Chapter 3:
Provider Responsibilities

Review/Revised: 01/18, 01/19, 01/20, 06/20, 1/21, 1/22, 4/22, 12/22, 1/23, 4/23, 8/1/2023

3.0 MEDICARE PARTICIPATION STANDARDS

All providers must meet the standards for participation and all applicable requirements for providers of health care services under the Medicare Program and follow facility standards established by CMS.

3.1 PERSONS EXCLUDED FROM MEDICARE PARTICIPATION

Providers must not employ, or contract with, any person who has been excluded from participation in the Medicare Program under Sections 1128 or 1128A of the Social Security Act (42 USC Sections 1320a-7 and 1320a-7a) for the provision of any (1) health care services, (2) utilization review, 3) medical social work or (4) administrative services. Please ensure that you check the Exclusion Lists prior to hiring new employees. 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) https://sam.gov/SAM/, formerly known as the General Services Administration (GSA) or Excluded Parties List System (EPLS).

3.2 MEDICARE, UPIN, NATIONAL PROVIDER IDENTIFICATION NUMBERS

All contracted providers who participate with BCBSAZ Health Choice Pathway may not be a "Medicare Participating" provider (including those who provide urgent or emergent services); however, providers are required to follow the appropriate requirements that apply to their specialty type identified by CMS.

Providers must submit claims with the appropriate provider identification number, regardless of reimbursement method, on a valid claim form OR via electronic method. Providers must utilize the most current diagnostic and procedure coding guidelines, including International Classification of Diseases (ICD), American Medical Association Current Procedural Terminology (AMA CPT), Health Care Financing Administration Common Procedural Coding System (HCPCS), National Drug Code (NDC), Diagnostic Statistical Manual (DSM), Current Dental Terminology (CDT), CMS 1500, Uniform Billing Data Elements (UB) Specification Manual, and State identified CPT/HCPCS codes as directed by BCBSAZ Health Choice Arizona Inc.

National Provider Identification (NPI) vs. Tax Identification Number (TIN)

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 and register their NPI with CMS and AHCCCS. For information regarding the NPI enrollment, visit the CMS website at https://nppes.cms.hhs.gov or call (800) 465-3203.

Important Information about NPI Numbers: The NPI rule requires health plans to identify providers based first on NPI number, instead of Tax ID. Therefore, all electronic payments and ERA's (835s) will be based on the NPI. This is especially important for Group Practices.

If Group Practices that now bill under one Tax ID do not register for a Group NPI, individual electronic payments will have to be made to each individual NPI holder. To avoid this administrative burden, request a Group NPI for your Group Practice.

Please also note that BCBSAZ Health Choice Pathway's claims payment system requires providers to enter their tax identification number on all claims in order to identify the address for payments. If the tax identification number is not included in the appropriate box of the claim form or match what is our BCBSAZ Health Choice Pathway payment system, payments may be denied or claims may be rejected and returned to the provider.

3.3 NOTIFICATIONS – PRACTICE/COMPANY CHANGES, UPDATES ADDITIONS

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, staff terminations include:

- 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. *

Please note that failure to keep information current may result in claim rejections, non-payments or returned check payments.

Providers are also required to complete the appropriate AzAHP form to Request for Participation/Update Information and fax the information 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 at a later time 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 - BCBSAZ Health Choice (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!

3.4 CONTRACT RENEWAL, CONTRACT TERMINATION or PROVIDER PROFESSIONAL TERMINATIONS

BCBSAZ Health Choice 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. BCBSAZ Health Choice routinely reviews its 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 BCBSAZ Health Choice Pathway 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; it may be mailed or faxed to BCBSAZ Health Choice Arizona Inc. Attn: 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 BCBSAZ Health Choice Pathway provider as a result 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, BCBSAZ Health Choice Pathway 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 Case Management Department for assistance.

3.5 CREDENTIALING AND RE-CREDENTIALING

All providers must be credentialed with BCBSAZ Health Choice Pathway *before* a contract can be offered or a provider can be added to an existing contract (associates). All providers who desire to participate in the BCBSAZ Health Choice Pathway provider network are required to meet minimum standards at the time of application and as of the date of the initial credentialing or re-credentialing.

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:

- 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 three months, the provider must explain the gap in writing).

A provider who has **not** been credentialed or contracted should not treat BCBSAZ Health Choice Pathway members without prior authorization except in certain situations such as: Emergency Medical Services, Urgently Needed Care, and Renal Dialysis when the Member is outside the BCBSAZ Health Choice Pathway's service area, but still in the United States.

BCBSAZ Health Choice Pathway conducts re-credentialing at least once every three (3) years.

Contracted providers will be notified by the BCBSAZ Health Choice Pathway Credentialing Department (See Chapter 5: Quality Management). It is important that providers complete the re-credentialing application as quickly as possible.

Failure to maintain a credentialed status with BCBSAZ Health Choice Pathway can 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 by BCBSAZ Health Choice. Evaluation includes the review of information obtained from any outside source with the exception of references, recommendations, or other peer-review protected information.

BCBSAZ Health Choice 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 BCBSAZ Health Choice. If an individual document is requested for review it may be faxed or emailed to a provider, at the provider's request.

BCBSAZ Health Choice 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 by BCBSAZ Health Choice and the anticipated date by which the completed file will be presented to the Credentialing Committee for decision.

BCBSAZ Health Choice does 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. BCBSAZ Health Choice shall ensure the credentialing and recredentialing process does not discriminate against healthcare providers solely on the basis of license or certification, or providers who serve high-risk populations or who specialize in the treatment of costly conditions. BCBSAZ Health Choice ensures 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 later 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 later 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.

3.6 DELEGATED PROVIDER FUNCTIONS

A contracted provider may not delegate any provider function without the advance written consent of BCBSAZ Health Choice Pathway. Upon receiving consent of BCBSAZ Health Choice Pathway, functions further delegated by provider shall be subject to the terms of the Subcontractor Agreement between BCBSAZ Health Choice Pathway and the provider in accordance with the most current applicable State, Federal, and NCQA Standards.

BCBSAZ Health Choice Pathway maintains 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 Pathway initiated audits (at least annually), to ensure compliance with applicable policies and procedures in coordination with respective regulatory requirements
- 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, Re-credentialing, 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 BCBSAZ Health Choice Pathway immediately:

- Health and Human Services-Office of Inspector General (HHS-OIG) List of Excluded Individuals/Entities (LEIE) http://oig.hhs.gov/fraud/exclusions.asp, and
- The System for Award Management (SAM) https://sam.gov/portal/SAM/#1, formerly known as the General Services Administration (GSA) or Excluded Parties List System (EPLS).
- CMS Preclusion List – In order for contracted and non-contracted providers to receive payment from a Medicare plan for health care items and services furnished to beneficiaries enrolled in Medicare plan, such providers must not be included on the Preclusion List. Likewise, for Part D drugs to be covered by a Part D plan, the prescriber must not be

included on the Preclusion List.

3.7 VERIFY ELIGIBILITY

Providers should check member eligibility at each point of contact, as eligibility can change at any time; however, eligibility is not a guarantee of payment.

Members who lose eligibility with Medicaid (AHCCCS) 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.

For assistance referring members please contact Member Services.

3.8 PRIMARY CARE PHYSICIAN

BCBSAZ Health Choice Pathway' Primary Care Physicians (PCPs) and Primary Care Obstetricians (PCOs) perform critical plan functions. BCBSAZ Health Choice Pathway relies on the providers 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. BCBSAZ Health Choice Pathway' Quality Management Committee periodically reviews guidelines for PCP management of BCBSAZ Health Choice Pathway members.

BCBSAZ Health Choice Pathway monitors the over and underutilization of covered services in both the inpatient and outpatient settings. This data is used to improve overall member's treatment outcome.

BCBSAZ Health Choice Pathway monitors PCPs to see if their members are being seen more or less frequently and for what reason in an effort to assist BCBSAZ Health Choice Pathway to predict and arrange for the necessary specialists, ancillary and hospital services members may require.

3.9 SPECIALISTS

For a list of specialists and services that require prior authorization refer to BCBSAZ Health Choice Pathway ***Prior Authorization Grid*** effective to the applicable date of service at https://www.healthchoicepathway.com/ -> For Providers -> *Prior Authorization & Clinical Guidelines.*

Specialists are required to submit the appropriate authorization number on their claims. BCBSAZ Health Choice Pathway contracted specialists work in concert with the members Primary Care Physicians to coordinate the overall care for the member. Our goal at BCBSAZ Health Choice Pathway is to develop partnerships with the Specialists in our network, as Specialty Physicians are critical to providing quality services to the BCBSAZ Health Choice Pathway members.

3.10 REFERRALS

The PCP is responsible for initiating and coordinating referrals to specialists within the BCBSAZ Health Choice Pathway network. It is critical that a strong communication link be maintained with specialists 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's record. BCBSAZ Health Choice Pathway encourages PCPs to maintain communication with the specialist when referring assigned members for specialty care. BCBSAZ Health Choice Pathway has simplified its 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. For a list of services that require authorization, refer to BCBSAZ Health Choice Pathway Prior Authorization Grid.

3.11 APPOINTMENT AVAILABILITY/APPOINTMENT WAITING TIME (NCQA HPA 2023, NET 2A – 2C)

Contracted PCPs and Specialists must maintain availability within the appointment standards according to the BCBSAZ Health Choice Pathway Subcontractor Agreement.

Providers are expected to establish a procedure for waiting time so that a member does not wait more than 45 minutes, except in emergency cases or unforeseen circumstances.

BCBSAZ Health Choice Pathway monitors providers' appointment availability and members in office waiting time on an on-going basis.

Please note that the standards below are applicable to both new and established patients. Additionally, providers seeing dual eligibility members are also subject to appointment availability standards outlined in the BCBSAZ Health Choice (Medicaid) Provider Manual, Chapter 3 - Provider Responsibilities, which include both AHCCCS Contractor Operations Manual (ACOM) 417 requirements and additional NCQA HPA 2023, NET 2A-NET 2C requirements.

Applicable to	Routine	Emergency & Urgent
PCPs	21 Calendar Days from the day of request	**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.
Specialists	45 Calendar Days from the day of the referral	**Urgent:** As expeditiously as the member's health condition requires but no later than 2 business days of request.
Dental	45 Calendar	As expeditiously as the member's health condition requires

Providers	Days from the day of the request.	but no later than 3 days of request

Behavioral Health (BH) Providers	***Routine Initial Assessment***	***Emergency & Urgent***
	Within 7 calendar days of referral or request for service.	**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.
	Within 48 hours for pregnant women with substance use disorders	
	(Routine) Ongoing services	
	For members aged 18 years or older: 23 calendar days non-IV drug users. For members under age 18 years old: No later than 21 days after initial assessment. All subsequent behavioral health services, as expeditiously as the 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 that 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 417-3 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 Arizona Provider Manual, *Behavioral Health Services*.

3.12 TELEPHONE AVAILABILITY

Members are encouraged and expected to contact their PCP to schedule appointments or seek medical advice. Because it is critical for members to be able to reach their physicians, telephones should generally be answered within 5 rings and hold times should not exceed 5 minutes.

BCBSAZ Health Choice Pathway monitors telephone accessibility to ensure that members can reach your office to schedule appointments or seek advice.

3.13 APPOINTMENT AVAILABILITY NON-COMPLIANCE

BCBSAZ Health Choice Pathway ensures contracted physicians; ancillary services and facilities are accessible to members to provide routine and emergent care on a timely basis.
Providers will be asked to implement a corrective action plan when the appointment availability standards are not met.

BCBSAZ Health Choice Pathway monitors the accessibility of contracted providers through:

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

- Member Surveys

Failure to comply with the appointment availability standards is viewed as an access to care issue by BCBSAZ Health Choice Pathway and may result in a closure of your membership panel.

3.14 AFTER-HOURS COVERAGE/PHYSICIAN VACATION COVERAGE

Each provider must have 24 hours per day, 7 days per week coverage.

It is not acceptable to refer BCBSAZ Health Choice Pathway members to the emergency room as a means to provide after-hours or vacation coverage.

It is the responsibility of the PCP to arrange for after-hours care and vacation coverage by a contracted BCBSAZ Health Choice Pathway 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 Provider Performance Representative of the arrangements made for vacation coverage. Notification of vacation coverage includes expected departure and return dates; name, address, and telephone number of covering physician; and if the covering physician office will be available to triage and/or answer questions for assigned members. If the covering physician is not available, the PCP should contact their Provider Performance Representative.

Network Services will provide names and telephone numbers of physicians who may be able to render same day treatment. BCBSAZ Health Choice Pathway will not reimburse physicians who provide coverage for a 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.

3.15 MAINTAINING THE MEDICAL RECORD

The primary care medical record is designated to contain documentation of all care and services rendered to the member by the PCP, Specialist, Inpatient care, and Ancillary services. This also includes documentation of care and services provided for mental health and/or substance abuse, ensuring the member has authorized the mental health/substance abuse provider to disclose that information.

Documentation may be direct or consist of summary, consultation letters, discharge notes and progress notes submitted by outside providers. The PCP must establish a medical record when information is received, even if the PCP has not yet seen the member. This information must be maintained in an appropriately labeled file that is associated with the member's medical record.

When a member changes to a new BCBSAZ Health Choice Pathway PCP, the medical records must be transferred to the new provider in a timely manner.

3.16 INSPECTION AND AUDIT OF RECORDS AND FACILITIES

Providers must provide medical records or copies of medical records for any BCBSAZ Health Choice Pathway member upon request by BCBSAZ Health Choice Pathway. Medical records must be available within five (5) working days of a request.

Failure to provide BCBSAZ Health Choice Pathway with medical records that result in a sanction to BCBSAZ Health Choice Pathway by CMS will result in such sanction being deducted in full from future payments to the offending provider.

BCBSAZ Health Choice Pathway will issue a written notification seven (7) days prior to the sanction being imposed.

3.17 MANAGING MEMBERS WITH DISABILITIES OR SPECIFIC NEEDS

The health care needs of members with disabilities or specific needs 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 BCBSAZ Health Choice Pathway Member Services by calling **(800) 656-8991**.

- Members with special needs may be characterized as:
    - Persons who have communication barriers, such as speaking a different language; low literacy, visual or hearing impaired; geographically isolated people; and/or people who are homeless
- People 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
- Complex and difficult-to-address health issues such as lupus, cerebral palsy, major functional disabilities
- Chronically mentally ill adults, substance abuse
- Diagnosis specific groups, such as HIV/AIDS cases
- Physically disabled adults, children, and frail elderly
- Organ transplant recipient or waiting for transplant

- Persons 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.

3.18 HISTORY AND PHYSICAL

It is expected that a complete history and physical is documented in the BCBSAZ Health Choice Pathway member's medical chart. The member's medical record will be reviewed during medical record audits.

3.19 HOSPITAL ADMISSIONS

BCBSAZ Health Choice Pathway uses 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 BCBSAZ Health Choice Pathway 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 the hospitalist program, the PCP or obstetrician is expected to follow the member in the hospital. The PCP or PCO should communicate directly with the Prior Authorization Department when a hospital admission is necessary.

All hospital admissions require prior notification.
BCBSAZ Health Choice Pathway conducts concurrent review of all inpatient admissions. BCBSAZ Health Choice Pathway uses accepted nationally recognized criteria when performing concurrent inpatient reviews.

3.20 ADULT IMMUNIZATION/PREVENTIVE SERVICES

BCBSAZ Health Choice Pathway members may directly access a contracted provider for mammography and influenza and pneumonia vaccines and women's health specialists for routine and all preventative health care.

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.

Physicians are strongly encouraged to provide immunizations for influenza and pneumonia vaccinations when medically indicated and in conjunction with current CDC recommendations. Collection of co-payments is prohibited for routine injections, routine immunizations, flu immunizations, and the administration of pneumococcal/pneumonia vaccine.

3.21 PATIENT EDUCATION

BCBSAZ Health Choice Pathway contracted providers are expected to provide appropriate prevention 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, and they must be included in the planning and implementation of their care.

It is expected that 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 the patient has the right to choose the final course of action among clinically acceptable options.

It is particularly expected that members will also be advised of the difference between urgent conditions, such as earaches or flu and emergent conditions. The member is to be instructed to contact their PCP first before visiting an emergency room or calling an ambulance unless it is a true emergency.

3.22 PRESCRIPTIONS

Prescriptions should be written to allow generic substitution when available and signature on prescriptions must be legible in order for the prescription to be dispensed. It is the responsibility of the physician to obtain prior authorization prior to prescribing drugs not on the BCBSAZ Health Choice Pathway formulary.

For further detail, refer to BCBSAZ Health Choice Pathway Provider Manual Chapter 10: Prescription Benefits and Drug Formulary.

BCBSAZ Health Choice Pathway Formulary is available on the BCBSAZ Health Choice Pathway web site at https://www.healthchoicepathway.com/.

(Note: if you do not have internet access, contact your Provider Performance Representative to arrange for a paper copy).

3.23 DRUG UTILIZATION CONCERNS

Providers with concerns about a member's drug utilization should refer the member or contact BCBSAZ Health Choice Pathway Care Management Department.

BCBSAZ Health Choice Pathway may identify members as having a potential substance abuse issue through provider information, utilization review, pharmacy reports, or emergency room visits. BCBSAZ Health Choice Pathway will contact the PCP when there is a suspected substance abuse problem and assist with coordination of care.

3.24 MEMBER DEATH

BCBSAZ Health Choice Pathway 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.

3.25 EMERGENCY ROOM

An "emergency" is a medical condition or behavioral health (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could result in:

- Serious jeopardy to the health of the individual
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part; or
- Serious physical harm to self or another person.

Providers may not refer members to the Emergency Room due solely to non-availability of same day appointment.

BCBSAZ Health Choice Pathway contracts with several Urgent Care Centers.

Ask your Provider Performance Representative for details and a location near you.

3.26 FRAUD AND ABUSE

BCBSAZ Health Choice Pathway is committed to detecting, reporting, and preventing potential fraud and abuse. Fraud and abuse is 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 Medicare or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Providers must train staff on the following aspects of the Federal False Claims Act provisions:

- The administrative remedies for false claims and statements
- Any state laws relating to civil or criminal penalties for false claims and statements
- The whistleblower protections under such laws

3.27 REPORTING FRAUD, WASTE AND ABUSE

If a provider is aware of potential Fraud, Waste or Abuse of the Medicare system, a referral should be made to BCBSAZ Health Choice Pathway. The process for reporting is the same as you report now with the AHCCCS program for BCBSAZ Health Choice Arizona.

BCBSAZ Health Choice Pathway HMO D-SNP
Attn: Compliance
8220 N. 23rd Ave.
Phoenix, AZ 85021

The Medicare Drug Integrity Contractor (MEDIC) for Arizona is assigned to take in all Fraud Waste and Abuse referrals.

BCBSAZ Health Choice Pathway will work with the MEDIC on all referrals.

You may also call the AlertLine to report Fraud, Waste and Abuse at 1-800-237-0916.
The line is available 24 hours a day, 7 days a week.

Hotline Operated by BCBSAZ Health Choice:

1-800-237-0916 (Compliance Hotline–anonymous option/all products and locations)

Hotlines Operated by BCBS:

Anonymous Compliance Hotline (888) 474-3683

Special Investigations Unit Hotline (602) 864-4875

Privacy Hotline (602) 864-2255

BCBSAZ Health Choice maintains a strict non-retaliation policy. Individuals will not be retaliated against for filing any compliance issue or concern or suspected FWA.

Hotlines Operated by Federal or State Regulators:

- ✓ 1-877-772-3379(Medicare Prescription Fraud Hotline/MEDIC);
- ✓ 1-800-447-8477(Medicare Fraud Hotline/HHS-OIG);
- ✓ AHCCCS/OIG(Arizona Medicaid)
  - 602-417-4045(AZ: Suspected Medicaid Provider Fraud-In Maricopa County) or1-888-ITS-NOT-OK or 888-487-6686 if calling from outside of Maricopa County;
  - 602-417-4193 (AZ: Suspected Medicaid fraud by an AHCCCS member if calling from within Maricopa County) or 1-888-ITS-NOT-OK or 888-487-6686 if calling from outside of Maricopa County);
  - Or, report using online form: https://www.azahcccs.gov/Fraud/ReportFraud/

3.28 BCBSAZ HEALTH CHOICE PATHWAY CLAIM SUBMISSIONS

Please refer to the BCBSAZ Health Choice Arizona Provider Manual located at: https://www.healthchoiceaz.com/providers/provider-manual/ for general billing rules as well as contractual requirements and processes.

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors. BCBSAZ Health Choice Pathway offers the ability to submit claims/encounters electronically through our clearinghouse Change Healthcare.

For contracted providers, please contact your software vendor, visit Change Healthcare directly www.changehealthcare.com/enrollment, or your BCBSAZ Health Choice Provider Performance Representative can provide more information about electronic billing. For non-contracted providers, please contact your software vendor for more information about electronic billing.

EDI Claim/Encounter Submission

	Electronic Submission*
All HCP Form Types	Through Electronic Clearinghouse, Payer ID 62180
All HCA Form Types	Through Electronic Clearinghouse, Payer ID 62179

All providers are recommended to submit claims/encounters electronically. Electronic billing ensures faster processing and payment of claims, eliminates the cost of sending paper claims, allows tracking of each claim/encounter sent, and minimizes clerical data entry errors.

We understand that at times you may need to submit a claim through the mail, here's some reminders:

- When a claim is submitted, please ensure that the printed information is aligned correctly with the appropriate section/box on the form.
- Claims for services must be legible and submitted on the correct form for the type of service billed. Claims that are not legible or not submitted on the correct form will be returned to the provider without processing.
- Paper claims or copies that contain highlighter or color marks, copy overexposure marks, or dark edges are not legible on the imaging system. Liquid paper correction fluid ("White Out") **may not** be used. Correction tape **may not** be used.
- Do not submit double-sided, multiple-page claims. Each claim page must be submitted on a separate piece of paper, with the pages numbered (e.g., 1 of 3, 2 of 3, 3 of 3, etc.). To ensure that all pages of a multiple-page, UB-04 claim are processed as a single claim the pages **must** be numbered. Totals should not be carried forward onto each page, and each page can be treated as a single page. **The total should be entered on the last page only.**
- Please do not staple documents or claims. If there is a document being submitted with the claim, the document should lay directly behind the claim.

If your claim is not accepted, this submission does not count as a clean claim submission. If you receive a returned claim, the provider must re-file a legible copy of the claim on the correct claim form type and it must be refilled within the appropriate time frame detailed in an upcoming section. ***Please note**: *Faxed claims are not accepted for processing*.

MAILING ADDRESS FOR PAPER CLAIMS:

BCBSAZ Health Choice Pathway
P.O. BOX 52033
PHOENIX, AZ 85072-2033

BCBSAZ Health Choice Arizona
P.O. BOX 52033
PHOENIX, AZ 85072-2033

3.29 ADVANCE DIRECTIVES OR END OF LIFE CARE (NCQA HPA 2023, MA 4A)

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 or not 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 Medicare or Medicaid 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.