CHAPTER 3:

Provider Responsibilities

Reviewed/Revised: 10/1/18, 11/1/18, 7/9/19, 9/23/19, 1/1/20, 2/1/20, 3/1/20, 4/1/20, 5/1/20, 7/1/20, 11/1/20, 1/15/21, 3/25/21, 10/12/21, 10/29/21, 12/1/21, 4/1/22, 6/1/22, 8/16/22, 9/1/22, 4/20/23, 07/01/23, 10/01/23

3.0 AHCCCS PROVIDER REGISTRATION NUMBER

All participating providers must register with the Arizona Health Care Cost Containment System (AHCCCS) and obtain a unique provider registration number. To become an AHCCCS provider, a provider must sign the Provider Participation Agreement (PPA). Per the PPA, providers must follow all AHCCCS guidelines, policies, and manuals, including but not limited to the following: the AHCCCS Medical Policy Manual (AMPM), the AHCCCS Fee-For-Service Provider Billing Manual, AHCCCS Claims Clues, and Reporting Guides. These guidelines, policies, and manuals are available on the AHCCCS website: https://azahcccs.gov/. Please refer to AHCCCS Medical Policy Manual (AMPM) , AHCCCS Contractor Operations Manual (ACOM), AHCCCS News & Press Releases (azahcccs.gov), FAQs (azahcccs.gov), and Medical Coding Resources as available on the AHCCCS website to insure you have reviewed the most recent versions of state guidance.

The AHCCCS Provider Enrollment Portal (APEP) is a secure web-based enrollment process, designed to ease enrollment by decreasing processing time. It also allows providers to submit new enrollment or modifications to an existing provider ID effectively any time of the day. For registration or questions, providers may call the AHCCCS Provider Registration Department directly at (480) 417-7670, Option 5 or 1 (800) 794-6862, or visit the AHCCCS website at https://azahcccs.gov/PlansProviders/NewProviders/registration.html

3.0.1 Referring, Ordering, Prescribing, Attending (ROPA) Providers Required to Register with AHCCCS

The Patient Protection and Affordable Care Act (ACA) and the 21st Century Cures Act (Cures) require all health care providers who provide services to, order (refer), prescribe, or certify health care services for AHCCCS members must be enrolled as an AHCCCS provider. Additional reference is available in section 3.18.2 of this chapter. For more information about the AHCCCS initiative, visit the AHCCCS ROPA page: https://www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html

3.0.2 AHCCCS PROVIDER TYPES

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician, etc.) established by AHCCCS. The AHCCCS Provider Registration Unit will assist providers in identifying the most appropriate provider type, based on the provider's license/certification and other documentation. A listing of provider types can be found in AMPM 610, Attachment A- AHCCCS Provider Types. We use this same provider type as designated by AHCCCS within our systems.

3.0.3 AHCCCS PROVIDER CATEGORIES OF SERVICE (COS)

Within each provider type, mandatory and optional categories of service (COS) are identified. Mandatory COS are defined by mandatory license or certification requirements. The provider must submit documentation of license and/or certification for each mandatory COS.

Optional COS are those the provider may be qualified to provide and chooses to provide.

- Optional COS, which do not require additional license and/or certification, are automatically posted to the provider's file.
- Optional COS, which do require additional licensure and/or certification, are posted once proof of current, valid licensure and/or certification is received.

Mandatory and optional COS, licensure/certification requirements, and the applicable procedure codes for each provider type are listed in the Provider Profile. Providers may be limited to certain procedures within a COS. If limitations are applicable, the allowable procedures are identified in the Provider Profile.

3.1 NATIONAL IDENTIFICATION NUMBER (NPI)

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

3.1.1 CORRESPONDENCE, PAY-TO, SERVICE ADDRESSES, AND GROUP BILLERS

We maintain a correspondence address, a pay-to address or addresses, and a service address or addresses for each provider except group billers. Billing providers and group billing providers, who have elected to act as a financial representative for a provider or a group of providers, who have authorized the arrangement, may register as a Group Biller with AHCCCS. Group billers may not provide services or bill as the service provider. They will receive a separate Group Billing AHCCCS Registration Number. For group billers, we maintain a correspondence address and a pay-to address only. For additional information regarding group Billers please see Chapter 3 of the AHCCCS FFS Provider Manual. 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 BCBSAZ Health Choice Provider Portal *Provider Demographic Request* link within our online provider portal at: www.HealthChoiceAZ.com, under 'For Providers' –> *Provider Portal.* 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 (ERA). EOBs 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, the provider must notify us of the new service address to ensure the new service address locator codes are updated.

3.2 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.

3.3 FEDERAL EXCLUSION

As a registered provider with the AHCCCS Administration, (Arizona's Medicaid Program), you 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. See also 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).

3.4 BCBSAZ HEALTH CHOICE CREDENTIALING AND RECREDENTIALING

In collaboration with several other health plans in Arizona, we are an associate of the 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 plans. We work with the Council for Affordable Quality Healthcare (CAQH) where provider information is housed and updated making it accessible for providers.

You can find the provider application and instructions for participation on the BCBSAZ Health Choice website: www.HealthChoiceAZ.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.healthchoiceaz.com/providers/overview/.

All providers must be credentialed with BCBSAZ Health Choice before a contract can be considered effective or prior to being added to an existing contract (associates). A provider who has not been credentialed or is not contracted cannot treat our members and will not receive payment for services rendered to our members. All providers who desire to participate in the provider 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) as established by AHCCCS AMPM 950, 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 the Credentialing Department or a designated entity. It is important that providers complete the recredentialing (CAQH) application as quickly as possible and keep the information maintained. 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's submission, the provider will have the ability to correct erroneous information 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 our premises. 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 not 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 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 latter of the date reviewed by the Clinical 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. In the event the AHCCCS registration date occurs after the effective date of the contract or the Credentialing approval date, the AHCCCS registration date will prevail as the effective date of participation loaded within the claims system.

For Behavioral Health providers the effective date of participation loaded within the claims processing system will be the latter of, the effective date of the contract, start date with the group, the AHCCCS registration effective date, 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.

3.5 MINIMUM SUBCONTRACT PROVISIONS

The Minimum Subcontract Provisions (MSPs) are referenced and incorporated into the AHCCCS Provider Participation Agreement as well as AHCCCS Medicaid Contracts, including Intergovernmental Agreements. AHCCCS Contractors' subcontracts must reference and require compliance with the MSP.

Applicable AHCCCS minimum subcontract provisions are located on the AHCCCS website at: https://www.azahcccs.gov/PlansProviders/HealthPlans/minimumsubcontractprovisions.html

3.6 CONTRACT RENEWAL, CONTRACT TERMINATION or PROVIDER PROFESSIONAL TERMINATIONS

Provider contracts renew automatically for successive one-year terms. Providers are to follow the Termination requirements outlined within the BCBSAZ Health Choice 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 or practice/company staff with signature authority. 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 due to 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.

3.7 DELEGATION OF PROVIDER FUNCTIONS

A contracted provider may not delegate any provider function without advance written consent from us. Upon receiving consent, functions further delegated by a provider shall be subject to the terms of the Subcontractor Agreement between BCBSAZ Health Choice and the provider in accordance with the most current applicable AHCCCS and NCQA Standards.
Applicable AHCCCS minimum subcontract provisions are located on the AHCCCS website at:

https://www.azahcccs.gov/PlansProviders/HealthPlans/minimumsubcontractprovisions.html

In accordance with the AHCCCS Contractor Operations Manual (ACOM), Chapter 438, all Administrative Services Subcontractors (and/or Delegated Entities) are required to develop and maintain a Business Continuity Plan, which must be submitted to us upon request.

Additionally, the AHCCCS Medical Policy Manual (AMPM) is also available via the AHCCCS website at: https://www.azahcccs.gov/shared/MedicalPolicyManual/

3.8 DELEGATED CREDENTIALING ENTITIES

Delegated Credentialing Entities agree to comply with all applicable BCBSAZ Health Choice policies and procedures in coordination with respective AHCCCS policies and NCQA 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 BCBSAZ Health Choice initiated 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 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 reporting to AHCCCS/OIG in accordance with the AHCCCS ACOM Policy 103:
    - 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).

Current AHCCCS Policies regarding credentialing activities is available via the AHCCCS website in Chapter 950 of the AHCCCS Medical Policy Manual located at:
AHCCCS Medical Policy Manual (AMPM) (azahcccs.gov)

3.9 CHANGES TO PROVIDER INFORMATION ON FILE

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

*In addition, the provider must register the change with AHCCCS prior to the effective date of change. * 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!

3.10 LICENSURE/CERTIFICATION UPDATES

We require providers to have current copies of their state license, DEA certificate and Malpractice insurance on file. The 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.

3.11 CONTINUITY OF CARE/LOSS OF ELIGIBILITY

Providers terminating their contract 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.

3.12 APPOINTMENT AVAILABILITY/ APPOINTMENT WAITING TIME

Contracted PCPs and Specialists must maintain appointment availability within the standards prescribed by AHCCCS (per the AHCCCS Contractor Operations Manual, Chapter 417) as well as the current NCQA NET 2 Standards. Providers are expected to establish a procedure for waiting time so a member does not wait more than 45 minutes, except in emergency cases or unforeseen circumstances. We monitor providers' appointment availability and members in office waiting time on an on-going basis.

The standards below are applicable to both new and established patients:

<table>
<tr><th>Applicable to</th><th>Routine</th><th colspan="2">Emergency & Urgent</th></tr>
<tr><td>PCPs</td><td>21 Calendar Days from the day of request</td><td colspan="2">Emergency: As expeditiously as the member's health condition requires on the same day of the request or within 24 hours.

Urgent: As expeditiously as the member's health condition requires but no later than 2 business days of request</td></tr>
<tr><td>Specialists</td><td>45 Calendar Days from the day of the referral</td><td colspan="2">Urgent: As expeditiously as the member's health condition requires but no later than 2 business days of request</td></tr>
<tr><td>Dental Providers</td><td>45 Calendar Days from the day of the request</td><td colspan="2">As expeditiously as the member's health condition requires but no later than 3 business days of request</td></tr>
<tr><td rowspan="4">Behavioral Health (BH) Providers</td><td colspan="2">Routine Initial Assessment: Within 7 calendar days of referral or request for service

Within 48 hours for pregnant women with substance use disorders</td><td rowspan="4">Emergency & Urgent
Emergency: Within 6 hours for a non-life-threatening emergency

Urgent: As expeditiously as the member's health condition requires but no later than 24 hours from identification of need</td></tr>
<tr><td colspan="2">(Routine) Ongoing Services</td></tr>
<tr><td colspan="2">For members aged 18 years or older: 23 calendar days non-IV drug users</td></tr>
<tr><td colspan="2">For members under age 18 years old: No later than 21 days after the initial assessment</td></tr>
<tr><td></td><td colspan="2">All subsequent behavioral health services, as expeditiously as the</td></tr>
</table>

	member's health condition requires but no later than 45 calendar days from identification of need.	

Maternity Services	***First Trimester***	***Second Trimester***	***Third Trimester***	***High Risk Pregnancy***
	Within 14 calendar days of request	Within 7 calendar days of request	Within 3 business days of request	As expeditiously as the member's health condition requires and no later than within 3 business days of identification of high-risk status or immediately if an emergency exists

Response for Referrals or Requests for Appointments for Psychotropic Medications

For eligible members who may need to be seen by a Behavioral Health Medical Practitioner (BHMP), it is required the person's need for medication be assessed immediately and, if clinically indicated, that the person be scheduled for an appointment within a timeframe that ensures:

- The person does not run out of any needed psychotropic medications; or
- The person is evaluated for the need to start medications to ensure that the person does not experience a decline in his/her behavioral health condition, but no later than 30 calendar days from the identification of need as per **ACOM 417 Appointment Availability, Monitoring and Reporting.**
- WHEN: Have a BHMP assess the urgency of the need immediately. Provide an appointment with a BHMP within a timeframe indicated by clinical need, but no later than 30 calendar days from the identified need.
- WHAT: Screening, consultation, assessment, medication management, medications, and/or lab testing services as appropriate.
- WHO: All Title XIX/XXI eligible persons, all Non-Title XIX/XXI persons enrolled with a T/RBHA, all persons determined to have a Serious Mental Illness and any person in an emergency or crisis.

*Additional information regarding appointment standards and timeliness requirements for behavioral health services can also be found in Chapter 18 of the BCBSAZ Health Choice Provider Manual, *Behavioral Health Services*.

3.13 NON-EMERGENCY MEDICAL TRANSPORTATION

In our ongoing efforts to ensure the provision of quality care and services for our members, we contract with Medical Transportation Brokerage of Arizona (MTBA). MTBA is a non-emergency medical transportation company committed to providing quality and timely medical transportation. Members are encouraged and expected to:

- Contact their PCP to schedule appointments or seek medical advice.
- Arrive and depart no more than an hour before and after scheduled appointment.
- Because it is critical for members to be able to reach their physicians, hold times should not

exceed 5 minutes. We monitor telephone accessibility to ensure that members can reach you to schedule appointments or seek advice.

*Transportation to behavioral health appointments may be coordinated through the member's assigned behavioral health home.

3.14 APPOINTMENT AVAILABILITY NON-COMPLIANCE

In accordance with AHCCCS policy, we ensure contracted physicians, ancillary services and facilities are accessible to enrolled members to provide routine and emergent care on a timely basis. Providers will be asked to implement a corrective action plan when appointment availability standards are not met.

We monitor the accessibility of contracted providers through:

- Member complaints
- Quality management audits
- Emergency room utilization
- Appointment availability surveys
- Site visits by BCBSAZ Health Choice staff

Failure to comply with the AHCCCS appointment availability standards is viewed as an access to care issue and may result in a limitation on membership or a reduction in assigned members.

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

We ensure that 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-Medicaid members. If the practitioner serves only Medicaid recipients, we ensure the provider's hours offered to AHCCCS members are comparable to those offered to fee-for-service members.

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 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 BCBSAZ Health Choice physician.

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 that 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 BCBSAZ Health Choice 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 BCBSAZ Health Choice Provider Performance Representative. The 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.

3.16 MISSED DENTAL APPOINTMENTS

We require providers to notify us of members who miss their scheduled appointment. Missed appointments should be reported using the Missed Dental Appointment Log (Exhibit 3.5.2). The Missed Dental Appointment Log should be faxed or emailed weekly to at Fax (480) 760-4716 or HCHEPSDTCHEC@azblue.com. We contact these members to educate them on the importance of keeping scheduled appointments and to provide dental awareness education.

3.17 MISSED MEDICAL APPOINTMENTS

BCBSAZ Health Choice strongly encourages providers to notify us of members who miss their scheduled appointment. Missed appointments should be reported using the Missed Medical Appointment Log (Exhibit 3.5.1). The Missed Medical Appointment Log should be faxed weekly to BCBSAZ at (480) 760-4716 or e-mail to hchdentaldeptHCA@azblue.com. We contact these members to educate them on the importance of keeping scheduled appointments and to discuss any barriers in attending the medical appointment. We also encourage providers to remind members of upcoming appointments as a way to decrease no shows and to contact patients who miss appointments and educate them about the importance of preventive care appointments.

3.18 PRIMARY CARE PROVIDER

Primary Care Providers (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. Capitated providers are required to submit claims regardless of reimbursement.

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. For example, an average AHCCCS member will seek primary care related services 3.5 times each year. We monitor our PCPs to see if their members are seen more or less frequently and for what reason. This helps us predict and arrange for the necessary specialists, ancillary and hospital services they may require.

For guidance as to which specialists/services require Prior Authorization, refer to Chapter 6: Medical Authorizations & Notifications. Specialists are required to submit the appropriate 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.

3.18.1 PHYSICIAN/ADVANCED PRACTICE PRACTITIONER REGISTRATION

Hospitals and clinics may not bill the AHCCCS Administration or its Managed Care Organizations (MCO) for physician and Advanced Practitioner services using the hospital or clinic NPI number.

Physicians and Advanced Practitioners must register with AHCCCS and 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 register as group billers and 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.

3.18.2 AHCCCS REGISTRATION IN ACCORDANCE WITH 42 CFR 455.410

Per 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 to be reimbursed for covered services provided to AHCCCS members. After January 1st, 2016, if a provider is not enrolled with AHCCCS as a valid and/or active provider, claims will deny.

A provider who chooses to order, refer, or prescribe items and/or services for AHCCCS members, but who chooses not to submit claims to AHCCCS directly, must still be registered with AHCCCS to ensure payment of those items and/or services. If a rendering provider submits a claim to AHCCCS based on the order, referral, or prescription of a provider *not* registered with AHCCCS then that claim will be denied.

To ensure payment of claims when submitting for items and/or services ordered, referred, or prescribed by another provider, the rendering provider must ensure that the ordering/referring/prescribing provider is both registered with AHCCCS and that their NPI number is on the submitted claim.

3.19 GENERAL DENTISTS

We rely on our contracted 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 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.

3.20 DENTAL SPECIALISTS

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.

3.21 EPSDT

The Early Periodic Screening, Diagnostic and Treatment (EPSDT) program is federally mandated and includes all AHCCCS eligible members from birth through age 20. EPSDT includes well child visits and referrals for dental, vision and behavioral health care. Refer to Chapter 16: *Family Planning, Maternal Health and Children's Services* for complete details. EPSDT Clinical Sample Template Order Sheet– see Exhibit 3.7

EPSDT Clinical Sample Templates

All EPSDT screening services must be documented on age appropriate, standardized EPSDT Clinical Sample Templates or equivalent forms. All components must be completed and documented.

Please indicate that the child is a BCBSAZ Health Choice member by filling in the appropriate box. The EPSDT Clinical Sample Templates must be returned to us. You may batch these forms monthly and return them in bulk to the mailing address, email, or fax below:

BCBSAZ Health Choice
Attn: EPSDT Coordinator
8220 N. 23rd Ave
Phoenix, AZ 85021
Email: HCHEPSDTCHEC@azblue.com
Fax: (480) 760-4716

The AHCCCS EPSDT Clinical Sample Templates or equivalent form must be used by providers to document all age-specific, required information related to EPSDT screenings and visits. You can go to the AHCCCS Medical Policy Manual Chapter 430 Attachment E and download the templates at: https://www.azahcccs.gov/shared/MedicalPolicyManual/index.html. Keep one copy for your medical records. ***Offices using electronic medical records please note:*** the EPSDT portion MUST adhere to and contain all the components found within the AHCCCS EPSDT Clinical Sample Templates.

All immunizations provided to our members are to be documented in the Arizona State Immunization Information System (ASIIS). Access to ASIIS is:
https://asiis.azdhs.gov/

3.22 FAMILY PLANNING

Arizona statute requires that AHCCCS members of reproductive age have available Family Planning services. PCPs are responsible for ensuring that members have information and access to these services. Refer to Chapter 16: *Family Planning, Maternal Health, and Children's Services* for complete details.

3.23 MEMBERS WITH SPECIAL NEEDS

Members with special needs may be characterized as:

- People who have communication barriers, such as
  - Speak a different language
  - Low literacy
  - Visual or hearing impaired
  - Geographically isolated people
  - Are homeless
- 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

- People whose eligibility status complicates understanding of managed care and enrollment, such as:
  - Dually eligible Medicare/Medicaid members
  - 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 on-going 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.

3.24 HISTORY AND PHYSICAL

It is expected that 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.

3.25 HOSPITAL ADMISSIONS

We use a fully participatory hospitalist program at most of its network hospitals. The PCP may contact the appropriate BCBSAZ Health Choice 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 situations where a hospital is not covered under our hospitalist program, the PCP or obstetrician should expect to follow the member in the hospital.

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 BCBSAZ Health Choice within 1 calendar day.
- Fax Inpatient Notifications to 480-760-4732

All non-emergency hospital admission for psychiatric inpatient/subacute, Level I Behavioral Health Inpatient Facilities for person underage of 21, Behavioral Health Residential Facilities (BHRF), Therapeutic Foster Care For Children (TFC), and Adult Behavioral Health Therapeutic Homes require prior authorization.

- Fax Request to 480-760-4732 within 1 calendar day.

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 accepted nationally recognized criteria when performing concurrent inpatient review. We strongly recommend the facility notifies the plan as quickly as possible to ensure a collaborative discharge planning process and post discharge Transition of Care support is in place. Notification also facilitates the claims payment process.

3.26 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 providers report all immunizations administered to children under age 19 to Arizona State Immunization Information System (ASIIS).
Providers must participate with the Vaccines for Children (VFC) program to obtain vaccines. Failure to maintain current standing as a VFC provider may be grounds for contract termination.

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.

3.27 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. Refer to Chapter 5: *Quality Management* for health education and preventive services.

3.28 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.

3.29 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 our formulary. For further details, refer to Chapter 17: *Pharmacy and Drug Formulary* or refer to our website at www.HealthChoiceAZ.com.

3.30 REFERRALS

The PCP is responsible for initiating and coordinating referrals to specialists within the BCBSAZ Health Choice network as well as to the Children's Rehabilitative Services (CRS) and the Regional Behavioral Health Authorities (RBHAs) for persons with Serious Mental Illness, and behavioral health providers for people with other behavioral health conditions.

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 our referral process to make it easier. Specialists are responsible for requesting prior authorization for follow up services and other referrals as necessary. For a list of services that require authorization, refer to Chapter 6: Authorizations and Notifications.

3.31 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.

3.32 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.

3.33 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 established by AHCCCS Guidelines: Emergent – same day; Urgent – within 2 days (PCPs) - within 3 days (Specialists/Dentists).

3.34 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. The goal is to ensure AHCCCS funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies. Every dollar lost to the misuse of AHCCCS benefits is one less dollar available to fund programs which provide essential medical services for Arizona residents.

The Office of the Inspector General audits and investigates providers and members who are suspected of defrauding the AHCCCS program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud for criminal prosecution.

As a Medicaid and/or Medicare services provider, it is your responsibility to immediately report matters involving fraud, waste, and abuse. The direct link for reporting suspected fraud, waste, and abuse through the AHCCCS webpage is:
https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx

Additional information and education regarding reporting suspected instances of fraud, abuse, or waste are located on the AHCCCS OIG webpage at: https://azahcccs.gov/Fraud/ReportFraud/.

Below is the AHCCCS Office of the Inspector General (OIG) website link, which provides training tutorials for providers and the general public that includes (a) administrative remedies for false claims and statements; (b) applicable laws related to civil or criminal penalties for false claims and statements; and (c) whistleblower protections under such laws.

If an incident is identified that warrants self-disclosure, providers are required to report the incident within 10 calendar days to AHCCCS/OIG by completing and submitting the Provider Self-Disclosure form available on the AHCCCS/OIG webpage https://www.azahcccs.gov/Fraud/Providers/

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

- http://oig.hhs.gov/compliance/physician-education/index.asp
- Federal OIG Guidance on False Claims Act provisions: http://oig.hhs.gov/newsroom/video/2011/heat_modules.asp . (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 to the AHCCCS program, or in 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:

Falsifying Claim/Encounters ○ Altering a claim Incorrect coding ○ Double billing Submitting false data ○ Substitution of services	Falsifying Services ○ Billing for services/supplies not provided ○ Misrepresentation of services/supplies	Administrative/Financial ○ Kickbacks ○ Falsifying credentials Fraudulent enrollment practices ○ Fraudulent TPL reporting ○ Fraudulent recoupment practices
Member Issues (Abuse) ○ Physical abuse ○ Mental abuse ○ Emotional abuse ○ Sexual abuse ○ Discrimination ○ Neglect ○ Financial abuse ○ Providing substandard care of medical condition	Member Issues (Fraud) ○ Eligibility determination issues Resource misrepresentation ○ (transfer/hiding) ○ Residency ○ Household composition ○ Citizenship status ○ Income ○ Prescription alteration Misdiagnosis ○ Durable medical equipment theft ○ Failure to report Third Party Liability	Denial of Services ○ Denying access to medically necessary covered services/benefits ○ Limiting access to medically necessary covered services or benefits ○ Specialist under-utilization ○ Misrepresentation

REPORTING FRAUD AND ABUSE (INCLUDING PRESCRIPTION FRAUD)

We encourage providers and provider office staff to report potential fraud and abuse by contacting their Network Services Representative who will refer the case to the Compliance Department for investigation.

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

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

We also provide the internal reporting hotline: AlertLine - any event for any product: **1-800-237-0916**

Although providers and their staff are encouraged to report potential fraud and abuse cases through BCBSAZ Health Choice as described above, they may also use one of the following external/confidential hotlines:

AHCCCS Fraud/Abuse
AHCCCS Office of Program Integrity / Mail Drop 4500
801 E. Jefferson
Phoenix, AZ 85034

- Provider Fraud
  - If you want to report suspected fraud by a medical provider, please call the number below:
  - In Arizona: 602-417-4045
  - Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686
- Member Fraud
  - If you want to report suspected fraud by an AHCCCS member, please call the number below:
  - In Arizona: 602-417-4193
  - Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686
- or, report using online form: https://www.azahcccs.gov/Fraud/ReportFraud/

3.35 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 that 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 offered through BCBSAZ Health Choice, please call your Network Service Representative.

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

discrimination based on 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. Physicians that participate in state Medicaid programs are subject to the provisions of this law.

It is the first federal civil rights law to broadly prohibit discrimination based on 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.

3.36 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. The Advance Directive should also be uploaded to Contexture, the Arizona HIE.

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 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 Medicaid covered services. This 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.

3.37 MARKETING

According to the current AHCCCS Health Plan Marketing Policy, we must have signed contracts with PCP's, specialists, dentists, and pharmacies to be included in marketing outreach programs that focus on AHCCCS members. Providers should contact the BCBSAZ Marketing Department at Rainey.Holloway@azblue.com to ensure any marketing materials that target BCBSAZ Health Choice members are approved by the AHCCCS Division of Health Care Management. Upon receiving the request, we will coordinate the provider's request with AHCCCS for approval for any marketing materials intended for use by providers.

3.38 CORPORATE COMPLIANCE; INTEGRATED HEALTH HOME (IHH), BEHAVIORAL HEALTH HOME (BHH) AND SUB-CONTRACTOR REQUIREMENTS

We require all Integrated Health Homes (IHHs), Behavioral Health Homes (BHHs) and Sub-Contractors to develop and implement an agency-specific and agency-wide Corporate Compliance Program which shall encompass the Office of the Inspector General's (OIG) Seven Elements of an Effective Compliance Program as follows:

- Policies & Procedures
- Designation of a Compliance Office & Compliance Committee
- Training & Education
- Communication
- Disciplinary Guidelines
- Monitoring & Auditing
- Prompt Response & Corrective Actions

Additionally, all IHHs, BHHs and sub-contractors shall develop and implement an annual Corporate Compliance Plan addressing how fraud and abuse will be prevented and detected. It is further recommended other providers (who are not IHHs/BHHs) also implement a Corporate Compliance Program and develop a Corporate Compliance Plan. Resources, including evaluation template and training materials are available upon request.

DEFINITIONS

The following definitions pertaining to this chapter are sources from the Code of Federal Regulations, Title 42, Part 455. Applicable links are provided:

- Fraud means an 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 some fraud under applicable Federal or State law (42 CFR 455.2).
- Abuse [Program 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 recipient practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2)
- Waste is defined by the Centers for Medicare &Medicaid Services (CMS) as the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicaid and Medicare Program. Waste is general not considered to be caused by criminally negligent actions, but rather the misuse of resources.
- Knowingly or knowingly and willfully means that a person, with respect to information
  - Has actual knowledge of the information;
  - Acts in a deliberate ignorance of the truth or falsity of the information; or
  - Acts in a reckless disregard of the truth or falsity of the information; and
  - Proof of specific intent is not required (42 CFR 402.3).
- Suspected fraud or abuse is defined as evidence or information that would lead a reasonable person to believe that fraud or abuse is occurring or has occurred.
  This would normally involve evidence of a material loss or unnecessary expense, a pattern of occurrence and something to show intent to defraud or unsound business practices. An alternate phrase for "suspected fraud or abuse" could be "reasonable belief of fraud or abuse" (A.R.S. §36-2918.01).

CORPORATE COMPLIANCE TRAINING

- All IHH/BHH and sub-contractor employees are required to complete Corporate Compliance Training:
  - Within 90 days of hire
  - All employees at least annually thereafter (must be completed no later than February 1st each year).

Training for all IHH/BHH employees and subcontractors must include:

- Fraud and abuse detection, prevention, and reporting requirements, in accordance with Provider Manual Section 3.34 Fraud and Program Abuse Reporting.
- All other providers are required to provide Corporate Compliance Training within 90 days of employees' hire date.

We will provide the IHHs/BHHs and sub-contractors with a mandatory Essential Learning training each year. For IHHs/BHHs and sub-contractors without access to the E-Learning module, a PowerPoint version of the training will be made available. Annually, the material will be reviewed and updated (if necessary).

IHHs and BHHs will be required to complete and sign form *IHH/BHH Corporate Compliance Form* (Exhibit 3.38) *the Training Certification Form (*section 3.38.1) verifying that all employees and sub-contractors at their agencies have received the training and must submit it to our Corporate Compliance Officer no later than February 1st each year. One-on-one training provided by our Corporate Compliance Officer to any new IHH/BHH Corporate Compliance Officer is mandatory within three months of assignment.

Other Providers (Sub-Contractors)

Within 90 days of hire all employees and sub-contractors must receive training on general compliance, HIPAA, and fraud and abuse requirements and protocols.

Providers must train all employees and sub-contractors in fraud and abuse detection, prevention, and reporting requirements, on an annual basis. Training resources and materials are available to providers upon request.

EXCLUDED PROVIDERS

The 2007 Federal Sentencing Guidelines require organizations to use reasonable efforts not to employ, in positions of substantial authority, any individual the organization knew or should have known through the exercise of due diligence, has engaged in illegal activities or other conduct inconsistent with an effective compliance and ethics program. Ongoing reasonable efforts include but are not limited to:

- Prior to employment, required disclosures, background checks, comparison with federal excluded persons lists and primary source verification of credentials and references;
- During employment, ongoing monitoring;

To ensure that it does not have a prohibited relationship with an individual who is excluded from participating in federal programs in violation of 42 CFR § 438.610 and 42 CFR 1001.1901, which prohibits health care organizations from knowingly having a relationship with any person or entity that is debarred, suspended or otherwise excluded from participating, organizations are expected to maintain and comply with policies and procedures related to the excluded provider process. These include using government sanctions lists, including the OIG's List of Excluded Individuals/Entities (LEIE), the System for Awards Management (SAM), including the Excluded Parties Listing System (EPLS), and CMS Preclusion List to determine if any of the organization's directors, officers, employees, or contractors who provide items and services that are significant and material to the organization under its contract with BCBSAZ Health Choice appear on any of the exclusion lists.

These reviews are conducted prior to the start of an individual or entity's relationship with the organization, and then monthly thereafter. If any of the individuals appear on any of the exclusion lists the organization will terminate the prohibited relationship. The organization will notify us immediately of any confirmed instances of an excluded provider that is or appears to be in a prohibited relationship with the organization or its sub-contractors.

Integrated Health Homes (IHHs), Behavioral Health Homes (BHHs) and Sub-Contractors – Requirements for conducting Exclusion Checks

IHHs/BHHs and sub-contractors are required to submit annual attestations (Exhibit 3.38) to the BCBSAZ Health Choice Corporate Compliance Officer (and/or Designee) via e-mail. Any positive results will be reported to us immediately upon discovery.

BCBSAZ Health Choice e-mail contact(s) notification for submission of IHH/BHH Exclusion Report(s) submissions:

- Nicole Larson, BCBSAZ Health Choice Corporate Compliance Officer (Nicole.Larson@azblue.com)
- BCBSAZ Health Choice Compliance inbox (HCH.Compliance@azblue.com)

Note:

Please ensure attestations are sent via e-mail; and, that submissions are sent to the BCBSAZ Health Choice Corporate Compliance Officer (with a cc: to the point of contact for Providers Services) – as referenced above.

Other Providers

Other providers are required to conduct the monthly checks and must maintain those records on-site. Those records must be made available to our Corporate Compliance Officer upon request, for desk reviews or onsite audits. For any questions or concerns regarding identified or potential compliance issues, please contact the BCBSAZ Health Choice Corporate Compliance Officer:

Nicole Larson,
Corporate Compliance Officer
480-760-4902; Nicole.Larson@azblue.com