416 - PROVIDER MANUAL AND REQUIRED NOTIFICATIONS

EFFECTIVE DATES: 10/01/08, 11/01/12, 10/01/13, 05/01/14, 10/01/14, 04/01/15, 07/01/16, 10/01/17, 10/01/18, 10/01/19, 10/01/20, 04/01/21, 10/01/22, 10/01/23, 10/01/24

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I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP, and DES/DDD (DDD) Contractors. This Policy establishes requirements for Contractors regarding the contents of their provider manual and other provider notification requirements.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

AMERICANS WITH DISABILITIES ACT (ADA)	**CLOSED-LOOP REFERRAL SYSTEM (CLRS)**	**EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)**
ELECTRONIC VISIT VERIFICATION (EVV)	**HOME AND COMMUNITY BASED SERVICES (HCBS)**	**MEMBER**
PRIMARY CARE PROVIDER (PCP)	**PROVIDER**	**SERIOUS EMOTIONAL DISTURBANCE (SED)**
SERIOUS MENTAL ILLNESS (SMI)	**VALUE-BASED PURCHASING (VBP)**	

III. POLICY

The Contract contains multiple requirements for communications between Contractors and the Contractor's provider network. The list below instructs the Contractor on content and timing of these communications. The list does not supersede any additional requirements that may be specified in Contract.

A. PROVIDER MANUAL

The Contractor shall develop, distribute, and maintain a provider manual as specified in this Policy.

The Contractor shall ensure that each contracted provider is made aware of the provider manual available on the Contractor's website or, if requested, issued a hard copy of the provider manual. The Contractor is encouraged to similarly make available a provider manual to any individual or group that submits claim and encounter data.

The Contractor remains liable for ensuring that all providers, whether contracted or not, meet the applicable AHCCCS requirements with regard to covered services, billing, etc.

At a minimum, the Contractor's provider manual shall contain information on the following:

1. The ability of a member's Primary Care Provider (PCP) to treat behavioral health conditions within the scope of their practice.

2. Introduction to the Contractor, its organization and administrative structure.

3. Provider responsibility and the Contractor's expectation of the provider.

4. Overview of the Contractor's provider services department and its function.

5. Expected response times for provider inquiries (for example telephone contacts, letters, emails, and faxes), including but not limited to the expected response times for provider calls.

6. Listing and description of covered and non-covered services, requirements, and limitations including behavioral health services.

7. Appropriate and non-appropriate use of the emergency department.

8. Information on requirements for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services, specifically:
   a. Required use of the AHCCCS EPSDT Periodicity Schedule (AMPM Policy 430, Attachment A)
   b. Screenings include:
      i. Comprehensive history,
      ii. Developmental/behavioral health screening,
      iii. Comprehensive unclothed physical examination,
      iv. Appropriate vision testing,
      v. Hearing testing,
      vi. Laboratory tests, such as blood lead testing,
      vii. Dental screenings, and
      viii. Immunizations.
   c. EPSDT providers shall document immunizations into Arizona State Immunization Information System (ASIIS), and
   d. Providers shall enroll every year in the Vaccine for Children program.

9. Description of dental services coverage and limitations.
   a. Required use of the AHCCCS Dental Periodicity Schedule (AMPM Policy 431, Attachment A) for EPSDT members.

10. Description of maternity/family planning services and supplies as specified in AMPM Policy 410 and AMPM Policy 420.

11. The Contractor's criteria and process for referrals to specialists and other providers, including access to behavioral health services.

12. Information on the Closed Loop Referral System (CLRS), how providers can use it to refer members to community-based services.

13. The Contractor's process for referrals and provision of Augmentative and Alternative Communication (AAC) related services, including AAC device evaluations.

14. Grievance and Appeal System process and procedures for providers and members.

15. Billing and encounter submission information.

16. Contractor policies and procedures relevant to the providers including, but not limited to:
    a. Utilization management,
    b. Claims submission,
    c. Electronic Visit Verification (EVV),
    d. Criteria for identifying provider locations that provide physical access, accessible equipment, and/or reasonable accommodations for members with physical or cognitive disabilities, and
    e. PCP assignments, including how provider participation in Value-Based Purchasing (VBP) initiatives impacts member assignments to a PCP as specified in AMPM Policy 510.

17. Contractor's procedure for providers to request a PCP assignment roster, that the roster will be provided within 10 business days of receipt of the request, and include, at a minimum:
    a. Assigned members' name,
    b. Assigned members' date of birth,
    c. Assigned members' AHCCCS ID,
    d. AHCCCS ID of the assigned PCP, and
    e. Effective date of member assignment to the PCP.

18. AHCCCS Policies relevant to contractor payment responsibilities including, but not limited to:
    a. Description of the Change of Contractor policies. Refer to ACOM Policy 401 (ACC) and ACOM Policy 403 (ALTCS E/PD), and
    b. Nursing Facility (NF) and Alternative Home and Community Based Service (HCBS) setting contract termination procedures. Refer to ACOM Policy 421 (ALTCS E/PD).

19. Reimbursement policies, including reimbursement for members with other insurance as specified in ACOM Policy 434, and Medicare cost sharing as specified in ACOM Policy 201.

20. A link, or directions on how to find all required policies, protocols, and procedures required under AMPM Policy 541 that describe how member care will be coordinated with governmental and tribal agencies and entities.

21. Cost sharing responsibility.

22. Explanation of remittance advice.

23. Criteria for the disclosure of member health information.

24. Medical record standards.

25. Prior Authorization (PA) and notification requirements, including a list of most frequently used services which require authorization, and instructions on how to obtain a complete listing of services that require authorization.

26. Requirements for out of state placements for members.

27. Claims medical review.

28. Concurrent review.

29. Coordination of care requirements.

30. Credentialing and re-credentialing activities.

31. Fraud, waste, and abuse as specified in ACOM Policy 103.

32. The AHCCCS Drug List information including:
    a. How to access the drug lists electronically or by hard copy upon request, and
    b. How and when updates to these lists are communicated.

33. Prescribing and monitoring of all medications including specific protocols for opioids and psychotropic medications, including, at a minimum, PA requirements and limits specified in AMPM Policy 310-V, the Contractor's monitoring process for prescribers in AMPM Policy 310-FF, and informed consent requirements in AMPM Policy 320-Q.

34. AHCCCS appointment standards.

35. Requirements pertaining to duty to warn and duty to report as specified in AMPM Policy 960.

36. Submission requirements under the AHCCCS DUGless Portal Guide for behavioral health providers regarding their responsibilities for submitting to AHCCCS demographic information.

37. Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act of 1964 requirements, as applicable.

38. Information on the process providers must use to notify the Contractor for changing an address, contact information or other demographic information.

39. Information on services available through the AHCCCS Provider Enrollment Portal (APEP) and how to access the portal. How to update provider registration data including current population groups sets served.

40. The responsibility of providers required by AHCCCS to identify demographic data regarding their population group sets served to report and update any changes to these group sets within 10 days of the change, as outlined in AMPM Policy 610.

41. Eligibility verification.

42. Cultural competency information, including notification about Title VI of the Civil Rights Act of 1964. Providers should also be informed of how to access interpretation services to assist members who speak a language other than English including Sign Language as specified in ACOM Policy 405.

43. Peer review and the provider's ability to dispute the peer review process.

44. Medication management services as specified in Contract.

45. The member's rights under 42 CFR 457.1220 and 42 CFR 438.100, including:
    a. A member's right to be treated with dignity and respect,
    b. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand,
    c. A member's right to participate in treatment decisions regarding his or her health care, including the right to refuse treatment,
    d. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation,
    e. Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR Part 164 and applicable State law, and
    f. Exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the member.

46. That the Contractor has no policies which prevent the provider from advocating on behalf of the member as specified in 42 CFR 457.1222 and 42 CFR 438.102.

47. How to access or obtain Practice Guidelines and coverage criteria for authorization decisions.

48. General and informed consent for treatment requirements.

49. Advance directives.

50. Transition of members.

51. Encounter validation studies.

52. Incidents, accidents, and deaths reporting requirements as specified in AMPM Policy 961.

53. All Contractors except CHP shall also include information on pre-petition screening, court ordered evaluations, and court ordered treatment.

54. Behavioral health assessment and service planning requirements:
    a. As specified in AMPM Policy 320-O,
    b. Requirements for behavioral health providers to assist individuals as specified in the AMPM Policy 650,
    c. Outreach, Engagement, and Re-Engagement for Behavioral Health applicable to providers as specified in AMPM Policy 1040,
    d. Serious Emotional Disturbance (SED) eligibility determination process as specified in AMPM Policy 320-P,
    e. Serious Mental Illness (SMI) eligibility determination process as specified in AMPM Policy 320-P,
    f. Partnership requirements with families and family-run organizations in the children and adult behavioral health system, and
    g. Peer support/recovery training, certification, and clinical supervision requirements as specified in AMPM Policy 963.

55. The DES/DDD, ALTCS E/PD and ACC-RBHA Contractors shall also include:
    a. Housing criteria for individuals determined to have an SMI,
    b. Seclusion, restraint, and emergency response reporting requirements, and
    c. The SMI grievance and appeal process.

56. The ACC-RBHA Contractors shall also include:
    a. Requirements for grant funded services provided to Special Populations,
    b. Behavioral health crisis intervention service requirements, and
    c. An explanation of the process for members not eligible for TXIX/XXI services to file a complaint, grievance, and/or request for hearing when not determined SMI.

57. The DDD Contractor shall include guidance on which services are the responsibility of DDD qualified vendors and which services are the responsibility of providers contracted with the DDD Subcontracted Health Plans. This must include directions for providers on how the provider can obtain guidance when they are unsure of these responsibilities.

B. REQUIRED NOTIFICATIONS

The Contractor is required to provide written or electronic communication to contracted providers in the following instances:

1. Exclusion from Network - Under Federal Regulation 42 CFR 457.1208 and 42 CFR 438.12 the Contractor is required to provide written notice of the reason for declining any written request for inclusion in the network.

2. Material Changes - The Contractor is required to notify providers in advance of any Material Change to the Provider Network and/or Business Operations as specified in ACOM Policy 439.

3. AHCCCS Guidelines, Policy, and Manual Changes - The Contractor is responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals. In the event of a modification to AHCCCS Policy, guidelines, and manuals, the Contractor shall issue a notification of the change to its effected subcontractors within 30 days of the published change and ensure amendment of any affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six months of the update, whichever comes first.

4. Contractor Provider Manual Changes – The Contractor is responsible for ensuring that its providers are notified when modifications are made to its provider manual.

5. Subcontract Updates – In the event of a modification to the AHCCCS Minimum Subcontract Provisions (MSP), the Contractor shall issue a notification of the change to its subcontractors within 30 days of the published change and ensure amendment of affected subcontracts. Affected subcontracts shall be amended on their regular renewal schedule or within six months of the update, whichever comes first.

6. Termination of Subcontract – The Contractor shall notify hospitals and/or provider groups at least 90 days prior to any subcontract termination without cause. Subcontracts between Contractors and individual practitioners are exempted.

7. Disease/Chronic Care Management – The Contractor shall disseminate information as specified in AMPM Policy 1023.

8. Other communication upon request of AHCCCS. In these instances, AHCCCS will provide prior notification as is deemed reasonable or prudent.