CHAPTER 3:

Provider Responsibilities

Reviewed/Revised: 01/01/2024

3.0 NETWORK SERVICES CONTACT INFORMATION

ACA StandardHealth with Health Choice is committed to ensuring you have an open line of communication with us at all times. Should you ever feel the need to escalate an issue, view the Provider Escalation Notice, exhibit 1.1.

Contact ACA StandardHealth with Health Choice

For information and assistance, call toll-free:
1-800-322-8670.

Medical Prior Authorization Fax:
1-800-422-8120

Language or ASO interpretation services:
1-800-322-8670

Provider Portal:
480-760-4651

PHARMACY – Formulary and medication lists, excluded drug lists, pharmacy coverage guidelines, drug prior authorization information and forms, and other forms and resources for ACA StandardHealth with Health Choice:

- Qualified health plans (QHPs)

Other Provider Networks
American Specialty Health (ASH) for Chiropractors 1-800-972-4226

Hours of Operation

Provider Services
Monday – Friday | 8 a.m. – 5 p.m.

Claims
Monday – Friday | 8 a.m. – 5 p.m.

Member Services
Monday – Friday | 8 a.m. – 5 p.m. (except holidays)

ACA StandardHealth with Health Choice
8220 N. 23rd Avenue
Phoenix, AZ 85021

3.1 YOUR NETWORK PROVIDER PERFORMANCE REPRESENTATIVE (PPR)

You can find the contact information for your assigned Provider Performance Representative by calling 1-800-322-8670.

Your assigned PPR serves as your primary contact to support your network participation with ACA StandardHealth with Health Choice. Your PPR works with you to answer questions, respond to concerns, and facilitate ease of doing business and a strong partnership.

Your PPR may communicate through email, phone calls, virtual meetings, and on-site visits to provide information on topics such as:

- Contracting and credentialing processes
- Current communications content, including:
- Provider email notices
- Provider newsletter
- Provider Manual
- Member Benefit Guides
- Claims/Claim Reconsiderations
- How to access the provider directory and validate/update directory listings
- Participation expectations and guidelines
- Resources and tools available on the provider portal
- Dispute resolution processes/Administrative disputes
- Provider/Practice Changes

3.2 NATIONAL IDENTIFICATION NUMBER (NPI)

HIPAA requires that all providers use a NPI number as the only provider identifier in electronic transmissions such as claims billing and claims payment. Providers must obtain an NPI For information regarding the NPI enrollment, visit the CMS website at https://nppes.cms.hhs.gov or call (800) 465-3203.

3.2.1 CORRESPONDENCE, PAY-TO, SERVICE ADDRESSES

ACA StandardHealth with Health Choice will maintain a correspondence address, a pay-to address or addresses, and a service address or addresses for each provider. The *correspondence address* and

fax number provided is the address and fax number where billing instructions, letters, and all other correspondence, except checks, are disseminated.

Each provider has only one correspondence address.

- Even if a provider has multiple service addresses, the provider has only one correspondence address.
- A provider must indicate the address where the provider wishes correspondence to be sent regardless of the service address(es).

If the provider changes practices, partnerships, or place of practice, the provider must update the correspondence address in a timely manner (90-days advance notice per contract); otherwise, new correspondence will not be directed to the correct address.

The provider may update this by using the Provider Portal *Provider Demographic Request* link within our online provider portal at: Log in - Health Choice Provider Portal (healthchoiceaz.com).

The *pay-to address* is the address on the reimbursement check from BCBSAZ Health Choice.

> The Remittance Advice, along with the reimbursement check, are mailed to the provider's pay-to address, as determined by the provider's tax identification number (see next section).

NOTE: ACH payments (electronic reimbursement) are sent directly to your bank. Paper copies of the Remittance Advice are mailed to your pay-to address unless the provider is set up to receive Electronic Remittance Advice. EOBs (Explanation of Benefits) are always available online through your secure provider portal. If your pay-to address is a lockbox at the bank you can update this information through the *Provider Demographic Request* link within your provider portal or contact your Provider Performance Representative to change the pay-to address to the location where your payment posting occurs. This will prevent delays in receiving the remits from the lockbox.

Monitoring EFT Payments. Providers are required to monitor receipt of EFT payments and to promptly report missing payments and erroneous or unauthorized entries. We will notify you of any scheduled delays or delays resulting from system issues. If you notice any other disruption in your normal payment cycle, please contact us immediately. If you do not notify us of missing payments within 14-days, we will not be liable for any losses incurred or interest on late payments.

The *service address* is the business location where the provider sees patients or otherwise provides services.

A locator code is assigned to each service address.

As new service addresses are reported to us, additional locator codes are assigned. When a service address is no longer valid, then the provider must notify us of the new service address to ensure the new service address locator codes are updated.

3.3 TAX IDENTIFICATION NUMBER

A provider's tax identification number determines who the payee is and where the payment is sent. It also allows us to properly report payment information to the IRS on form 1099- MISC. We require providers to enter their TIN on all claims submitted for processing. If no TIN is on file, the claim system will reject or deny the claim because it will be unable to direct payment to a specific address.

3.4 FEDERAL EXCLUSION

Providers are obligated under 42 C.F.R. §1001.1901(b), to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS- OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at www.oig.hhs.gov/fraud/exclusions.asp, as well, The System for Award Management (SAM) SAM.gov | Duns - Sam UEI formerly known as the General Services Administration (GSA) or Excluded Parties List System (EPLS).

3.5 BCBSAZ HEALTH CHOICE CREDENTIALING AND RECREDENTIALING

In collaboration with several other health plans in Arizona, we are an associate of AzAHP Alliance. The purpose of this alliance is to enable providers to complete a credentialing application form one time as the form is interchangeable between Arizona health plans. We work with the Council for Affordable Quality Healthcare (CAQH) where provider information is housed and updated making it accessible for providers.

CAQH ProView™ is a national, online database that collects information to eliminate the need for professional providers to complete multiple credentialing applications for different healthcare organizations. A healthcare organization must be a "participating plan" with CAQH, and the provider must authorize the plan to access credentialing information. Use of CAQH is free for providers, and registration can be completed at ProView.caqh.org. Providers must authorize us to access their completed profile by using the authorization function in ProView. Providers are responsible for updating their information.

You can find the provider application and instructions for participation on the BCBSAZ Health Choice website: https://www.standardhealthhc.com, under 'For Providers' -> 'Provider Overview & Joining Our Network' -> "How to Become a Provider of BCBSAZ Health Choice ".

There is a guide entitled *Network Participation Instructions, Found at:* https://www.standardhealthhc.com

All providers must be credentialed before a contract can be offered or prior to being added to an existing contract (associates). A provider who has not been credentialed or is not contracted cannot treat members and will not receive payment for services rendered to our members. All providers who desire to participate in the network are required to meet minimum standards at the time of application and as of the date of the initial credentialing or recredentialing.

All provider credentialing verifications are completed and then reviewed by the Credentialing Committee within the timeframe(s) outline in established Arizona laws (A.R.S. § 20-3451 et seq.), in receipt of the completed application.

An application is complete when at least all the following elements are present and accurate:

- A completed, signed, and dated Council for Affordable Quality Healthcare (CAQH) application.
- Current Attestation (not expired)
- Current Certificate of Insurance (COI)
- Current DEA Certification
- 5-Year Work History (If a gap in work history exceeds six months, the provider must explain the gap in writing).

We conduct recredentialing at least once every three (3) years. Contracted providers will be notified by our Credentialing Department or a designated entity. Part of the recredentialing process includes a medical records audit which will be conducted anytime during the 3-year period prior to recredentialing. It is important that providers complete the recredentialing application as quickly as possible. Failure to maintain a credentialed status may result in contract termination and non-payment of claims.

Providers have the right to review the information submitted to support their Credentialing application for evaluation. Evaluation includes the review of information obtained from any outside source except for references, recommendations, or other peer-review protected information. We will not reveal the source of the information if the information is not obtained to meet organizational credentialing verification requirements or if its disclosure is prohibited by law.

When the information varies substantially from the provider, the provider will have the ability to correct erroneous information that was submitted by another source within ten (10) business days of discovery. If the entire file is to be reviewed, it must be done so on the premises of ACA StandardHealth with Health Choice. If an individual document is requested for review it may be faxed or emailed to a provider, at the provider's request. We will document receipt of corrected information within the practitioner's credentialing file.

Providers also have the right to be informed of the status of their credentialing or recredentialing applications upon request. Information shared with the provider will include a status report of any required outstanding documents we haven't received and the anticipated date by which the completed file will be presented to the Credentialing Committee for decision.

We do not make credentialing decisions based on an applicant's race, ethnicity, national identity, gender, age, sexual orientation, or the types of conditions treated, procedures performed, or patients seen by the applicant. We ensure the credentialing and recredentialing process does not discriminate against healthcare providers solely based on license or certification, or providers who serve high-risk populations or who specialize in the treatment of costly conditions.

We ensure compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare, Marketplace, or Medicaid or that employ individuals or entities that are excluded from participation.

***Please Note* Credentialing approval date is never backdated.** The credentialing approval date is the later of the date reviewed by the Chief Medical Officer/designee or the Credentialing Committee date. The date variance can occur if the provider has adverse actions which require committee discussion prior approval.

For Physical Health providers the effective date of participation loaded within the claims processing system will be the later of, the effective date of the contract or the Credentialing approval date.

For Behavioral Health providers the effective date of participation loaded within the claims processing system will be the later of, the effective date of the contract, start date with the group, or the effective date of the professional liability/malpractice certificate of insurance coverage. The participation date will be made retroactive at a maximum of six months prior to the credentialing approval date.

The provider is responsible for ensuring all claims are submitted within timely filing requirements. The credentialing process includes a comprehensive review of required information before a provider can be contracted or added to an existing group contract.

URAC credentialing standards

BCBSAZ's URAC accreditation applies to all lines of business except dental stand-alone plans and our Medicare Advantage plans. The URAC credentialing standards require us to meet nationally-recognized quality guidelines for verifying the education, training, liability record, and practice history of network providers. Our URAC accreditation provides an important consideration for consumers and employers in the selection of their healthcare network.

Individual provider types

BCBSAZ credentials these individual provider types:

- Medical doctor (MD)
- Doctor of osteopathy (DO)
- Dentist (DDS/DMD)
- Doctor of podiatric medicine (DPM)
- Optometrist (OD)
- Clinical psychologist (PhD/EdD)
- Doctor of chiropractic (DC) – credentialed through a delegated arrangement with American Specialty Health (ASH)
- Nurse practitioner (NP)
- Physician assistant (PA)
- Acupuncturist
- Audiologist (AUD)

- Behavior analyst (BCBA – autism)
- Certified Lactation consultant (IBCLC)
- Certified nurse midwife (CNM)
- Licensed clinical social worker (LCSW)
- Licensed independent substance abuse counselor (LISAC)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)• Physical therapist (PT)
- Registered dietician (RD)
- Speech language pathologist (ST)

Institutional provider types

- Hospital (including hospital departments and specialty hospitals)
- Urgent care center
- Freestanding (ambulatory) surgical center (ASC)
- Skilled nursing facility (SNF)
- Rehabilitation treatment center (RTC) and extended active rehabilitation (EAR) facility
- Laboratory
- Behavioral health recovery care center
- Birthing center
- Cardiac rehabilitation program
- Comprehensive outpatient rehabilitation facility (CORF)
- Diabetic training program
- Durable medical equipment (DME) provider – includes orthotics, prosthetics, and independent diagnostic testing facilities (IDTFs)
- Facility designated as a federally qualified health center (FQHC)
- Home health agency
- Home infusion agency
- Hospice agency
- Mammography center
- MRI center
- Outpatient dialysis center
- Pain management clinic
- PET center
- Physical therapy and rehab outpatient facility
- Portable X-ray supplier
- Radiation therapy clinic
- Radiology center (includes MRI, CT, PET, ultrasound, and mammography)
- Rural health clinic
- Sleep lab
- Specialty pharmacy

- Ultrasound center

We value our network providers and work hard at being a good business partner. If and when disputes arise, we have processes in place to help resolve them. The nature of the dispute determines the specific resolution protocols:

Credentialing disputes related to a provider's professional competence or conduct, including:

a. Terminations for professional competency or conduct, or quality-of-care issues

b. Immediate suspension or termination for concerns about member safety

1. CREDENTIALING DISPUTES – resolution process

a. Terminations for professional competency, conduct, or quality of care

Contracted providers may dispute AZ Blue's decision to terminate a contract for lack of professional competence or for professional misconduct. Examples of these disputes include, but are not limited to:

- Belief that a quality-of-care issue exists that may cause harm to a patient's health, welfare, or safety
- Adverse action taken by a hospital
- Disciplinary action taken by a licensing board
- Trend or pattern of quality-of-care issues

If a provider is terminated for professional competency or conduct:

1. AZ Blue will notify the provider in writing of the reason for the termination, including reference to the evidence (or documentation) supporting the termination. If applicable, we will enclose a copy of the AZ Blue Provider Appeals Process (for terminations related to quality-of-care issues), which includes detailed information about the provider's reconsideration rights and the right to be represented by legal counsel.

2. The provider may request **reconsideration** in writing (including relevant information) no later than 30 calendar days after receipt of notice of termination from AZ Blue.

   2a. A reconsideration panel consisting of at least three qualified individuals who did not participate in the original decision, with at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees, will review the reconsideration request at its next meeting (scheduled at least quarterly).

   2b. The panel will notify the provider in writing within seven calendar days of its decision, including the right to an in-person hearing.

3. If the provider is not satisfied with the panel's decision, the provider has 30 calendar days from receipt of the decision to request a **second-level reconsideration** (with relevant information and a personal appearance before a second panel).

    3a. A second panel of three individuals who did not participate in the first-level decision, including at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees, will hold the second-level reconsideration hearing. The panel will be convened no sooner than 60 calendar days before and no later than 90 calendar days after AZ Blue receives the provider's request, unless an extension is necessary (for up to an additional 60 calendar days). Written notice will be sent to the provider at least 60 calendar days prior to the date of the scheduled hearing.

    3b. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within seven calendar days of the decision.

b. Immediate suspension or termination related to concerns about member safety

If an AZ Blue medical director believes a provider is practicing in a manner that poses a significant risk to the health, welfare, or safety of members, AZ Blue can either immediately suspend or terminate the provider for cause.

- If the circumstances require an investigation for AZ Blue to know whether the concerns are justified, AZ Blue will immediately suspend the provider contract and conduct an expedited investigation.
- If the circumstances do not require an investigation for AZ Blue to know whether the concerns are justified, AZ Blue will immediately terminate the provider contract.
- Examples of circumstances that might result in immediate suspension or termination include, but are not limited to:
    - Insufficient or no professional liability insurance
    - Sanction by Medicare/Medicaid
    - Exclusion from any federal programs
    - A change in license status which prohibits the provider from practicing or places limitations that materially limit the provider's ability to provide a full range of medically necessary services to members.
    - Fraudulent activity

When a suspension or termination occurs:

1. AZ Blue will promptly remove the provider from the directory and send the provider written notice of the action and the reason for it, including reference to the evidence (or documentation) supporting the termination. If applicable, we will enclose a copy of the AZ Blue Provider Appeals Process (for terminations related to quality-of-care issues), which

includes detailed information about the provider's available reconsideration rights (certain types of felony convictions cannot be appealed) and the right to be represented by legal counsel.

2. The provider has 30 calendar days from receipt of the notice to send AZ Blue a written request for **reconsideration** if the triggering event allows for reconsideration rights (certain types of felony convictions cannot be appealed). The request should include relevant information.

    2a. A reconsideration panel will review the reconsideration request at its next meeting (scheduled at least quarterly). The panel will have at least three qualified individuals who did not participate in the original decision, with at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees.

    2b. The panel will notify the provider in writing of its decision within seven calendar days after the meeting, including the right to an in-person hearing.

3. If the provider is not satisfied with the panel's decision, the provider has 30 calendar days from receipt of the decision to request a **second-level reconsideration** (with relevant information and a personal appearance before a second panel).

    3a. . The panel may extend the time A personal appearance panel will hold a second-level reconsideration hearing no sooner than 60 calendar days before and no later than 90 calendar days after AZ Blue's receipt of the request period for up to an additional 60 calendar days, for good cause. Written notice will be sent to the provider at least 60 calendar days prior to the date of the scheduled hearing.

    (The panel will have three individuals who did not participate in the first-level decision, including at least one participating provider who is a clinical peer of the requesting provider and who is not otherwise involved in AZ Blue provider network management or other AZ Blue committees.)

    3b. The panel's decision is final and will be communicated to the provider in writing, via certified mail, within seven calendar days of the decision.

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3.6 CONTRACT , CONTRACT TERMINATION or PROVIDER PROFESSIONAL TERMINATIONS

Provider contracts renew automatically for successive one-year terms. Providers are to follow the Termination requirements outlined within your Services Agreement. Refer to your contract.

Contract Articles: Duties of Provider and Provider Professionals and **Term and Termination.**
Providers who move or leave a contracted group may not be automatically offered a contract at their new place of employment. A contract offer or renewal in such cases is contingent upon network need. We routinely review our provider network and may make changes based upon network management considerations. Should you plan to leave a contracted group and go out on your own please contact your Provider Performance Representative.

Because members must be notified at least 30 (thirty) days in advance of a terminating provider, providers are required to notify your Provider Performance Representative in writing of your decision to terminate or of all terminated providers in the group practice at least 90 (ninety) days in advance. This notice must be signed by the physician/provider or practice/company staff with signature authority> It may be mailed, faxed, or emailed to Network Services. Providers terminating their contracts without cause are required to continue to treat members until their treatment course is completed. Early notification will assist you and the member in transferring care, should that be required. Authorization may be necessary for these services.

Should a member need to be transferred to another provider because of termination, the provider can assist in the process by:

- Providing a copy of the member's medical record to the member or accepting provider, should it be requested.
- Speaking with the accepting provider regarding transfer of care issues.

The transferring provider will communicate all health care treatment to ensure continuity of care for the member.

In some areas where there are limited specialty providers, we may allow a non-participating provider to continue care if a member is under active treatment. Authorization may be necessary for these services. If you identify a member in this circumstance, please contact our Care Management Department for assistance.

Provider selection and participation criteria
Selection criteria for providers to be contracted for and to remain in the provider networks include, but are not limited to:

1. *Quality of care,* such as:
   - Credentialing requirements, including verification of education, training, experience, licensure, malpractice/liability insurance coverage, and sanctions/malpractice history
   - Evidence-based practices consistent with current professional standards
2. *Quality of service,* such as: Demonstrating the highest professional and ethical standards of services
   - Interacting with members in a culturally competent manner that exemplifies dignity and respect
   - Complying with access and availability guidelines
   - Adhering to policies, procedures, and requirements in our participation agreements and

the Provider Manual
   - Maintaining a safe and professional healthcare environment
3. *Alignment with our business needs* such as:
   - Provider types and specialties
   - Number of members routinely seen by provider
   - Exclusive network considerations

We do not discriminate against any provider seeking qualification as a participating provider. However, we may decline a request from an otherwise qualified provider, and non-renew/terminate the contract of a current provider, based on specific business needs and administrative/operational considerations. Participation in an exclusive network is based on, but is not limited to, the following factors: credentialing status, hospital system affiliation, contract rates, quality of care, quality of service, and network need.

Standard participation agreements
All participating providers are required to sign a written agreement.

Mental health parity
Providers must comply with and maintain parity between the behavioral/mental health and medical benefits covered under BCBSAZ benefit plans, pursuant to applicable federal and/or state law and regulations and any related regulatory or sub-regulatory guidance.

Confidentiality and data use
Network providers are contractually required to follow HIPAA security standards and uphold the confidentiality of certain types of information, including but not limited to:

- Price and fee terms in the participation agreement
- Medical records and personal health information (PHI)
- Data or data transmissions not intended for the provider
- Specific communications protocols
- Proprietary information including policies, program information, requirements, guidelines, etc.

Confidential information received from us may be used only for the purpose for which it was disclosed. It may not be sold, separated, fragmented, used out of context, disclosed for reasons other than its intended purpose, or comingled with other data. Providers must return or destroy confidential information upon conclusion of the business purpose(s) for which it was disclosed unless this is not feasible for legal or licensure reasons. In such cases, providers must continue to protect the confidential information as described above.

Contract Administrative Disputes involving matters not related to quality of care, may include but not are limited to; Contract concerns such as breaches, or other administrative matters will be presented to your Provider Performance Representative in writing. All Contract Administrative dispute will be acknowledged within three business days or receipt.

3.7 DELEGATED CREDENTIALING ENTITIES

Delegated Credentialing Entities agree to comply with all applicable policies and procedures and URAC Standards. We maintain established policies to ensure oversight and monitoring of delegated duties which include, but are not limited to the following:

- Participation in pre-delegated audits to ensure the ability to meet or exceed applicable regulatory standards;
- Participation in audits (at least annually), to ensure compliance with applicable policies and procedures in coordination with respective regulatory requirements; and
- Submit rosters (at least monthly) identifying terminated providers (aka, provider no longer with the delegated entity) and newly added providers.
- Documentation that the following sites have been queried at the time of Credentialing, Recredentialing, and in between Credentialing cycles monthly for Ongoing Monitoring. Any provider that is found to be on any of the lists below may be terminated and the identity of the provider must be disclosed to us immediately for immediate
    - Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) https://oig.hhs.gov/exclusions/exclusions_list.asp , and
        - The System for Award Management (SAM) https://www.sam.gov/SAM/ formerly known as the General Services Administration (GSA) or Excluded Parties List System (EPLS).

3.8 CHANGES TO PROVIDER INFORMATION ON FILE

Provider data verification and notification of changes

Participating providers must comply with contractual and regulatory requirements to verify their demographic information every 90-days and to *promptly* inform us of any changes to:

- Tax ID number(s)
- Name
- National provider identifier (NPI)
- Hospital privileges
- Opening and closing patient panels
- Rosters of practitioners associated with tax IDs and group NPIs
- Business email address, physical office address(es), website URL address, phone numbers, and other demographic changes
- EFT bank account information

Failure to respond to our validation requests will result in removal of your information from the provider directory. The information will be reinstated upon your verification.

Use the Provider Information Change form for timely notification of changes

According to the Consolidated Appropriations Act (CAA), provider must ensure timely notice of changes in previously reported information. *Providers must notify us of changes* 90 days in advance of the change date or *promptly upon knowing the changes are forth coming.*

Contracted providers are required to notify your Provider Performance Representative in writing of ***any changes*** at least 90 days prior to the effective date of change.

Examples of changes, updates, additions, staffing:

- Practice/company name/change of ownership
- Physical services addresses
- Payee address
- Tax identification number
- NPI
- Staff additions/terminations
- Phone and/or fax numbers

By not keeping your information current, you may experience claim rejections, non-payments, or returned check payments. Providers or administrative staff will complete the appropriate AzAHP form to Request for Participation or Change Information and submit request on Letterhead (or a notice signed by the Practice/Company staff). Providers can submit directly through your secure online Provider Portal E-Apply feature.

Completing the online form allows users to save information and return later to finish without risk of losing the information. Once completed, the form can be printed and mailed to other health plans that require the AzAHP Practitioner form. For practitioners practicing at the same location information can be copied from one form into another form. Currently, only the Practitioner AzAHP form is available for online submission.

Visit us online at: Provider Education - Health Choice Arizona (healthchoiceaz.com) for additional instruction on submitting online Credentialing request(s). Providers can also submit and initiate

Credentialing in the following ways:

If the provider is not yet contracted:
Email form to HCHContracting@azblue.com

For contracted providers:
Submit request via your secure provider portal (E-Apply) or
Email to the Credentialing Department at: HCHCredentialing@azblue.com

If we can provide staff training, please contact your Provider Performance Representative.

Keeping your staff trained saves you time and money!

3.9 LICENSURE/CERTIFICATION UPDATES

We require providers have current copies of their state license, DEA certificate and Malpractice insurance on file. Our Credentialing Department sends letters to providers requesting current copies of these documents when the documents on file have expired.

Failure to provide us with these documents can result in termination from the network.

3.10 CONTINUITY OF CARE/TIME FRAME FOR TRANSITIONAL CARE

Terminating Providers or Contract terminations without cause are required to continue to treat members until their treatment course is completed. Authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. If you identify a member in this circumstance, please contact our Prior Authorization Department for assistance.

Continuing Care Period for Qualified Health Plans (QHP) ACA StandardHealth with Health Choice contracted providers, at minimum, must continue rendering services to members who are continuing care patient for a period ending 90-days following the date of contract termination, or such earlier date that the member no longer qualifies as a Continuing Care Patient. Members have continuing care rights under applicable law 42 USC 300gg-138. The new NSA provisions impact the time period required by law. For specific patients in a course of treatment, the period may be longer than the 90-day period.

3.11 APPOINTMENT AVAILABILITY/ APPOINTMENT WAITING TIME

Ongoing monitoring of participating providers

To ensure and evaluate the accessibility to services and compliance with other participation obligations, we may periodically perform telephonic or on-site reviews of PCP and specialist offices. These visits address various aspects of the administrative requirements and are facilitated by the provider's assigned Provider Performance Representative. Provider requirements for member access to healthcare services include the following appointment availability and wait times:

Access to Service and Availability Guidelines	
Type of Care [(URAC MHP v8,1, NM 3-3(a)(i) & (a)(ii)]	**Appointment Wait Time Standards Must Be**
Routine and preventive care visits: Includes services that promote good health, reduce the likelihood of disease, or provide early detection of a disease or illness. Examples include routine primary care visits, immunizations, and screening tests.	***Within 15 days***
Behavioral Health: Includes services by a behavioral health practitioner such as addiction medicine, board-certified behavioral analyst, developmental/behavioral pediatrics, licensed clinical social worker, licensed independent substance abuse counselor, licensed marriage and family	***Within 10 days***

therapist, licensed professional counselor, psychologist, neuropsychology, psychiatric nurse practitioner, psychiatrist, and neuropsychiatry**.**	
Specialty care visits (Non-Urgent): Includes services by a physician or practitioner who has education, training, or qualifications in a specialty other than those practiced by primary care providers. Examples include but not limited to visits to a cardiologist, orthopedic surgeon, ophthalmologist, psychiatrist, or dermatologist.	***Within 30 days***
** Qualified health plans (QHPs) are ACA-compliant and available to individuals/families on the Health Insurance Marketplace.*	

After-hours coverage: Includes services in response to the patient's non-emergency medical and mental health needs outside of regular office hours. Examples include an answering service, on-call practitioner, and phone system messaging that clearly conveys access options.		**24 hours/day, 7 days/week**
Office wait time: Wait time is measured from the scheduled appointment time until the patient is seen by a healthcare professional, barring unforeseen emergencies.		**Within 30 minutes**
Telephone wait time during office hours: Wait time is measured from the time the telephone call is answered until the patient is given an opportunity to discuss the purpose of the call.		**Within 3 minutes**
Medical telephone triage: A healthcare professional shall triage patient telephone messages and return calls.	**Emergency calls** **Urgent calls non-urgent calls**	**Immediately** **2 business hours** **4 business hours**

3.12 APPOINTMENT AVAILABILITY /WAIT TIME NON-COMPLIANCE

We ensure contracted providers are accessible to members to provide routine care on a timely basis. Providers will be asked to implement a corrective action plan when appointment wait time standards are not met.

We monitor the accessibility of contracted providers through:

- Appointment availability surveys
- Member complaints
- Quality management audits
- Site visits

Failure to comply to the access to care appointment availability standards may result in a limitation on membership or a reduction in assigned members.

3.13 HOURS OF OPERATION AND AFTER-HOURS COVERAGE / PHYSICIAN VACATION COVERAGE

We ensure network practitioners offer (at a minimum) standard hours of operation that are no less (in number or scope) than the hours of operation offered to non-ACA Plan members. We ensure the provider's hours offered to ACA Plan members are comparable to those offered to other commercial patients.

Each provider must have twenty-four (24) hours per day, seven (7) days per week coverage. It is not acceptable to refer members to the emergency department as a means to provide after-hours or vacation coverage. It is the responsibility of the PCP to arrange after-hours care and vacation coverage by a contracted physician/provider.

Acceptable coverage includes the following:

- An answering service that picks up the physician office's telephone after hours. The operator will then contact the physician or his covering physician.
- An answering machine that either directs the caller to the office of the covering physician or directs the caller to call the physician at another number.
- Call forwarding services automatically send the call to another number that will reach the physician or his covering physician.

Unacceptable coverage includes the following:

- An answering machine that directs the caller to leave a message (unless the machine will then automatically page the doctor to retrieve the message).
- An answering machine that directs the caller to go to the emergency room and gives no other option.
- An answering machine that has only a message regarding office hours, etc., without directing the caller appropriately, as outlined above.
- An answering machine that directs callers to page a beeper number.
- No answering machine or service.
- If your answering machine directs callers to a cellular phone, it is not acceptable for charges to be directed to the caller (i.e., members should not receive a telephone bill for contacting the physician in an emergency).

The PCP must notify their Provider Performance Representative of arrangements made for vacation coverage. Notification for vacation coverage includes expected departure and return dates; name, address, and telephone number of covering physician; and if covering physician office will be available to triage and/or answer questions for assigned members. If the covering physician is unavailable, the PCP should contact their Provider Performance Representative. Provider Performance Representative will provide names and telephone numbers of physicians who may be able to render same day treatment. We will not reimburse physicians who provide coverage for a capitated physician or a fee-for-service physician. Reimbursement of the covering physician is the sole responsibility of the PCP who is absent. Arrangements should be made in advance between the physicians.

3.14 PRIMARY CARE PHYSICIAN (PCP) REQUIREMENTS

Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) perform critical functions for the health plan. We rely on you to provide an efficient and effective model of care that assures assigned members receive the medical care and services they require. PCPs are gatekeepers or medical managers and are responsible and accountable for the coordination, supervision, deliverance, and documentation of health care services to assigned members. Our Quality Management Committee periodically reviews guidelines for PCP management.

We monitor the over and under-utilization of covered services, in both the inpatient and outpatient settings. This data is used to improve overall performance of the health plan using local and national benchmarks. We monitor our PCPs to see if their members are seen more or less frequently and for what reason. That helps us predict and arrange for the necessary specialists, ancillary and hospital services they may require. Specialists are required to submit the appropriate referring provider and/or authorization number on their claims. Our contracted specialists work in concert with the member's Primary Care Provider to coordinate the overall care for the member. Our goal is to develop partnerships with the specialists in our network.

3.14.1 PHYSICIAN/ADVANCED PRACTICE PRACTITIONER REGISTRATION

Hospitals and clinics may not bill for physicians and Advanced Practitioner services using the hospital or clinic NPI number.

Physicians and Advanced Practitioners must bill for services under their individual NPI numbers. Advanced Practitioners include:

- Registered Nurse Practitioners
- Certified Nurse-Midwives
- Certified Registered Nurse Anesthetists (CRNAs)
- Surgical First Assistants
- Physician Assistants
- Affiliated Practice Dental Hygienist

Hospitals and clinics may bill as an agent for physicians and Advanced Practitioners. In these cases, the claims submitted to us must include *both* the physician's/Advanced Practice Practitioner's NPI as the rendering/service provider and the hospital's/clinic's or group biller NPI number.

3.15 PEDIATRIC GENERAL DENTISTS

We rely on our contracted pediatric general dentists to provide an efficient and effective model of care that assures members receive the dental care and services they require. The general dentist acts as a gatekeeper and is responsible and accountable for the coordination, supervision, delivery, and documentation of dental health care services to our pediatric members. We monitor the over and under- utilization of covered dental services. This data is used to improve overall performance of the Health Plan using local and national benchmarks.

3.16 PEDIATRIC DENTAL SPECIALISTS

Pediatric dental specialists are required to submit the appropriate authorization number on their claims. Our contracted dental specialists work in concert with the members referring dentist to coordinate the overall oral health care for the member.

3.17 MEMBERS WITH SPECIAL NEEDS

Members with special needs may be characterized as:

1. People who have communication barriers, such as
   - Speak a different language
   - Low literacy
   - Visual or hearing impaired
   - Geographically isolated people
   - Are homeless
2. Those who require health and related services of a type or amount beyond required by people in general as:
   - Common and often mild chronic health issues with unique presentations, for example, allergies, arthritis, and hypertension
   - Complex and manageable health issues, for example, asthma, diabetes, heart failure, or behavioral health conditions
   - Complex and difficult-to-address health issues such as lupus, cerebral palsy, major functional disabilities
   - Adults with Serious Mental Illness
   - Children with Serious Emotional Disturbance
   - People who have substance use disorders
   - Diagnosis specific groups, such as HIV/AIDS cases
   - Physically disabled adults, children, and frail elderly
   - Organ transplant recipient or waiting for transplant
3. People whose eligibility status complicates understanding of managed care and enrollment, such as:
   - Uninsured families and children less familiar with the health system or managed care, who may be eligible under the states' expansion programs

The health care needs of this population often differ from the general population in the type, scope, frequency, coordination, and duration of care needed. Should you have a member with special health care needs, please contact our Care Management Department by calling (800) 322-8670. Additionally, we actively engage in ongoing efforts to identify designated provider locations for accommodating members with physical or cognitive disabilities. If your provider location offers unique features to help accommodate members with various special needs as outlined above, please contact your Provider Performance Representative at (800) 322-8670 so that we can ensure your accommodations are identified in our Provider Directory.

3.18 HISTORY AND PHYSICAL

It is expected a complete history and physical (for medical providers) will be documented in the

member's medical chart. This will be reviewed during medical record audits.

3.19 HOSPITAL ADMISSIONS

We use a fully participatory hospitalists program at most of its network hospitals. The PCP may contact the appropriate contracted hospitalist group to arrange hospitalization or call us for assistance. The PCP will continue to manage the patient's care after discharge. The hospitalist program does not cover pediatric or obstetrical cases. In these situations, as well as those cases where a hospital is not covered under our hospitalist program, the PCP or obstetrician should expect to follow the member in the hospital. The PCP or PCO should communicate directly with our Prior Authorization Department when a hospital admission is necessary.

All non-emergency hospital admissions for Inpatient Acute, Rehabilitation, Long Term Acute Care, Skilled Nursing Facilities, Hospice and Observation require notification.

- All facilities must notify us
- Fax Inpatient Notifications to 480-760-4732

All non-emergency hospital admission for psychiatric inpatient/subacute, Level I Behavioral Health Inpatient Facilities, Behavioral Health Residential Facilities (BHRF), require prior authorization.

- Fax Request to 480-760-4732.

Electroconvulsive Therapy (ECT), Transcranial Magnetic Therapy (TMS) and out of network outpatient provider behavioral requests require prior authorization.

- Fax Request to 1-877-HCA-8120 (1-877-422-8120).

In the event acute or behavioral health inpatient hospitalization services delivered are to evaluate and stabilize an emergency medical condition, the plan must be notified of the admission within 1 calendar day.

We conduct concurrent review of all inpatient admissions. We use evidence-based, nationally recognized criteria when performing concurrent inpatient review.
We strongly recommend the facility notifies the plan as quickly as possible to help guarantee full coverage of medical services rendered.

3.20 IMMUNIZATIONS

CHILDREN IMMUNIZATIONS

Age-appropriate immunizations are to be provided following the standards adopted by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices, which includes the recommended immunization schedule for persons aged 0 through 18 years approved by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetricians and Gynecologists (ACOG). Those members who are unable to document prior immunization should be immunized until current with their appropriate age group. Arizona law requires that providers report all immunizations administered to children under age 19 to Arizona State Immunization Information System (ASIIS).

ADULT IMMUNIZATION

Age-appropriate immunizations, when administered, shall be provided following the standards adopted by the CDC's Advisory Committee on Immunization Practices (ACIP), which includes the Adult Immunization Schedule approved by the AAFP, the American College of Physicians (ACP), the ACOG, and the American College of Nurse Midwives. Providers are strongly encouraged to administer immunizations to adults for influenza and pneumonia when medically indicated and in conjunction with current CDC recommendations.

3.21 PATIENT EDUCATION

Contracted providers are expected to provide appropriate prevention, health promotion and disease management education. Providers may discuss medically necessary or appropriate treatment options with members even if the options are not covered services. Health maintenance education is not only expected and encouraged it is required. Members should receive counseling about disease prevention and the importance of regular health maintenance visits. Documentation of this counseling must be included in the planning and implementation of the member's care.

It is expected providers will educate patients about their unique health care needs; share the findings of physical examinations; discuss potential treatment options, side effects and management of symptoms; and, in general recognize that the patient has the right to choose the final course of action among clinically acceptable options.

It is particularly expected that members will be advised about the difference between urgent conditions, such as earaches, or flu, and emergent conditions and be instructed to contact their PCP first before visiting an emergency room or calling an ambulance unless they have a real emergency.

3.22 PROVIDER'S RIGHT TO ADVOCATE

It is our position that a provider has rights to advocate on a member's behalf regarding the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits, and consequences of treatment or non-treatment
- 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.

3.23 PRESCRIPTIONS

Prescriptions should be written to allow generic substitution when available and signature on prescriptions must be legible for the prescription to be dispensed. Providers with electronic medical records should prescribe medications electronically. It is the responsibility of the prescriber to obtain prior authorization prior to prescribing drugs not on the Pharmacy Formulary.

Refer to the chapter: *Pharmacy and Drug Formulary,* for additional guidance.

3.24 REFERRALS

The PCP is responsible for initiating and coordinating referrals to specialists in our network. It is critical that a strong communication link be maintained with specialists and/or behavioral health providers who treat your patients. A record of the referral and any treatment notes from the specialists/behavioral health provider must be maintained in the member record.

We encourage PCPs to maintain communication with the specialist when referring assigned members for specialty care. We simplified the referral process to make it easier for the PCPs. Specialists are responsible for requesting prior authorization for follow-up services and other referrals as necessary.

3.25 MEMBER DEATH

Providers are required to notify the Member Services Department of a member's death. Please provide the member's name, member's ID number, date of birth, date, and place of death.

3.26 DRUG UTILIZATION CONCERNS

Our goal is to provide safe, quality care for assigned members. Providers with concerns about a member's drug utilization should refer the member to our Care Management Department. We may identify members as having a potential substance abuse issue through provider information, utilization review, pharmacy reports, or emergency room visits. We will contact the PCP when there is a suspected substance abuse problem and assist with coordination of care.

3.27 EMERGENCY DEPARTMENT

An "emergency" is medical or behavioral health condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could result in:

- Placing the patient's health, including mental health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Serious physical harm to self or another person.

Emergency medical services are covered for members when there is a demonstrated need and/or after triage/emergency medical assessment services indicate an emergency condition. A provider is not required to obtain prior authorization for emergency services.

*** Providers May Not Refer Members to The Emergency Department Due Solely to Non-Availability of A Same Day Appointment.**

We contract with a number of Urgent Care Centers. Ask your Provider Performance Representative for details and a location near you. All assigned members are considered ACTIVE

patients. Every effort should be made to meet the appointment availability standards.

3.28 FRAUD, WASTE, AND ABUSE (FWA)

- **DEFICIT REDUCTION ACT/FALSE CLAIMS ACT**

Under the Deficit Reduction Act of 2005 (DRA) (Public Law 109-171 Section 6032) and in coordination with applicable state laws and contractual specifications, we are required to ensure all contracted providers receive training and train their staff on aspects of the Federal False Claims Act provisions.

You may locate compliance resources for physicians on the Federal OIG site at the following links:

- Federal OIG Guidance on False Claims Act provision: Go to video on False Claims Act.

We are committed to detecting, reporting, and preventing potential fraud and abuse. Fraud and abuse are defined as:

Fraud*:* Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law. (Source: 42 CFR 455.2)

Member Abuse*:* Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse, or sexual assault. (Source: 42 CFR 455.2)

Provider Fraud*:* Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost, or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of Fraud and Abuse include:

<u>Falsifying Claim/Encounters</u> ○ Altering a claim Incorrect coding ○ Double billing Submitting false data ○ Substitution of services	<u>Falsifying Services</u> ○ Billing for services/supplies not provided ○ Misrepresentation of services/supplies	<u>Administrative/Financial</u> ○ Kickbacks ○ Falsifying credentials Fraudulent enrollment practices ○ Fraudulent TPL reporting ○ Fraudulent recoupment practices
<u>Member Issues (Abuse)</u> ○ Physical abuse ○ Mental abuse ○ Emotional abuse ○ Sexual abuse ○ Discrimination	<u>Member Issues (Fraud)</u> ○ Eligibility determination issues Resource misrepresentation ○ (transfer/hiding) ○ Residency ○ Household composition	<u>Denial of Services</u> ○ Denying access to medically necessary covered services/benefits ○ Limiting access to medically necessary covered services or benefits

○ Neglect ○ Financial abuse ○ Providing substandard care of medical condition	○ Citizenship status ○ Income ○ Prescription alteration Misdiagnosis ○ Durable medical equipment theft ○ Failure to report Third Party Liability	○ Specialist under-utilization ○ Misrepresentation

REPORTING FRAUD AND ABUSE (INCLUDING PRESCRIPTION FRAUD)
We encourage providers and provider office staff to report potential fraud and abuse to us by contacting their Network Provider Performance Representative who will refer the case to the Compliance Department for investigation.

You may also feel free to contact the Compliance Department directly at:

ACA StandardHealth with Health Choice
Attn: Compliance Department
8220 N. 23rd Ave
Phoenix, AZ 85021

AlertLine - any event for any product: **1-800-237-0916**

3.29 AMERICANS WITH DISABILITIES ACT (ADA) & TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Under Title III of the ADA, requirements for public accommodations such as a provider's office mandate they must be accessible to those with disabilities. Providers should ensure their offices are as accessible as possible to persons with disabilities and should make efforts to provide appropriate accommodations such as large print, materials, or easily accessible doorways for those with disabilities.

Under the provisions of Title VI of the Civil Rights Act of 1964, no person shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

For more information pertaining to available ADA resources please call your Network Service Representative.

<u>Section 1557 of the Patient Protection and Affordable Care Act</u>
Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits

discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, and is intended to advance health equity and reduce health care disparities.

It is the first federal civil rights law to broadly prohibit discrimination on the basis of sex in federally funded health programs. It also includes important protections for individuals with disabilities and enhances language assistance for people with limited English proficiency.
Providers must comply with the following requirements:

- Post a notice of nondiscrimination and taglines in the top 15 languages spoken by individuals with limited English proficiency.
- Develop and implement a language access plan
- Designate a compliance coordinator and adopt grievance procedures (applicable to group practices with 15 or more employees)
- Submit an assurance of compliance form to Office of Civil Rights at the Unites States Department of Health and Human Services

For more information regarding the non-discrimination provisions of Section 1557 of the ACA, please see https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

3.30 ADVANCED DIRECTIVES OR END OF LIFE CARE

Hospitals, nursing facilities, home health agencies, hospice agencies, and organizations responsible for providing personal care must comply with Federal and State law regarding Advance Directives for adult members.

These providers are encouraged to provide a copy of the member's executed Advance Directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.

Requirements of the Federal and State law include:

- Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care,
- And the right to execute an advance directive. 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.)
- Provide written information to adult members regarding each 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).
- Documenting in the member's medical record whether the adult member has been provided the information and whether an advance directive has been executed.
- Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
- Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.

- PCPs that have agreements with any of the aforementioned entities must comply with paragraphs listed above.

End of Life (EOL) Care is a member centered approach with the goal of preserving member rights and maintaining member dignity while receiving any other medically necessary covered services. EOL care includes educating members and families about illness and treatment choices; to keep them healthy; and to afford them greater flexibility in deciding what his or her treatment course will be when faced with life limiting illness regardless of age or stage of the illness. EOL care allows members to receive Advance Care Planning, palliative care, supportive care, and hospice services.

3.31 MARKETING (INCLUDING USE OF THE BCBSAZ NAME OR LOGO)

Permission to use the BCBSAZ name or logo (Brands)
The Blue Cross® and Blue Shield® Brands (Brands) are the intellectual property of the Blue Cross Blue Shield Association (BCBSA), which has licensed these marks to BCBSAZ. The BCBSA Brand Regulations provide the standards and guidelines for use of the Brands by all licensees. See below for specific provider guidelines.

Signs and communications within Arizona
BCBSAZ-contracted providers may place small signs on their premises, and issue communications within Arizona, to indicate their participation in the BCBSAZ provider network. A provider must obtain written approval from BCBSAZ prior to issuing a communication that includes the Brands.

Website
A contracted provider may also display the BCBSAZ name/logo on its internet site, provided that such site does not advertise or promote provider locations outside of Arizona, and use complies with all other regulations.

Joint communications
Joint communications are any public communication in which the Brands and the name or brand(s) of an unlicensed entity appear—e.g., the name or brands of a contracted provider. With prior written approval, BCBSAZ may permit the use of the BCBSAZ name/logo in other types of joint communications with a provider in connection with BCBSAZ programs or services, subject to the regulations.

Blue symbols (cross and shield)
When the Blue symbols are used, the BCBSAZ name and Independent Licensee tagline must appear to the right or below the symbols.

Narrative text
When used in narrative text, the BCBSAZ name must be spelled out with registered trademark symbols (Blue Cross® Blue Shield® of Arizona) and include the BCBSA Independent Licensee tagline (An Independent Licensee of the Blue Cross Blue Shield Association). The symbols only need to be used at the first reference within a communication (once per page in digital communications).

Examples of narrative text

Correct examples:

- Contracted with ACA StandardHealth with Health Choice an Affordable Care Plan of Blue Cross® Blue Shield® of Arizona, an Independent Licensee of the Blue Cross Blue Shield Association.

Incorrect examples:

- Contracted with Blue Cross/Blue Shield.
- Contracted with BC/BS or BCBS.
- We accept Blue.
- We accept Blue Cross.

Prohibited use

• A provider may not use the Brands in Yellow Pages or similar telephone directories, and in communications or activities outside of Arizona.

• A provider may not use the words “blue,” “cross,” or “shield” in reference to its name, office location, internet URLs, email, Facebook, Twitter, YouTube, or other social media accounts.

For questions about or requests for prior approval of Brand use in communications, please contact your Provider Performance Representative.