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Welcome to the IHS/638 Third Quarter Forum

August 01, 2019
Attendance: WebEx Only
2:00 P.M. – 3:30 P.M.

AHCCCS Tribal Liaison

Amanda Bahe

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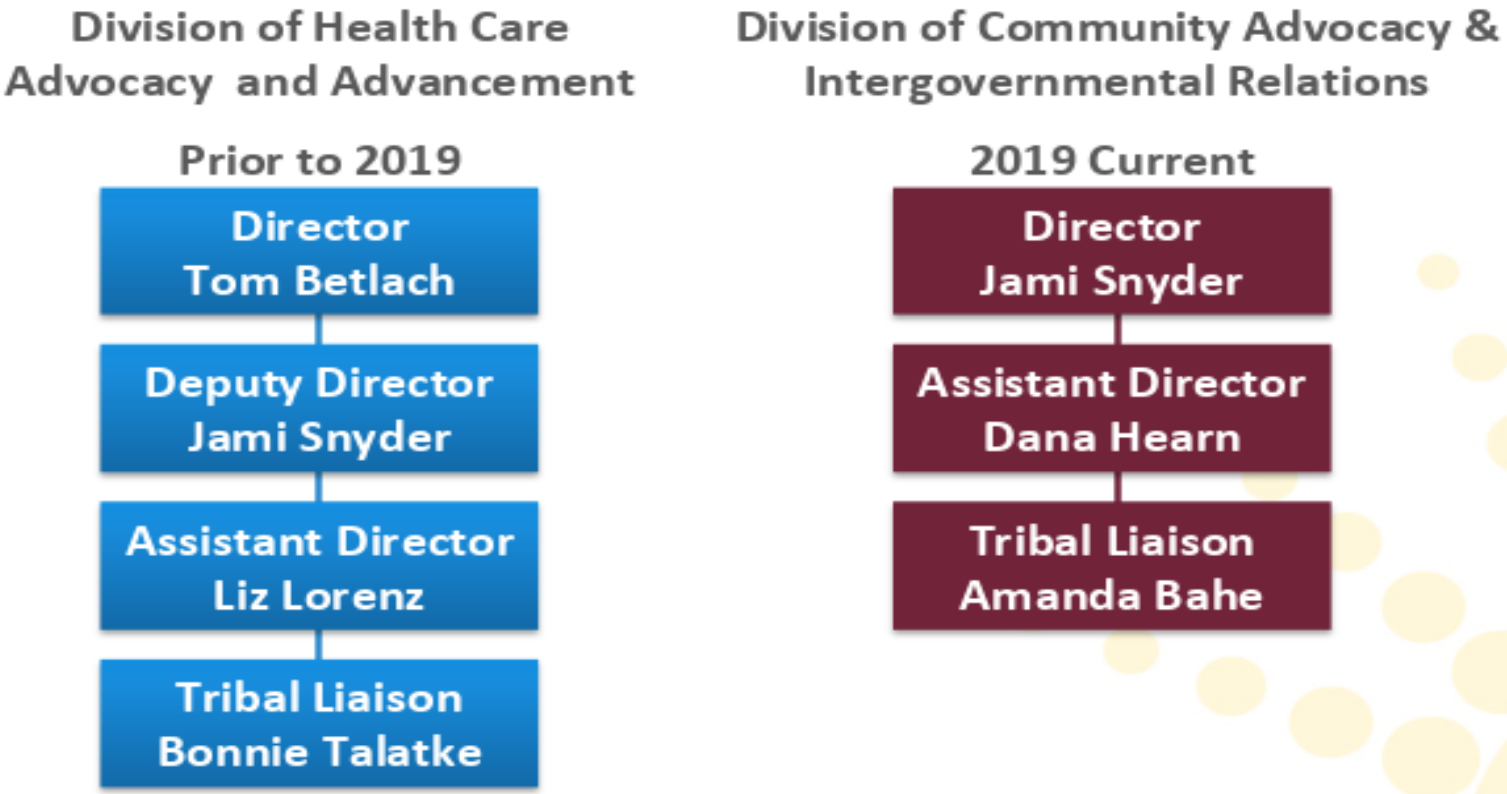
Organizational Structure Update

Tribal Liaison Reporting Structure



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Reaching across Arizona to provide comprehensive quality health care for those in need

Division of Community Advocacy & Intergovernmental Relations (DCAIR)

- Federal Relations
  - Waiver
  - State Plan
  - Tribal Liaison
- Public Information Officer/Graphic Designer
- Advocacy & Stakeholder Group
  - Committees & Councils
  - Office of Individual and Family Affairs (OIFA)
  - Office of Human Rights (OHR)

Email Notifications (AKA Constant Contacts)

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Email Notifications

AHCCCS offers providers, members, and the public the opportunity to sign up for various newsletters/email notifications published by Divisions within AHCCCS. By signing up, AHCCCS updates will be sent straight to your email inbox. You may unsubscribe at any time.

- These email newsletters were previously called Constant Contacts.

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Email Notifications

Several divisions offer these notifications.

- **Division of Fee for Service Management:** news for the various Fee for Service healthcare providers.
- **Division of Health Care Advocacy and Advancement:** Office of Individual and Family Affairs weekly newsletter
- **Division of Health Care Management:** contractor requests for proposals; EHR notifications; behavioral health covered services notifications; and ACOM, AMPM, and Tribal Consultation updates.
- **Office of the Director:** general monthly news; occasional updates from the tribal liaison, pharmacy department, and Justice initiatives.
- **Targeted Investments Program**
- **Office of Inspector General:** news for registered providers.

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Email Notifications

Each of these Divisions within AHCCCS has a variety of lists that you may sign up for. Each list is specified to individual provider, member, or the public's interests.

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Email Notifications

For instance, the Division of Fee for Service Management (DFSM) offers subscriptions specifically designed for:

DFSM Provider Email Notification Lists (for Providers)			
Behavioral Health Providers	DFSM Care Coordination	Hospitals / Facilities	Non-IHS/638 Case Managers
IHS/638 Providers	HCBS	IHS/638 Pharmacies	General Interest
TRBHA	Practitioners	IHS/638 Case Managers	All Providers
Ancillary	Transportation		

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DFSM's Email Notification System

Formerly known as Constant Contacts

The AHCCCS Provider Training team uses these email notifications to send out email alerts regarding changes to the program, claims and billing updates and requirements, system changes, upcoming trainings, forums and other business news.

Providers can sign up at the link below.

AHCCCS-DFSM : Sign Up to Stay in Touch

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The Office of the Director Notifications

The Office of the Director at AHCCCS sends a monthly email with general agency news (press releases, updates posted on our website, current requests for public comment).

You may also wish to subscribe to receive news alerts, updates from the pharmacy or justice team, or news from the tribal relations liaison. Click the link below to make your selections from the email lists.

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HCBS EMAIL LIST and EVV

AHCCCS has created a Constant Contact email notification list to communicate updates on recent developments for Home and Community Based Services' initiatives such as the EVV initiative.

AHCCCS encourages anyone (members, families, advocates, service providers, etc.) interested in the EVV initiative, such as opportunities for public comment, to sign up to receive communication. To subscribe to the Home and Community Based Settings Updates click on the sign up button below:

AHCCCS-DHCM : Sign Up to Stay in Touch

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AHCCCS CLAIMS CLUES UPDATES

DFSM publishes a monthly newsletter for providers. It is available online and provides information about the following:

- Claims and billing updates
- Billing policies and requirements
- System changes
- Changes to program benefits

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/claimsclues.html

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Division of Developmental Disabilities

Integration of Services

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Integrating Services for ALTCS DDD Members

- Please note that the AHCCCS American Indian Health Program (AIHP) is a separate program administered by the Division of Fee for Service Management (DFSM) at AHCCCS.
- The DDD American Indian Health Plan is administered by the Division of Developmental Disabilities.
- The two programs are different.

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Integrating Services for ALTCS DDD Members

Starting October 1, 2019, members that are enrolled with the ALTCS Division of Developmental Disabilities that are receiving Behavioral Health services form the Regional Behavioral Health Authorities (RBHAs) will transition to the new DDD Health Plans.

United Healthcare Community Plan and **Mercy Care**

Who will this change effect: This will include members with a designation of Serious Mental Illness (SMI) and also for members with qualifying Children's Rehabilitative Services (CRS) conditions.

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DDD Health Plans Additional Services

The DDD Health plans will offer eligible members:

- Physical
- Emergency Alert System Services
- Nursing Facilities
- Limited Long Term Services and Supports (LTTS)
- **Habilitative physical therapy for members age 21 and over.**
- Physical Children's Rehabilitative Services (CRS)

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DDD Health Plans

All other LTSS and Support Coordination will be provided by DDD. This model will enhance care treatment between providers and improve member health.

Member Choice: Members can also choose a DDD Health Plan before the October 01, 2019 start date.

American Indian/Alaskan Native members will have multiple choices, depending on their geographic area. They always have the choice to receive services from the American Indian Health Program (AIHP) or from a managed care health plan in their area. Additionally, if they are served by a Tribal Regional Behavioral Health Authority (TRBHA), they may receive behavioral health services from that TRBHA.

https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/DDD.htmlIntegrating Services for ALTCS DDD Members

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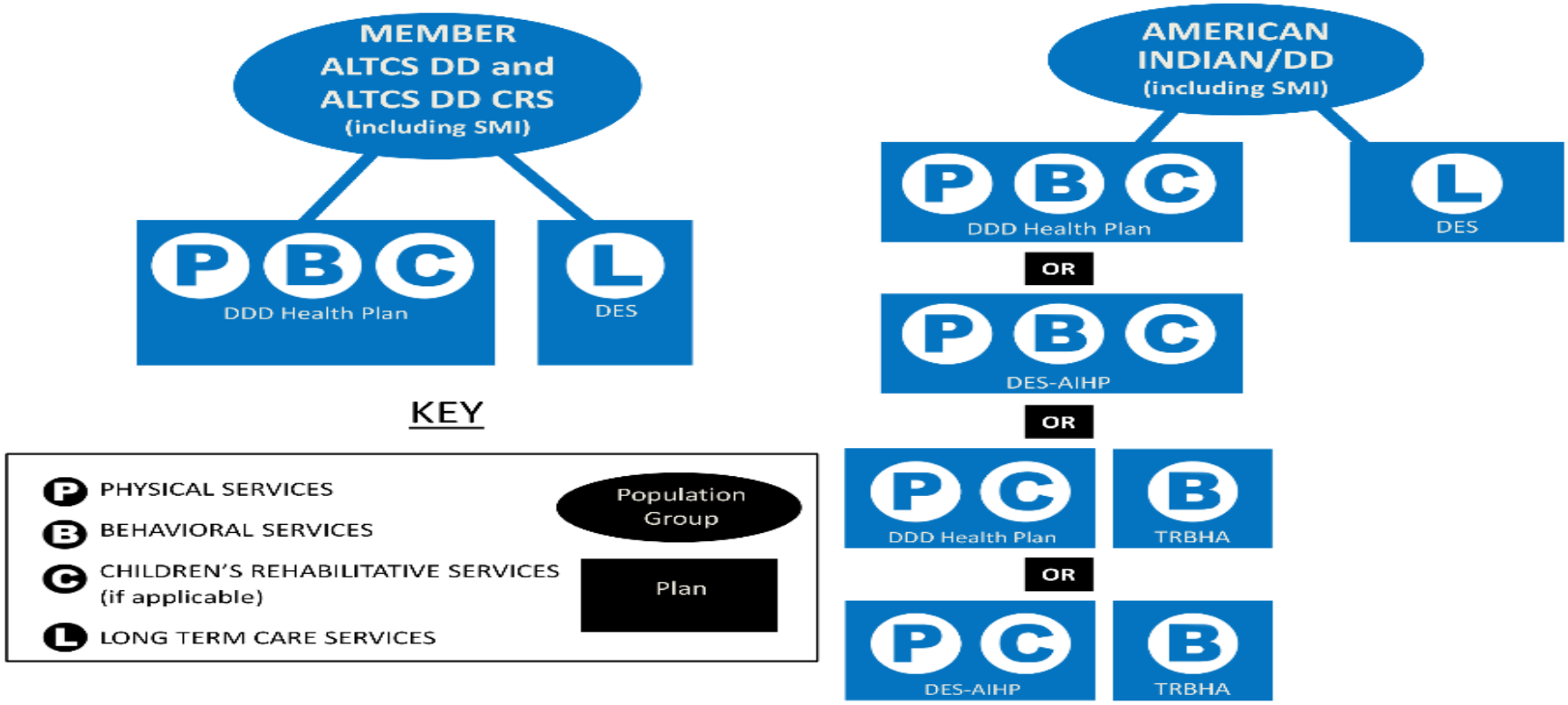
Integration for Members enrolled with DES/DDD Effective October 1, 2019



KIDSCARE CHANGES EFFECTIVE 10/01/2019

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KidsCare Enrollment Updates

There will no longer be a mandatory freeze of KidsCare funds in upcoming months.

Previously, funding was set to freeze if federal matching dollars (FMAP) dropped below 100%. The FMAP was due to drop below 100% in September. However, HB 2754 was amended to allow KidsCare to continue, and applications will continue to be processed.

https://www.azahcccs.gov/Members/GetCovered/Categories/KidsCare.html

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Non-Title XIX Services

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New Exhibit on Non-Title XIX Services

An exhibit regarding Non-Title XIX Services will soon be added to the Fee-For-Service Provider Billing Manual.

- FFS Manual - It will be listed as Exhibit 19-1 under Chapter 19, Behavioral Health Services.
- https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

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Non-Title XIX Services

Non-Title XIX/XXI Services must be coordinated with the RBHA and the member's ACC health plan (including AIHP), *or* with the member's TRBHA or Tribal ALTCS Program.

- **<u>NOTE:</u> Claims for Non-Title XIX/XXI populations are not submitted to AHCCCS DFSM.**

- Providers should work with the RBHA within their Geographic Service Area (GSA), the member's TRBHA, or the member's Tribal ALTCS program regarding Non-Title XIX/XXI services.

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Non-Title XIX Services

Non-Title XIX/XXI Services must be coordinated with the RBHA and the member's ACC health plan (including AIHP), *or* with the member's TRBHA or Tribal ALTCS Program.

- **<u>NOTE:</u> Claims for Non-Title XIX/XXI populations are not submitted to AHCCCS DFSM.**

- Providers should work with the RBHA within their Geographic Service Area (GSA), the member's TRBHA, or the member's Tribal ALTCS program regarding Non-Title XIX/XXI services.

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Acupuncture Services

Acupuncture services are not covered by AHCCCS Fee for Service, but may be available under Non-title 19 funding.

Acupuncture is considered to be "the application by a certified acupuncturist practitioner pursuant to A.R.S. §32-3922 of auricular acupuncture needles to the pinna, lobe, or auditory meatus to treat alcoholism, substance abuse or chemical dependency."

***Not covered by AHCCCS. This is a non-Title XIX Service.

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Acupuncture Services

- **97810** – Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
  - Billing Unit: 15 Minutes
  - Modifier: N/A
- **97811** – Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)
  - Billing Unit: 15 Minutes
  - Modifier: N/A
- **97813** – Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
  - Billing Unit: 15 Minutes
  - Modifier: N/A
- **97814** – Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)
  - Billing Unit: 15 Minutes
  - Modifier: N/A

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Childcare Services

Childcare supportive services may be available for a member's dependent child(ren) when the member is receiving medically necessary Medication Assisted Treatment, Outpatient (non-residential) treatment, or other supportive services for substance use disorder (SUD).

For childcare services, the following limitations apply:

- Members receiving MAT or Outpatient (non-residential) treatment or support services for SUD treatment where the family is being treated as a whole, but the child is not an enrolled member receiving billable services from the provider,
- Where other means of support for childcare for the children are not readily available or appropriate, and
- Only Provider Types that provide MAT or Outpatient (non-residential) treatment or support services are eligible to bill for this service.

T1009 – Child sitting services for children of the individual receiving alcohol and/or substance use services.
Billing Unit: 15 minute interval
Modifier: No modifier is required, but SE may be used.

***Not covered by AHCCCS. This is a non-Title XIX Service.

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Substance Abuse Block Grant

Substance Abuse Block Grant (SABG) Funding Information

- The SABG is specifically allocated to provide services that are not otherwise covered by Title XIX/XXI funding. This includes substance use disorder treatment and support services for members who do not qualify for Title XIX/XXI eligibility,
- The SABG is to be used as the payer of last resort. SABG funding should not be used to supplant other funding sources and if funds from the Indian Health Services and/or Tribal owned/or operated facilities are available, the IHS/638 funds shall be treated as the payer of last resort.

Mental Health Block Grant

Mental Health Block Grant (MHBG) Funding Information

- The MHBG is allocated from SAMHSA to provide mental health services to adults with an SMI designation, children with an SED designation, and individuals in need of FEP services.
- MHBG funds are only to be used for allowable services identified in AMPM Exhibit 300-2B. Additional information can be found in AMPM 320-T, Non-Title XIX/XXI Services.

Covered Behavioral Health Services Guide

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Covered Behavioral Health Services Guide

In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:

- AHCCCS Medical Policy Manual (AMPM) Policy 310-B, Behavioral Health Services Benefit
  - Title XIX/XXI benefit information.
- AMPM Policy 320-T, Non-Title XIX/XXI Behavioral Health Services
  - Non-Title XIX/XXI service information.
- Appropriate AMPM Policies as necessary, including:
  - AMPM Policy 310-BB, Transportation; and
  - AMPM Policy 310-V, Behavioral Health Residential Facilities (BHRFs).

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Covered Behavioral Health Services Guide

Information from the CBHSG is being transitioned into the following areas (continued):

- The Fee-For-Service (FFS) and IHS/Tribal Provider Billing Manuals
  - Chapter 19, Behavioral Health Services, FFS Provider Billing Manual
    - Behavioral Health services billing information for FFS Providers
      - **Note**: Billing information in the FFS Provider manual is primarily directed to FFS providers; however, the general billing information not identified as specific to FFS providers may also be referred to by ACC (MCO) providers. For FFS Providers, any billing information noted as specific to ACC (MCO) only does not apply to FFS.
  - Chapter 12, Behavioral Health Services, IHS/Tribal Provider Billing Manual
    - Behavioral Health services billing information for IHS/Tribal Providers.

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PHARMACY UPDATES

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OPTUMRX

- **REMINDER:** Prescription claims, with a service date through March 31st, must be submitted to AHCCCS within 1 year from the Service Date.
- Prescription claims with a service date after March 31st must be submitted to the PBM, OptumRx, for claims adjudication and reimbursement.

BIN (bank identification number): identify which insurer needs to reimburse the pharmacy for the prescription.

PCN (processor control number): is a second identifier that is used to route pharmacy claims.

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Pharmacies will need OptumRx's BIN and PCN numbers for claims adjudication of the AIR.

All Inclusive Rate (AIR) Plan PBM Set-Up
BIN = 001553
PCN = AIRAZM
OPTUM RX Help Desk Phone Number;
Toll Free: 1 (855) 577-6310

Specialty Medication Plan PBM Set-Up
BIN = 001553
PCN = AIRAZM (previously SPCAZM)
Clarification Code: 09
OPTUM RX Help Desk Phone Number;
Toll Free: 1 (855) 577-6310

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KIDSCARE CLAIMS

KidsCare Eligibility

BIN = 001553

PCN = AZM

Clarification Code = 02

OPTUMRX Help Desk Phone Number;

KidsCare claims for DDD Members are to be submitted to OptumRx using the
BIN: 001553
PCN: AZMDDD
Clarification code of 02.

KidsCare claims for CMDP Members are to be submitted OptumRx using the
BIN: 001553
PCN: AZMCMDP
Clarification code of 02.

Toll Free: 1 (855) 577-6310

KidsCare claims for Members enrolled in all other ACC plans are to be submitted to the ACC Plan's PBMs' BIN and PCN.

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Pharmacy Updates

Fee for Service Acute/Log Term Care program Drug List 08/01/2019

https://www.azahcccs.gov/Resources/Downloads/PharmacyUpdates/AHCCCS_FFS_Drug_List.pdf

Providers may contact the pharmacy department at **AHCCCSPHARMACYDEPT@AZAHCCCS.GOV**

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Electronic Visit Verification

Electronic Visit Verification (EVV)

Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), in order to prevent a reduction in the Federal Medical Assistance Percentage (FMAP), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) by January 1, 2020 and for in-home skilled nursing services (home health) by January 1, 2023.

- The EVV system, must at a minimum, electronically verify the:
- Type of service performed.
- Individual receiving the service.
- Date of the service.
- Location of service delivery.
- Individual providing the service.
- Time the service begins and ends.

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Electronic Visit Verification (EVV)

EVV is an electronic based system that verifies when caregiver visits occur and documents the precise time services begin and end. It ensures that members receive their medically necessary services.

AHCCCS has selected *Sandata Technologies LLC* to deliver the statewide EVV system that will be made available to all service providers required to use EVV. Sandata Payer Management offers improved oversight into Home and Community Based program delivery.

***Service providers may choose to use an alternate EVV system vendor (at their own cost) and must interface with the statewide system as a data aggregator.**

EVV Web page: **Electronic Visit Verification (EVV) Website**

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Adult Immunization Coverage at County Health Departments

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Adult Immunization Coverage

Effective July 1, 2019, AHCCCS covers medically necessary covered immunizations for individuals 19 years of age and older when the vaccines are administered by AHCCCS registered providers through County Health Departments.

- These immunizations are covered even if the AHCCCS registered provider is not in the member's health plan network.

AHCCCS covered immunizations include, but are not limited to: Hepatitis A, Hepatitis B, Measles, Influenza, Pneumococcus, Rubella.

- Prior authorization is not required by AHCCCS Fee For Service or AHCCCS Contractors (ACC plans) for these services.

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Adult Immunizations Coverage

AHCCCS now covers immunizations received by individuals 19 years of age and older at County Health Departments, when given by providers who are registered with AHCCCS.

Important: AHCCCS does not cover Immunizations for Passport, Visa Clearance or for travel outside of the United States.

For additional information about AHCCCS adult immunization coverage, refer to AHCCCS MEDICAL POLICY MANUAL (AMPM), Covered Services 310-M, Immunizations.

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/310M.pdf

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County Health Departments that are currently registered with AHCCCS Fee For Service. This is not an All Inclusive List.

CLINIC NAME	Address	City	Zip
Apache County Public Health	PO Box 697	St. Johns	85936
Cochise County Health Social Services	1415 Melody Lane	Bisbee	85603
Coconino County Health Department	2625 N. King St.	Flagstaff	86004
Gila County Health Department	5515 S. Apache Ave.	Globe	85501
La Paz County Health Department	1112 Joshua Avenue #206	Parker	85344
Navajo County Public Health	600 N. 9th Place	Show Low	85901
Pima County Health Department	3950 S. Country Club Road Ste. 100	Tucson	85714
Pinal County - Kearny	355 Alden Road	Kearny	85137
Yavapai County Community	1090 Commerce Dr.	Prescott	86305

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BILLING 638 TRIBAL FEDERAL QUALIFIED HEALTH CENTER (FQHC)

Billing Overview
638 TRIBAL FQHC FACILITY

Tribal 638 Clinics that are either provider type **05 (Clinic) or 77 (BH outpatient clinic)** are eligible to elect to become a 638 FQHC.

The only requirement that the Tribal 638 Clinic must meet, in order to be recognized as an FQHC by Medicaid, is to be operated by a Tribe or Tribal organization under Public Law (P.L.) 93-638.

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638 FQHC REIMBURSEMENT

A 638 FQHC will submit claims for reimbursement at the facility rate, also called the Alternative Payment Methodology (APM).

The APM rate is the same rate of reimbursement as the **All Inclusive Rate (AIR)** currently set at $455.00 per visit for calendar year 2019.

The published APM rate may be paid for up to five (5) encounters/visits per member per day, per distinct visit.

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638 FQHC CLAIM SUBMISSION

- FQHC clinic visits will be billed under the provider's new provider type (C5).
- Claim Form Type: CMS 1500
- Reference: Link to the billing manual.

https://www.azahcccs.gov/PlansProviders/Downloads/IHS-TribalManual/IHS-Chapter20_638_FQHC.pdf

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638 FQHC CASE MANAGEMENT SERVICES

Claims for Case Management (behavioral health or medical), must be billed with CPT code T1016 and will be reimbursed at the *capped FFS fee schedule*. Case management claims must be submitted on the CMS 1500 claim form.

Note: A 638 FQHC that is also an American Indian Medical Home (AIMH) will not be eligible for reimbursement of T1016 Code.

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AMERICAN INDIAN MEDICAL HOME (AIMH)

WHAT IS THE AIMH

- The American Indian Medical Home is a care management model that puts AHCCCS American Indian Health Program (AIHP) members at the forefront of care.
- AIMHs help address health disparities between American Indians and Alaskan Natives in Arizona by enhancing case management and care.

Member AIMH Enrollment

- AIHP enrolled members can select an AIMH when they access a participating AIMH provider or by contacting the AHCCCS Division of Member Services at 602-417-7100 or 800-334-5283.
- Members who join the AIMH can do so voluntarily and will have the choice to decline participation, dis-enroll or switch AIMHs at any time.

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AIMH Eligible Provider Types

02 – Hospital
05 – Clinic (excluding Dental Providers)
IC – Integrated Clinic
C2 – Federally Qualified Health Center (FQHC)
C5 – 638 Federally Qualified Health Center (FQHC)
29 – Community/Rural Health Center (RHC)

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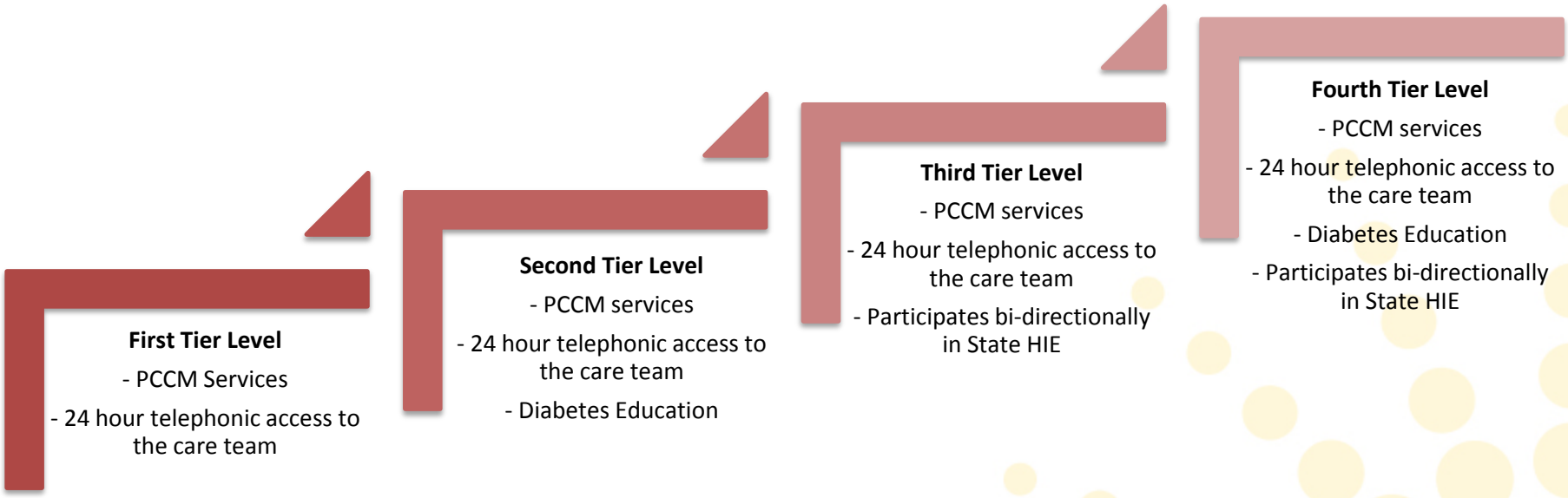
AIMH Service and Reimbursement per Tier Level



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Reimbursement

- Facilities who choose to become an AIMH will receive a Prospective Per Member Per Month (PMPM) rate for services provided by their medical home.
- Payments are dependent upon the AIMH tier level selected.
- Tier levels include annual rate increases.

AIMH 4.6% rate increase calculation – 10 year forecast

Calendar Year	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024	CY 2025	CY 2026	CY 2027
Level 1	13.26	13.87	14.51	15.18	15.87	16.60	17.37	18.17	19.00	19.88	20.79
Level 2	15.26	15.96	16.70	17.46	18.27	19.11	19.99	20.91	21.87	22.87	23.93
Level 3	20.76	21.71	22.71	23.76	24.85	25.99	27.19	28.44	29.75	31.12	32.55
Level 4	22.76	23.81	24.90	26.05	27.25	28.50	29.81	31.18	32.62	34.12	35.69

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Active AIMH's

- Phoenix Indian Medical Center (PIMC) – Tier 2
- Chinle Comprehensive Health Care Facility – Tier 4
- Winslow Indian Health Care Center – Tier 3
- Whiteriver Indian Hospital – Tier 2
- San Carlos Apache Healthcare – Tier 2

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AIMH Provider Requirements

- Be an IHS or Tribal 638 facility
- Enter into an AIMH IGA
- Primary Care Case Management (PCMH) accreditation
- Provide 24 hour telephonic access to the care team
- Dependent on selected tier level
  - Provide diabetes education
  - Participate bi-directionally in the State Health Information Exchange (HIE)

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Resources

- IHS/638 Providers can send questions to AIMH@azahcccs.gov
- Review AIMH information at https://www.azahcccs.gov/AmericanIndians/AmericanIndianMedicalHome/
- State Plan Amendment (SPA) https://www.azahcccs.gov/Resources/StatePlans/StatePlanAmendments.html

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ALL INCLUSIVE RATE BILLING (AIR)

Billing the All Inclusive Rate for Outpatient / Clinic Services

- IHS/638 **Outpatient services** provided in a Clinic our outpatient hospital setting must be billed with Revenue Codes 0510, 0511, 0512, 0516, per AHCCCS billing guidelines does not require a CPT or HCPCS code in Field 44 on the UB -04 claim form.
- IHS/638 **Pharmacy services (Prior to 04/01/2019)** per AHCCCS billing guidelines must be billed with Revenue Code 0519 and must have a valid NDC code in Field 43 on the UB-04.
- All IHS/638 **facility** claims must contain the appropriate Revenue Code and the current Outpatient / Clinic All Inclusive Rate for 2019 $455.00.

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AIR and the Four Walls

CMS has interpreted section 1905(a)(9) of the Social Security Act, in 42 CFR 440.90, to mean that "clinic services" do not include services furnished outside of the "four walls" of the clinic, except if the services are furnished by clinic personnel to a homeless individual. The "four walls" of the clinic refer to the physical building the clinic operates within.

Indian Health Care Providers (IHCPs) enrolled in Medicaid as clinics cannot bill for off-site services as "clinic services", and therefore cannot be paid for them at the facility rate (unless the patient is homeless). Instead, services that are provided off-site to persons who are not homeless may only be billed and paid for as an assigned claim from the provider who furnished the service off-site, for example, as a covered physician service paid for under the physician fee schedule. This is a result of a CMS document that was issued on January 18th, 2017.

Services provided outside of the "four walls" of the clinic, by either an IHCP or by a non-Tribal provider, shall be billed at the capped FFS rate.

Four Walls and 638 FQHC

Please note that there is an exemption from the Four Walls requirement for 638 FQHCs. Per Chapter 20, 638 FQHC, of the IHS/Tribal Provider Billing Manual:

FQHC facilities are exempt from the "4 Walls" requirement. An FQHC may bill the facility rate for services rendered to its patients outside of its "4 Walls" by a non-Tribal provider.

If an FQHC has a care coordination agreement with a non-Tribal provider, such as a neurologist, and the service is provided offsite (outside of the FQHC's building), the FQHC may still bill the facility rate for the service. However, the FQHC would need to bill for the service, not the offsite provider.

A Tribal 638 Clinic that elects to become a 638 FQHC will have the same exemption from the limitations of the "4 Walls" requirement that current FQHCs receive. A 638 FQHC will be able to bill for reimbursement at the facility rate, also called the Alternative Payment Methodology (APM). Services provided in the member's home or at a facility acting as the member's home, such as an assisted living or skilled nursing facility, would also be eligible for reimbursement at the APM facility rate.

Four Walls and the AIR

Resources (cited documents):

- https://www.medicaid.gov/federal-policy-guidance/downloads/faq11817.pdf
- http://www.tribalselfgov.org/wp-content/uploads/2017/03/TSGAC-Brief-CMS-Restrictions-on-Billing-Medicaid-for-Services-Outside-....pdf

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AHCCCS PROVIDER Enrollment Portal (APEP)

Coming Spring 2020 !

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AHCCCS Provider Enrollment Portal (APEP) Launch Date 2020

In the Spring of 2020, the AHCCCS provider enrollment process will move from a manual, paper-based system to a new, online system (the AHCCCS Provider Enrollment Portal) that will allow providers to:

- **Enroll as an AHCCCS provider;**
- **Update information (such as phone and addresses);**
- **Upload and/or update licenses and certifications;**
- **Updates in real time!**

If you have questions please contact Provider Enrollment at:

- 1-800-794-6862 (In State - Outside of Maricopa County)
- 1-800-523-0231 (Out of State)

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Behavioral Health Residential Facilities

Behavioral Health Residential Facilities

Information about BHRF requirements can be found on the AHCCCS website in the following areas:

- AMPM 320-V, Behavioral Health Residential Facilities https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320v.pdf

    - Please note that while IHS/638 providers do not have a PA requirement, providers must follow all other policy guidelines. These include, but are not limited to, the admission requirements, criteria for continued stay, discharge readiness, and assessment documentation.

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Dental Updates

Dental Updates

- As of 10/1/2017 adult members (21 years of age and older) receive an emergency dental benefit not to exceed $1,000 per member per contract year (October 1st to September 30th).
- This emergency dental benefit is to be used for emergency dental care and extractions.
- A dental emergency is defined as an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

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Dental Updates

- The outpatient AIR currently has a reimbursement rate of $455.00 per AIR.
- AHCCCS is considering the reimbursement of 3 dental AIRS for ALTCS and Tribal Members. Additional information will be released as decisions are made.

Dental Updates

- In order to bill for a dental AIR, the member's visit must meet one of the following guidelines:
  - The definition of an emergency dental visit for a non-ALTCS member, 21 years of age and older; *or*
  - Be an ALTCS member receiving services falling within the ALTCS dental services benefit; *or*
  - Be under the age of 21 (EPSDT) and receiving services falling within the current EPSDT or KidsCare dental benefit.

Dental Updates

Additional information about the ALTCS, EPSDT, KidsCare, and emergency dental benefits can be found in the FFS Provider Billing Manual, Chapter 10, Individual Practitioner Services. AMPM Chapters covering dental benefits include:

- Dental Emergencies – AMPM 310-D1, Dental Services
- ALTCS Dental Benefit – AMPM 310-D2, ALTCS Dental Services
- EPSDT Dental Benefit – AMPM 430, EPSDT Services and AMPM 431, Oral Health Care for EPSDT Aged Members

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Direct Care Agencies

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Direct Care Agencies

A direct care worker is a person who assists an elderly person or an individual with a disability with activities necessary to allow them to reside in their home.

- **These individuals, also known as Direct Support Professionals, must be employed/contracted by DCW Agencies.**

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Direct Care Agencies

Direct Care Services are available only to Arizona Long Term Care Service (ALTCS) members who reside in their own home.

- **The number and frequency of authorized Direct Care Services is determined through an assessment of the member's needs by the case manager with the member and/or the member's family, guardian, or representative, in tandem with the completion of the cost-effectiveness study.**

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Direct Care Agencies

- **Attendant Care services are not limited to the boundaries of the member's home. As indicated in the Service Plan, the Direct Care Worker, under Attendant Care, may accompany the member as necessary in order to meet his/her needs in a variety of settings, including, but not limited to:**
  - **A physician's office,**
  - **School setting, or**
  - **The workplace.**

Direct Care Agencies

- **Attendant Care services are not limited to the boundaries of the member's home. As indicated in the Service Plan, the Direct Care Worker, under Attendant Care, may accompany the member as necessary in order to meet his/her needs in a variety of settings, including, but not limited to:**
  - **A physician's office,**
  - **School setting, or**
  - **The workplace.**

Direct Care Agencies

- DCW Agencies hire/contract, supervise/monitor, and control/define the responsibilities and tasks of the Direct Care Worker as well as establish the rate of reimbursement/wages for the DCW.
- Agencies shall register with AHCCCS and sign and attest to meeting the terms of the AHCCCS Provider Participation Agreement.
- Agencies shall also ensure the basic testing, documentation, and training requirements for DCW's are satisfied.

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Direct Care Agencies

In 2019, DFSM plans to conduct annual monitoring of Direct Care Service Agencies serving Tribal ALTCS members who live in their own homes. The monitoring will ensure the provision of:

- **Service delivery in accordance with authorizations and the member's needs,**
- **Quality of care for members, and**
- **Training and supervision of Direct Care Workers.**

Monitoring will be occurring at least once a year via a desk level audit, and it will incorporate elements from AMPM Chapters 900 and 1200.

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Direct Care Agencies

It will be based on the following six Direct Care Agency standards:

Standard 1: The Direct Care Agency shall perform periodic supervisory visits to ensure quality services are provided by the Direct Care Worker.

Supervisory visits must be documented in the member's case file and cross-referenced in the Direct Care Worker's personnel files.

Standard 2: The Direct Care Agency ensures that the Direct Care Worker Agency supervisor completes a performance evaluation of the Direct Care Worker while the Direct Care Worker is present.

The Direct Care Agency must also ensure that supervisors follow supervisory visit timeframes.

Direct Care Agencies

Standard 3: The Direct Care Agency must ensure that supervisors meet timeframes and conduct Supervisory Visits that do not require the Direct Care Worker's presence.

The timing of these supervisory visits for the first 90 days is based on the date of the initial service provision, and not the date of the initial service authorization.

The first Supervisory visit occurs before the 5th day from the date of initial service provision, and the visit did not occur *on* the date of the initial service provision.

- The 30th day Supervisory visit occurs on/within five days after due date.
- The 60th day Supervisory visit occurs on/within five days after due date.
- The 90th day Supervisory visit occurs on/within five days after due date.
- Ongoing 90th day Supervisor visits occur at least every 90 days from the previous visit. This visit must not occur more than five days after its due date.

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Direct Care Agencies

Standard 4: The Direct Care Agency is responsible for ensuring compliance with the Training and Testing Period standards.

All documentation of testing and training must be in Direct Care Worker's personnel file.

Please note that the DCW must have current CPR and first aid certifications, *prior* to providing care to an ALTCS member.

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Direct Care Agencies

Standard 5: The Direct Care Agency is responsible for ensuring the Direct Care Workers have six hours of continued education annually.

Continued education shall include training on relevant topics (Principles of Caregiving, Alzheimer's Disease and Other Dementias" modules developed by representatives of residential care, home and community based care, experts in the fields of communication, and behavior). The same topics cannot be repeated year after year.

Direct Care Agencies

Standard 6: The Direct Care Agency shall integrate the use of the AHCCCS Direct Care Worker and trainer testing records online database into day to day business practices.

The primary purpose of the online database is to serve as a tool to support the portability or transferability of Direct Care Worker or trainer testing records from one employer to another employer.

Questions?

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Thank you!

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