanation
23.	**If an Unpaid Caregiver used, explain why**	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.

If an unpaid caregiver used, explain why.	
Member Choice	1
No Agency Staff Available	2
Other	3

Column Number	Instruction	Explanation
24.	**Explanation Column**	Complete this column when an explanation is required**.**

Examples of Critical Service Gap Tracking Log for Recording of Scenarios

Scenario 1:	
History	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.
Assessment/ Authorized	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.
Situation	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).
Resolution	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.

Scenario 2:	
History	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.
Assessment/ Authorized	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.
Situation	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.
Resolution	The agency makes several calls to try and find another caregiver. At 8:30 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.

Scenario 3:	
History	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.
Assessment/ Authorized	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.
Situation	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.
Resolution	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.

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:	
History	S. White is married and lives with her elderly spouse. The spouse is unable to do housework, shopping, laundry, etc.
Assessment/ Authorized	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.
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.
Resolution	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.

Scenario 5:	
Situation	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.
Resolution	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.

Scenario 6:	
History	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.
Assessment/ Authorized	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.
Situation	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.

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:	
History	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.
Assessment/ Authorized	The Support Coordinator has assessed and authorized 5 hours per day of Attendant Care, 7 days/week. Member Service Preference Level is 2.
Situation	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.
Resolution	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.

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

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Document ID: DDD-QVADS-2885-001

Version 1.0

August 05, 2014

Division of Developmental Disabilities

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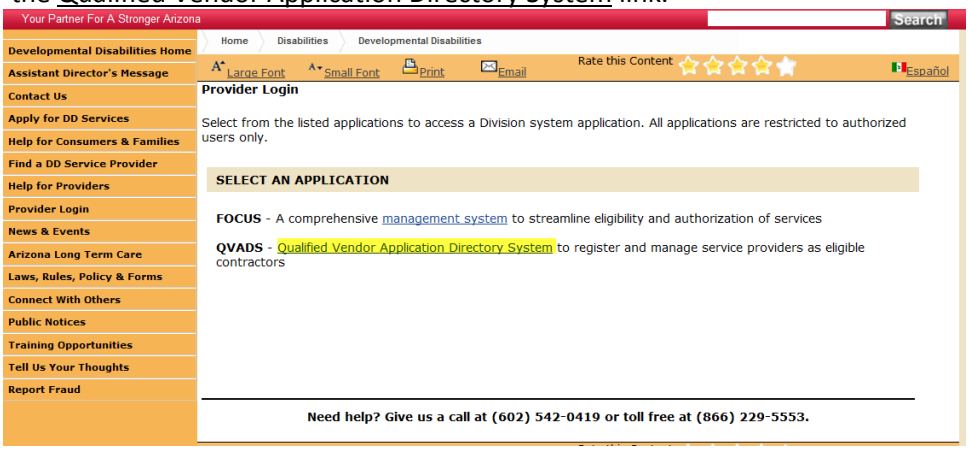
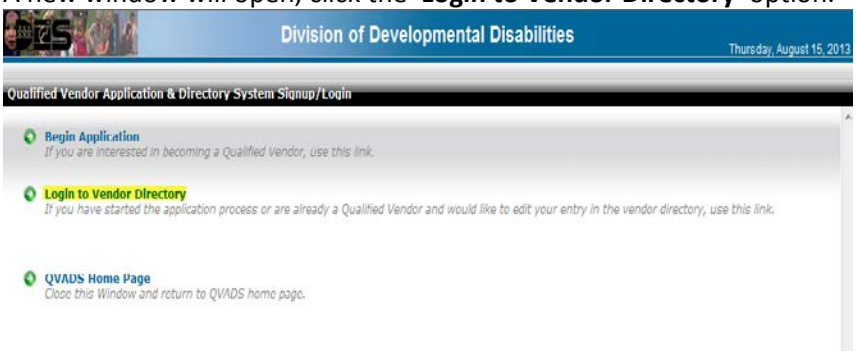
1 How to Login to QVADS

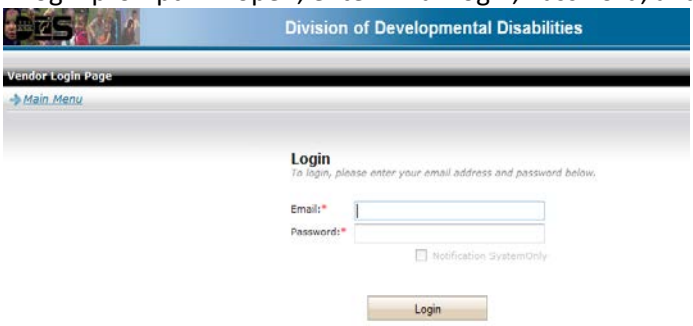
1. Login to QVADS by going to url https://www.azdes.gov/main.aspx?menu=96&id=2476 and click the Qualified Vendor Application Directory System link.



2. A new window will open; click the '**Login to Vendor Directory**' option.

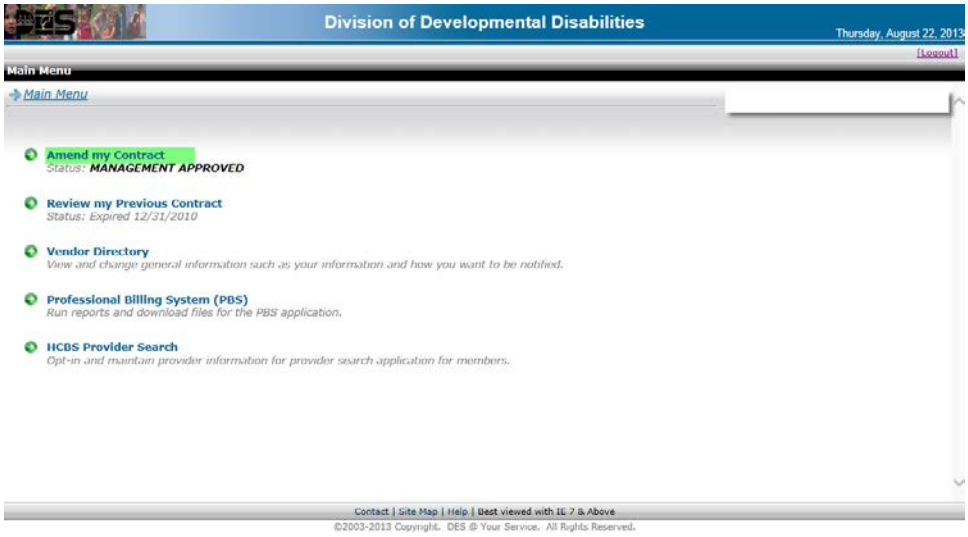


3. A login prompt will open; enter Email login, Password, and click [Login]

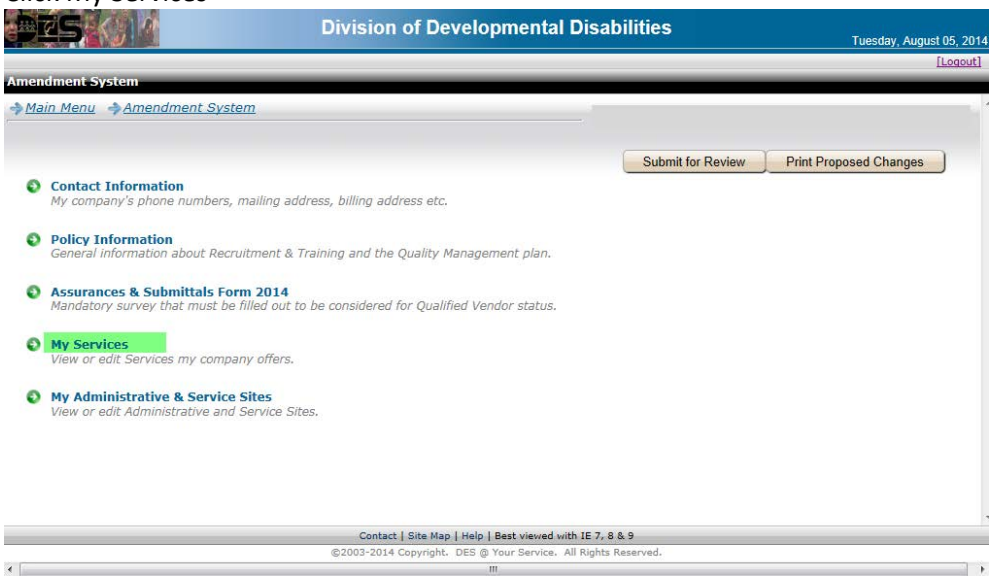


2 Updating the Agency with Choice Selection

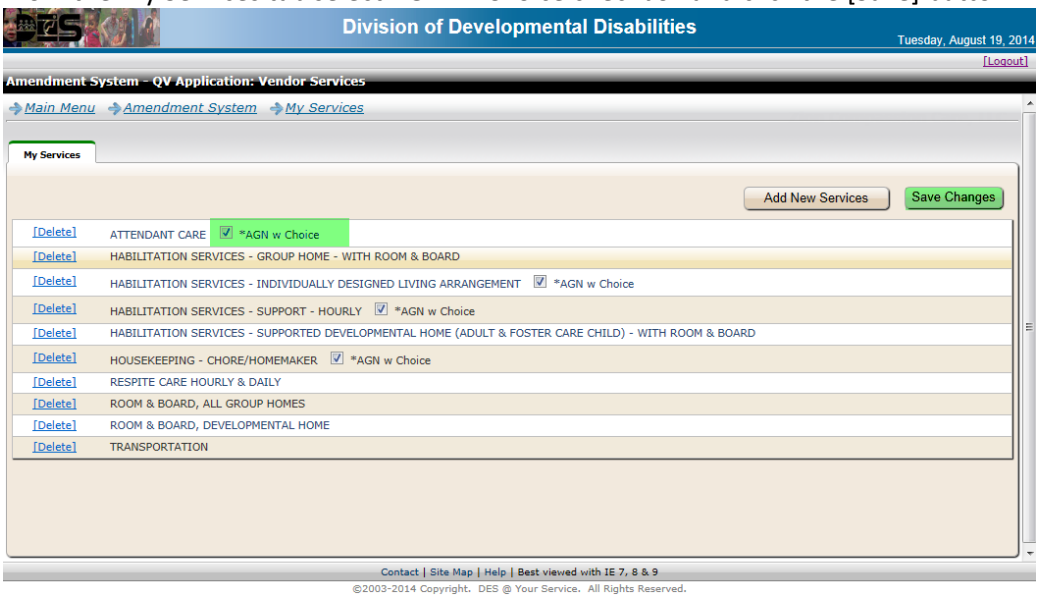
1. Click Amend my Contract



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.

DDD Agency With Choice User Guide – FOCUS Vendor

Version 1.0

July 28, 2014

DEPARTMENT OF ECONOMIC SECURITY
Your Partner For A Stronger Arizona

Division of Developmental Disabilities

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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.

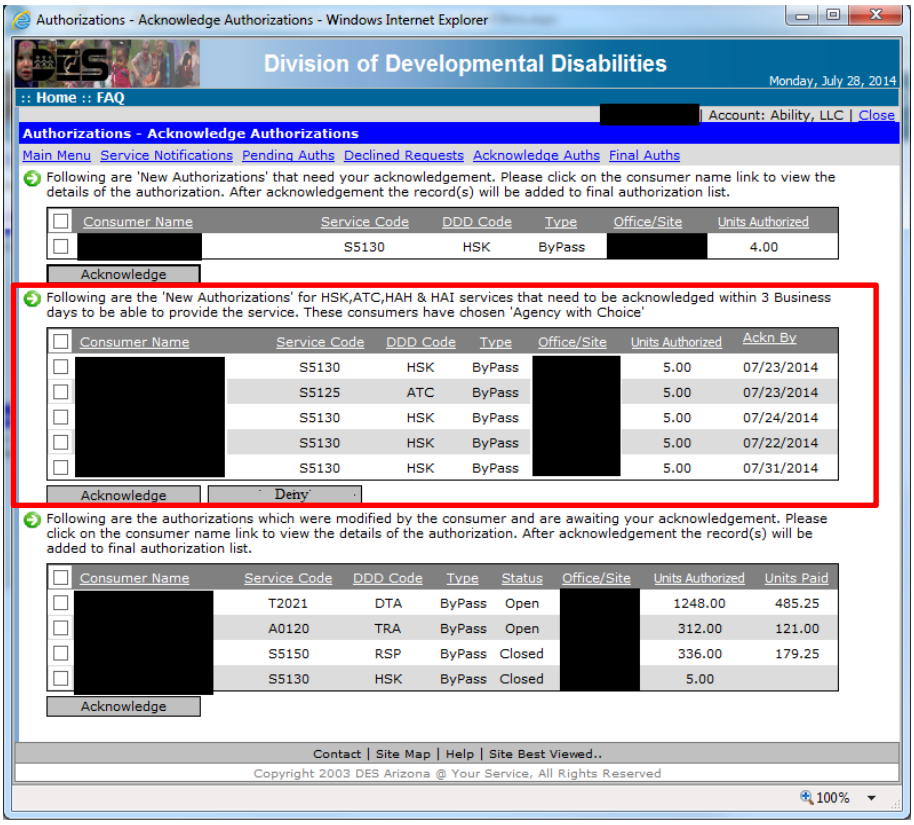
2.1 Acknowledge within 3 business days

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 busniess 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 modifer for submitting claims for services provided under Agency with choice option.

Example: