




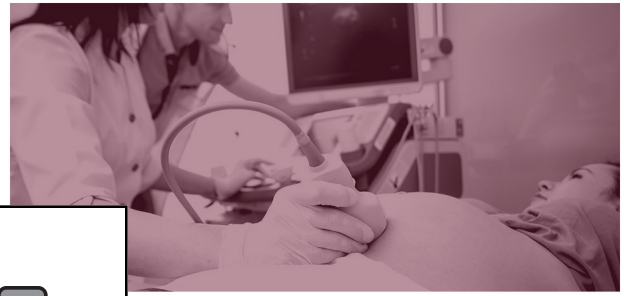


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# DFSM Tribal ALTCS

# 3rd Quarter Case Management Supervisor Meeting

Thursday, August 26, 2021

AHCCCS
Arizona Health Care Cost Containment System

# WELCOME TO ALL!

## Agenda Overview

- **Rachel Hunter: Project & Policy Updates**
- **Kevin Hoy: Deliverable Reports and Network Stats**
- **Soni Fisher: Open Line Request Form**
- **Cheryl Begay: Member Change Report & AHCCCS EI Updates**
- **Vanessa Torrez: PA & Claims Process for Customized Wheelchairs**
- **Rachel Hunter: TBD**
- **Tribal ALTCS Plan Recognition**

# Meeting Reminders

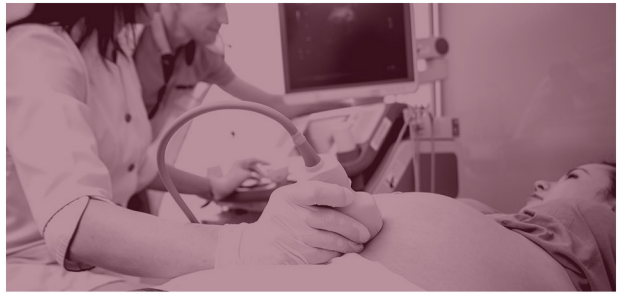
- Please mute your computer's microphone and/or phone when not speaking.
- Use the chat feature to add in comments/questions.
- Ask questions after the speaker has finished.
- Sit back, listen in and enjoy the meeting!
- This meeting will be recorded.

# ICE BREAKER

**What are some traditional foods or drinks you like to eat?**






# PROJECT & POLICY UPDATES

Rachel Hunter-Tribal ALTCS Administrator

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# AHCCCS Person Centered Service Planning Trainer TA Sessions

AHCCCS has set up a series of Technical Assistance (TA) sessions for trainers. The TA sessions will serve as a platform for trainers to share challenges and successes and engage in problem-solving, in preparation for the June 1st PCSP implementation. *TA sessions are optional.*

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# Meeting Reminders

## Survey Response: 4 Tribal ALTCS Programs

- Communication & Culture
- Goal Settings and Development Outcome
- Risk Assessments

## Follow-up and Next Steps

- AHCCCS will send out PCSP Overview
- Training will focus on Goals and Risk Assessments

# Policy Updates

**02/04/21 - 961,  Incident, Accident, Death Reporting**

Published 04/01/21

**03/04/21 - 1620-O, Abuse, Neglect, and Exploitation Reporting Standard**

Published 05/03/21

**04/01/21 - 1620-G Behavioral Health Standards**

Published

**05/20/21 - 1630 - Administrative Standards & Attachment A Case Management Plan Checklist**

Published

**AMPM – Currently Under Review**

- 810, Fee-for-Service Utilization Management
- 820, Fee-For-Service Prior Authorization Requirements

# Electronic Visit Verification (EVV)

**Project: Ongoing**

**Implementation Date: 01/01/2021 (TBD) Challenges with Sandata System**

**Providers and Services Subject to EVV:**

| Provider Description | Provider Type |
|---|---|
| Attendant Care Agency | PT 40 |
| Behavioral Outpatient Clinic | PT 77 |
| Community Service Agency | PT A3 |
| Fiscal Intermediary | PT F1 |
| Habilitation Provider | PT 39 |
| HomeHealth Agency | PT 23 |
| Integrated Clinic | PT IC |
| Non-Medicare Certified HomeHealth Agency | PT 95 |
| Private Nurse | PT 46 |

| Service | HCPCS Service Codes | DDD Focus Codes |
|---|---|---|
| Attendant Care | S5125 | ATC |
| Companion Care | S5135 | |
| Habilitation | T2017 | HAH, HAI |
| Home Health Services (aide, therapy, and part-time/intermittent nursing services) | | |
| Nursing | G0299 and G0300 | |
| Home Health Aide | T1021 | |
| Physical Therapy | G0151 and S9131 | |
| Occupational Therapy | G0152 and S9129 | |
| Respiratory Therapy | S5181 | |
| Speech Therapy | 9128 | |
| Private Duty Nursing (continuous nursing services) | S9123 and S9124 | HN1, HNR |
| Homemaker | S5130 | HSK |
| Personal Care | T1019 | |
| Respite | S5150 and S5151 | RSP, RSD |
| Skills Training and Development | H2014 | |

EVV Timeline

**Place of Service:**

| Place of Service Description | POS Code |
|---|---|
| Home | 12 |
| Assisted Living Facility | 13 |
| Other | 99 |

# Electronic Visit Verification (EVV) - Ongoing

## 32 FFS Providers (Tribal ALTCS) have not started or completed Sandata Training

- Some ideas the Tribal ALTCS Programs had to communicate EVV requirements.
  - Notify Tribal Business office
  - Add a comment to referrals sent to Direct Care Agencies

- EVV Requirements and Information is available on this link https://www.azahcccs.gov/AHCCCS/Initiatives/EVV/

# Electronic Visit Verification (EVV) (cont.)

| COMPLETED TRAINING | TRAINING NOT COMPLETED | ALT EVV |
|---|---|---|
| 33 | 14 | 1 |

**Internal: AHCCCS Staff participated in the Dashboard Training (Provider & Member Data)**

- ✓ AZ BI Session 2 - Overview of Dashboards (Charts and Graphs)
- ✓ AZ BI Session 3 - Card Building Choosing the Right Chart Type
- ✓ Continuing to provide support to DHCM and Providers

**External :** Tribal ALTCS Case managers

- ✓ Conduct reviews timely
- ✓ Update PAs on CA165 to ensure the correct data is communicated to the Sandata system.

Providers

- ✓ Continue testing devices
- ✓ 10 providers need to complete EVV training modules

# Electronic Visit Verification (EVV) (cont.)

The following providers have not started the EVV trainings.

| DIRECT CARE AGENCY | PROVIDER ID |
|---|---|
| Cedar RIDGE HOME CARE | 631940 |
| COS 1 LLC **(T)** | 993405 |
| DOG SPRING HOME CARE | 807065 |
| HASHINEE' HOME CARE | 873427 |
| **HOME CARING LLC (AHCCCS made contact and will follow)** | **398994** |
| HOPE HOME CARE | 160608 |
| **JOOBA HOME CARE (AHCCCS made contact and will follow)** | **380918** |
| MOUNTAIN VIEW HOME CARE | 908392 |
| **PINE VIEW HOME CARE (AHCCCS made contact and will follow)** | **549584** |
| SACRED HEARTS | 162473 |
| TOWERING ROCK NON-EMERGEN | 163119 |
| TSIN-NAN-TEE | 467942 |
| UNITY CARE LLC | 163218 |
| WHISPERING SHADOW CARE LL | 401386 |

# Tribal ALTCS Projects & Initiatives

## Creating a new TAT Report

| Documents | Subtotal |
|---|---|
| >80% | 23 |
| ALF BH | 273 |
| Contractor Change | 4 |
| DME | 811 |
| E1399 | 2 |
| Home Modification | 97 |
| Open Line Request | 451 |
| Out of State Placement | 49 |
| SNF | 343 |

## Total: 2053 Documents

- FAX
- Duplicate Documents
- Missing Information
- Approval Letter
- No PA Required
- Canceled
- Other Comments

**Create Standized Comments:**

- Incoming FAX (PA Request)
- Saving Approved Request in Docuware:

**Standard comments will help the team identify areas:**

- Need improvement
- Provide additional training
- Number of responses provided (FAX/Email)

# Tribal ALTCS Projects & Initiatives

## Created a new Docuware Turn Around Time Report

- Administrator and Manager monitors this report weekly.
- Provide assists to team members if a request has been outstanding for more than 72 hours.

## Case Management Manual

- Policy Updates will determine if we continue this project.

## Create New Training Modules for the Tribal ALTCS Programs

- Outlining the training topic.
- Continue working with DFSM Training Team.

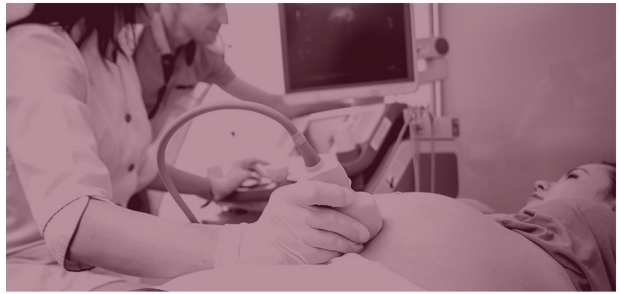
## Tribal ALTCS Nurse

- Creating new DLP for all areas of duties.

# ANY QUESTIONS?






# Deliverable Reports & Network Stats

Kevin Hoy, M.A. – Tribal ALTCS Manager

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# Caseload Ratio Report

## AHCCCS TRIBAL CONTRACTOR QUARTERLY CASELOAD RATIO REPORT

Tribal ALTCS Program:

Quarterly Report:

| Case Manager Name | HCBS - Own Home | | | | | HCBS - Alternative Setting | | | | | D - Acute Care Placement | | | | | Q - Institual Placement | | | | | WEIGHTED VALUE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | NON SMI | Value 2.2 | SMI | Value 3 | Subtotal | NON SMI | Value 1.8 | SMI | Value 1.9 | Subtotal | NON SMI | Value 1 | SMI | Value 1 | Subtotal | NON SMI | Value 1 | SMI | Value 1.4 | Subtotal | |
| | | | | | | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | | | | | | |
| Subtotal Member Count: | | | | | | | | | | | | | | | | | | | | | |

Provide explanation and plan of correction, including timeframes, if ANY weighted value exceeds 96 *(attach a separate sheet if more space is needed)*:

# AMPM 1630 Administrative Standards

A. Case Manager Qualifications

Section D-Caseload Management

*Adequate numbers of qualified and trained case managers shall be provided to meet the needs of members, and shall meet the caseload ratios detailed below, except as otherwise specified in this policy. Contractors and AHCCCS Tribal ALTCS Unit shall have written protocols to ensure newly enrolled ALTCS members are assigned to a case manager immediately upon enrollment.*

**Caseload formulas**

(# of members in an institutional setting x 1.0) ***Max member caseload is 96***

(# of members determined to have an SMI who are in an institutional setting x 1.4) ***Max member caseload is*** 68

(# of members in an HCBS (own home) setting x 2.2) ***Max member caseload is*** 43

(# of members determined to have an SMI who are in an HCBS (own home) setting x 3.0) ***Max member caseload is*** 32

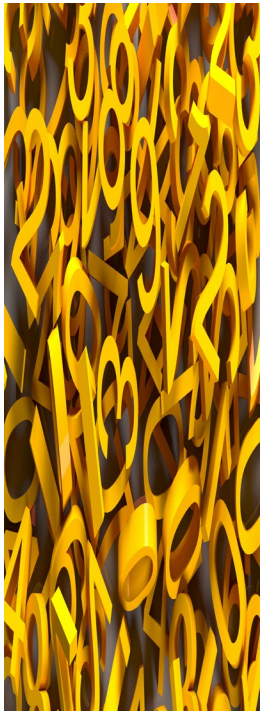
(# of members in an Alternative HCBS setting x 1.8) ***Max member caseload is*** 53

(# of members determined to have an SMI who are in an Alternative HCBS setting x 1.9) ***Max member caseload is*** 50

(# of members in Acute Care Only (ACO) status x 1.0) ***Max member caseload is*** 96

(# of members determined to have an SMI who are in Acute Care Only (ACO) status x 1.0) ***Max member caseload is*** 96

**No matter the mix, the caseload ratio must be under 96**



# Network Quarterly Report Stats-Caseload Ratio

- Submission 'on time rate': **87.5%**
- Use of new form: **100%**
- Total number of Network CMs: **90**
- Average per plan: **8.5** (excluding NN/with NN included 11.25)
- Network caseload average:

  **Range from 18-71 members** (affected by staff vacancies)

  **Average is 37.9 members per CM**
- Network weighted value: (affected by staff vacancies)

  **Average 58** (max is 96)

  **Range 31 to 97.4**

# Caseload Ratio-Helpful Suggestions

- Ideas on how to maintain manageable caseload numbers?
- Are your caseloads assigned by region? Age? Complexity?
- What do you do when a case manager seems to be struggling?

# Supervisory Audit Report

**SUPERVISORY AUDIT**
**QUARTERLY SUMMARY**

**Tribal Contractor/Office:** _____

| **From Month/Year:** | | **To Month/Year:** | |
|---|---|---|---|

| **# of Files Reviewed:** | |
|---|---|

| **Audit Question #** | **# Applicable** | **% YES** | **% NO** | **Corrective Action if NO > 10%** |
|---|---|---|---|---|
| 1A | | | | |
| 1B | | | | |
| 1C | | | | |
| Comments: | | | | |
| | | | | |
| 2A | | | | |
| 2B | | | | |
| 2C | | | | |
| 2D | | | | |
| 2E | | | | |
| Comments: | | | | |

# AMPM 1630 Administrative Standards

A. Case Manager Qualifications

Section I-Supervision:

- A system of internal monitoring of the case management program, to include case file audits and reviews of the consistency of member assessments and service authorizations shall be established and applied, at a minimum, on a quarterly basis.
- Results from this monitoring including the development and implementation of continuous improvement strategies to address identified deficiencies shall be documented and made available to AHCCCS upon request.

# Network Quarterly Report Stats-Supervisory Audit

**Supervisory Audit**

- Submission rate per month: 87.5%
- Average of total files reviewed: 30 files

  **Range: 11 files to 76 files**
- Average percentage of total membership: 20%

  **Range 2%-46%**
- Plans entering 100% for <1 questions (up to 43 possible questions to answer):

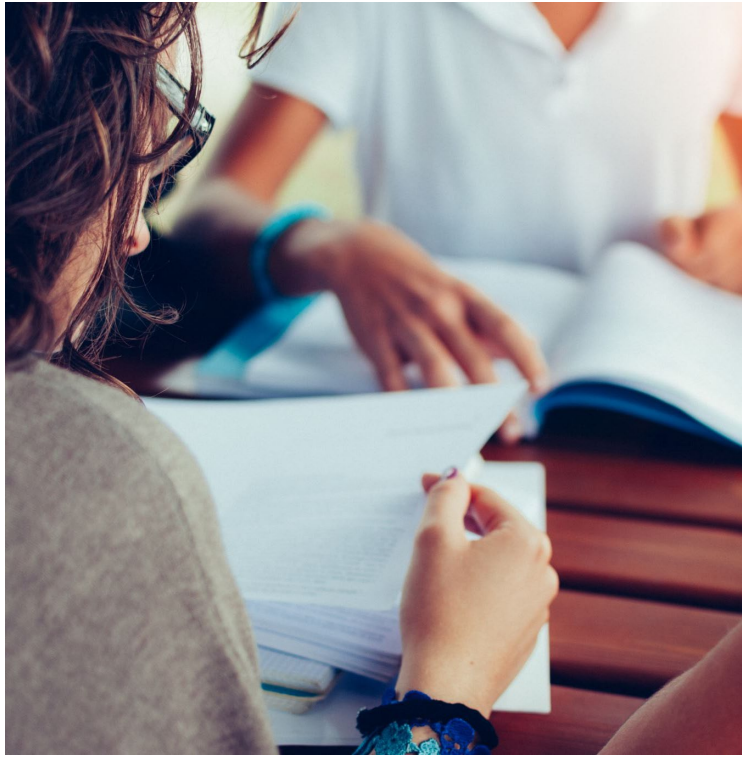
  **2 plans answered only 1 question as non-compliant**

  **2 plans answered all questions with 100%**
- Range of audit reports with a NO and comment:

  **0-16**
- There should be questions answered with NO, indicating an opportunity for performance improvement for your staff.

Example; *Was a Member Change Report submitted for all member changes (ie: address, placement, etc)? If this didn't occur, it's a NO. Schedule time to train the staff how to file an eMCR and when this is required.*

# Supervisory Audit-Helpful Suggestions

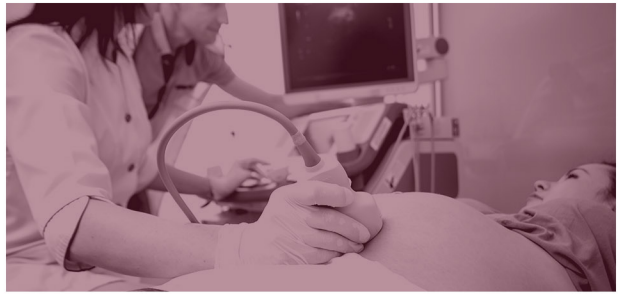


- Ideas in how you determine how many files to review?
- What do you do when the results from the file review indicates a case manager needs performance improvement assistance?

ANY QUESTIONS?






# Open Line Request Form

Soni Fisher – Tribal ALTCS Case Management Coordinator

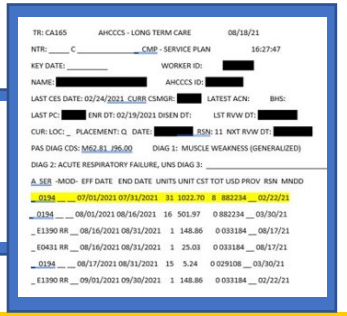
AHCCCS
Arizona Health Care Cost Containment System

# OPEN LINE REQUEST FORM

- We have created a fillable Open Line Request (OLR) form, in pdf format. A link to the form is provided **here**, and has been uploaded to the DTB under the "Common Forms" tool section.
- A dropdown box will allow you to select your Program/Office.
- **Tab** next and fill in the Case Manager name, Member's AHCCCS ID and Member's Name.
- Please provide a screen print of the CA165 and what the service line looks like prior to the corrections being made. You can roll your mouse cursor over the sample to view it, but the sample will not print.

**PLEASE INCLUDE A PRINTOUT OF THE CA165 SCREEN OF HOW THE SERVICE LINE CURRENTLY APPEARS** (roll mouse cursor to view sample below).

**PLEASE DEDUCT UNITS IF INFORMAL SUPPORT (IFS) OR HOSPITALIZATIONS (A23) OCCURRED DURING THE SERVICE LINE DATES OF SERVICE. ENSURE ALL DATE RANGES/UNITS ARE REFLECTED BELOW SO GAPS IN SERVICES DO NOT OCCUR:**


TR: CA165 AHCCCS - LONG TERM CARE 08/18/21
NTR: ____ C _____ CMP - SERVICE PLAN 16:27:47
KEY DATE: _____ WORKER ID: [redacted]
NAME: [redacted] AHCCCS ID: [redacted]
LAST CES DATE: 02/24/2021 CURR CSMGR: [redacted] LATEST ACN: BHS:
LAST PC: [redacted] ENR DT: 02/19/2021 DISEN DT: LST RVW DT: [redacted]
CUR: LOC: _ PLACEMENT: Q DATE: [redacted] RSN: 11 NXT RVW DT: [redacted]
PAS DIAG CDS: M62.81 J96.00 DIAG 1: MUSCLE WEAKNESS (GENERALIZED)
DIAG 2: ACUTE RESPIRATORY FAILURE, UNS DIAG 3: _____
A SER -MOD- EFF DATE END DATE UNITS UNIT CST TOT USD PROV RSN MNDD
_ 0194 __ 07/01/2021 07/31/2021 31 1022.70 8 882234 __ 02/22/21
_ 0194 __ 08/01/2021 08/16/2021 16 501.97 0 882234 __ 03/30/21
_ E1390 RR __ 08/16/2021 08/31/2021 1 148.86 0 033184 __ 08/17/21
_ E0431 RR __ 08/16/2021 08/31/2021 1 25.03 0 033184 __ 08/17/21
_ 0194 __ __ 08/17/2021 08/31/2021 15 5.24 0 029108 __ 03/30/21
_ E1390 RR __ 09/01/2021 09/30/2021 1 148.86 0 033184 __ 02/22/21

# OPEN LINE REQUEST FORM

- **Tab** next and *ensure that the entire date span of the original service line is accounted for*, i.e. If a member is hospitalized or receives Informal Support (IFS) during the month, ensure that the service information before and after the hospitalization/IFS is provided, along with *all applicable units, unit costs, and PID*.

**PLEASE MAKE THE FOLLOWING CORRECTIONS:**

| SER | MOD | EFF DATE | END DATE | UNITS | UNIT CST | PROV |
|---|---|---|---|---|---|---|
| 0194 | | 7/1/21 | 7/15/21 | 15 | 1022.70 | 882234 |
| A23 | | 7/16/21 | 7/18/21 | 3 | 0.00 | 029108 |
| 0194 | | 7/19/21 | 7/31/21 | 13 | 1022.70 | 882234 |
| | | | | | | |

- **Tab** next to the Explanation field and provide a brief explanation for the need for an OLR, i.e. Member hospitalized; Member received IFS, etc.

**PROVIDE AN EXPLANATION AS TO WHY THE LINE(S) NEED TO BE OPENED:**

Member was hospitalized from 07/16/21 to 07/18/21.

# OPEN LINE REQUEST FORM

- Above the signature line there is a statement that we are asking both the Case Manager and Supervisor to ensure has been completed by signing their name and dating, which states:

SIGNATURES ARE REQUIRED AND ACKNOWLEDGE THAT THE CASE MANAGER HAS NOTIFIED THE PROVIDER THAT AHCCCS WILL BE RECOUPING FUNDS PAID AND THE PROVIDER WILL NEED TO RESUBMIT THE CLAIM(S). ALSO, BOTH THE TRIBAL ALTCS CASE MANAGER AND SUPERVISOR ACKNOWLEDGE THEY HAVE BOTH REVIEWED AND SUBMITTTED THE NECESSARY DOCUMENTATION TO PROCEED WITH AN OPEN LINE REQUEST AND CORRECTIONS.

NOTE: IF ALL NECESSARY INFORMATION IS NOT INCLUDED IN THE REQUEST PACKET, IT CANNOT BE PROCESSED AND INSTRUCTIONS WILL BE PLACED ON THE CA165 COMMENTS SCREEN

- Print the form and both the Case Manager and Supervisor need to sign/date prior to faxing.

| TRIBAL ALTCS PERSONNEL | SIGNATURES | DATED: |
|---|---|---|
| CASE MANAGER: Sign & Date | | |
| SUPERVISOR: Sign & Date | | |

# OPEN LINE REQUEST FORM

- The reason we need both the Case Manager and Supervisor to sign is that we have received calls from numerous Providers asking why AHCCCS is recouping funds. It is the responsibility of the Case Manager, when they submit an OLR, to notify the Provider that AHCCCS will be recouping the paid funds as corrections need to be made to a service line, and that the Provider will need to resubmit claim(s) in order to be paid.
- A Supervisor's signature is attesting that he/she has reviewed and approved the OLR. In addition, it is their attestation that they have confirmed with the Case Manager that he/she has notified the Provider(s) that changes need to be made to the service line and AHCCCS will be recouping the paid funds. Therefore, the Provider will need to resubmit the claim(s).

# OPEN LINE REQUEST FORM

- Tribal ALTCS Case Management Coordinators will place comments on CA165 **only** if the OLR is missing something, incomplete, etc., and include instructions on what the Case Manager needs to do.
- There is a statement below the signature line which reflects:

> **NOTICE: CASE MANAGER TO PERIODICALLY REVIEW THE CA165 COMMENT SCREEN FOR STATUS UPDATES FROM AHCCCS TRIBAL ALTCS REGARDING THIS OPEN LINE REQUESTS.**

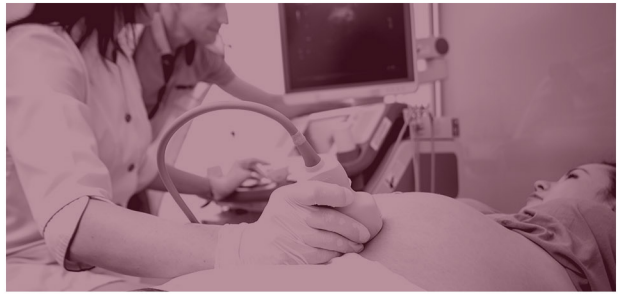
- This Open Line Request form will go into effect **September 1, 2021** (throughout all Tribal ALTCS Programs) and is to be completed/ included with every OLR that is submitted to AHCCCS.

# ANY QUESTIONS?


Let's take a quick 10-minute break and meet back here in 15 minutes so we can finish on time.






# ALTCS Member Change Report

Cheryl Begay – Tribal ALTCS Case Management Coordinator

AHCCCS
Arizona Health Care Cost Containment System

# ALTCS Member Change Report User Guide

- The ALTCS Member Change Report (MCR) User Guide applies to ALTCS/EPD, DES/DDD, and ALTCS Tribal Programs. The purpose of this User Guide is to provide a tutorial for the process of reporting to AHCCCS when a change needs to be made for a long term care member's eligibility or enrollment record via the electronic Member Change Report (eMCR).

- Member Change Request Online is an internet application that allows for electronic submission of change request forms to the AHCCCS.

Here is the link to create an account and login:

https://www.azahcccs.gov/PlansProviders/Downloads/ALTCSMCRUserGuide.pdf

# ALTCS MCR User Guide

- The electronic MCR process was implemented to increase efficiency and develop improved tracking and reporting mechanisms for both AHCCCS and Contractors.
- The MCR Guide provides the Contractor with examples of the screens used and the procedural steps for completing the various types of eMCRs.
- Reference AMPM Chapter 1600, Exhibit 1620-2 for guidelines on when to use a member change report form.
- https://azahcccs.gov/shared/Downloads/MedicalPolicyManual/1600/1620-2.pdf

# An electronic Member Change Report (eMCR) shall be sent to AHCCCS to report or request the following:

- To report a change in the member's demographic data (for example, address, marital status, name change, etc.).
- To report a change in the member's financial status (or that of his/her household) which may affect their Arizona Long Term Care System (ALTCS) eligibility, including the initiation of the member's spouse as the paid caregiver.
- To report a change in an ALTCS member's placement.
- To report a change in the member's DDD status and request a Pre-Admission Screening (PAS) reassessment.
- To report the closure of a member's service plan for reasons other that financial or medical eligibility (for example, the member dies, moves out of the state, or voluntarily withdraws from the program).

# EXHIBIT 1620-2, ALTCS MEMBER CHANGE REPORT **Cont.**

•To initiate a Contractor change for a member who is Elderly and/or has Physical Disabilities (E/PD), moves into another Contractor's service area and resides in a Home and Community Based (HCB) setting (does not include alternative residential settings).

•To request a PAS reassessment when the case manager thinks the member no longer meets medical eligibility criteria for either the ALTCS or Transitional programs.

•To request a PAS reassessment if a Transitional eligible member has a deterioration of condition and will be/has been admitted to a nursing home or Intermediate Care Facility (ICF) and is expected to stay more than 90 continuous days (this request must be sent within 45 days of admission to the institutional setting).

# EXHIBIT1620-2, ALTCS MEMBER CHANGE REPORT

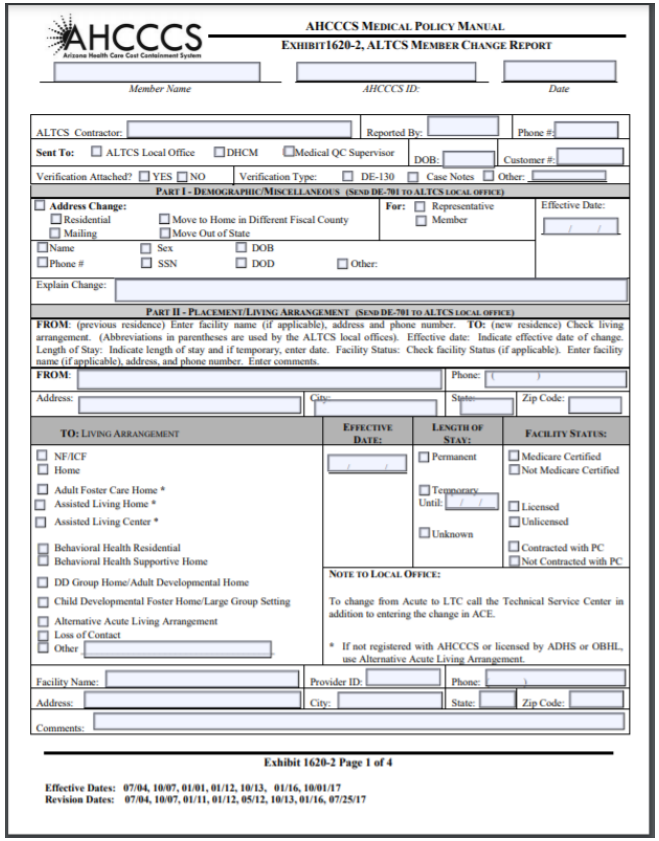
- To request an Acute Care Only determination for a member who has received no Long Term Care (LTC) services for a full calendar month because s/he refuses ALTCS covered services but s/he has not signed a Voluntary Withdrawal. “Refusing” includes being unwilling or unavailable to receive services offered or covered by the Contractor (examples: member is not home whenever provider comes to deliver care, member unwilling to move out of non-contracted alternative residential setting or member is temporarily out of a contractor’s service area). This determination could result in the member being disenrolled from ALTCS if his/her income exceeds 100% of the Federal Benefit Rate.

- To request a change in a member’s status from Acute Care Only back to full LTC when the member begins to accept LTC services.

# EXHIBIT1620-2, ALTCS MEMBER CHANGE REPORT CONT.

- To request a change in Contract Type when a member has received no LTC services for a full calendar month, due to no LTC service provider being available. This change will not cause a member to be disenrolled.
- To inform ALTCS when a member is temporarily out-of-state (>30 days).
- For Maricopa County E/PD members only – to report the member's request to change Contractors and the need for an enrollment choice.
- To report loss of contact with the member.

# EXHIBIT 1620-2, ALTCS MEMBER CHANGE REPORT, Pages 1 & 2.



AHCCCS
Arizona Health Care Cost Containment System

**AHCCCS MEDICAL POLICY MANUAL**
**EXHIBIT1620-2, ALTCS MEMBER CHANGE REPORT**

*Member Name* | *AHCCCS ID:* | *Date*

ALTCS Contractor: | Reported By: | Phone #:

**Sent To:** ☐ ALTCS Local Office ☐ DHCM ☐ Medical QC Supervisor | DOB: | Customer #:

Verification Attached? ☐ YES ☐ NO | Verification Type: ☐ DE-130 ☐ Case Notes ☐ Other:

**PART I - DEMOGRAPHIC/MISCELLANEOUS (SEND DE-701 TO ALTCS LOCAL OFFICE)**

☐ **Address Change:** ☐ Residential ☐ Mailing ☐ Move to Home in Different Fiscal County ☐ Move Out of State | **For:** ☐ Representative ☐ Member | Effective Date: / /

☐ Name ☐ Sex ☐ DOB
☐ Phone # ☐ SSN ☐ DOD ☐ Other:

Explain Change:

**PART II - PLACEMENT/LIVING ARRANGEMENT (SEND DE-701 TO ALTCS LOCAL OFFICE)**

**FROM**: (previous residence) Enter facility name (if applicable), address and phone number. **TO**: (new residence) Check living arrangement. (Abbreviations in parentheses are used by the ALTCS local offices). Effective date: Indicate effective date of change. Length of Stay: Indicate length of stay and if temporary, enter date. Facility Status: Check facility Status (if applicable). Enter facility name (if applicable), address, and phone number. Enter comments.

**FROM:** | Phone: ( )

Address: | City: | State: | Zip Code:

| **TO:** LIVING ARRANGEMENT | **EFFECTIVE DATE:** | **LENGTH OF STAY:** | **FACILITY STATUS:** |
|---|---|---|---|
| ☐ NF/ICF<br>☐ Home | / / | ☐ Permanent | ☐ Medicare Certified<br>☐ Not Medicare Certified |
| ☐ Adult Foster Care Home *<br>☐ Assisted Living Home *<br>☐ Assisted Living Center * | | ☐ Temporary Until: / / | ☐ Licensed<br>☐ Unlicensed |
| ☐ Behavioral Health Residential<br>☐ Behavioral Health Supportive Home | | ☐ Unknown | ☐ Contracted with PC<br>☐ Not Contracted with PC |
| ☐ DD Group Home/Adult Developmental Home<br>☐ Child Developmental Foster Home/Large Group Setting<br>☐ Alternative Acute Living Arrangement<br>☐ Loss of Contact<br>☐ Other | **NOTE TO LOCAL OFFICE:**<br>To change from Acute to LTC call the Technical Service Center in addition to entering the change in ACE.<br>* If not registered with AHCCCS or licensed by ADHS or OBHL, use Alternative Acute Living Arrangement. | | |

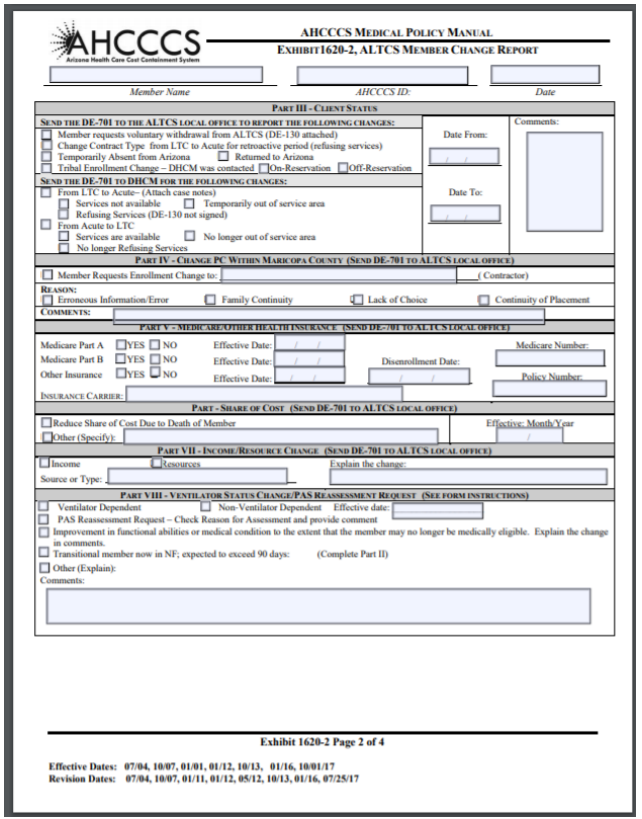
Facility Name: | Provider ID: | Phone: ( )

Address: | City: | State: | Zip Code:

Comments:

**Exhibit 1620-2 Page 1 of 4**

**Effective Dates:** 07/04, 10/07, 01/01, 01/12, 10/13, 01/16, 10/01/17
**Revision Dates:** 07/04, 10/07, 01/11, 01/12, 05/12, 10/13, 01/16, 07/25/17



AHCCCS
Arizona Health Care Cost Containment System

**AHCCCS MEDICAL POLICY MANUAL**
**EXHIBIT1620-2, ALTCS MEMBER CHANGE REPORT**

*Member Name* | *AHCCCS ID:* | *Date*

**PART III - CLIENT STATUS**

**SEND THE DE-701 TO THE ALTCS LOCAL OFFICE TO REPORT THE FOLLOWING CHANGES:**
☐ Member requests voluntary withdrawal from ALTCS (DE-130 attached)
☐ Change Contract Type from LTC to Acute for retroactive period (refusing services)
☐ Temporarily Absent from Arizona ☐ Returned to Arizona
☐ Tribal Enrollment Change – DHCM was contacted ☐ On-Reservation ☐ Off-Reservation

Date From: / /

**SEND THE DE-701 TO DHCM FOR THE FOLLOWING CHANGES:**
☐ From LTC to Acute– (Attach case notes)
☐ Services not available ☐ Temporarily out of service area
☐ Refusing Services (DE-130 not signed)
☐ From Acute to LTC
☐ Services are available ☐ No longer out of service area
☐ No longer Refusing Services

Date To: / /

Comments:

**PART IV - CHANGE PC WITHIN MARICOPA COUNTY (SEND DE-701 TO ALTCS LOCAL OFFICE)**

☐ Member Requests Enrollment Change to: ( Contractor)

**REASON:**
☐ Erroneous Information/Error ☐ Family Continuity ☐ Lack of Choice ☐ Continuity of Placement

**COMMENTS:**

**PART V - MEDICARE/OTHER HEALTH INSURANCE (SEND DE-701 TO ALTCS LOCAL OFFICE)**

Medicare Part A ☐ YES ☐ NO Effective Date: / /
Medicare Part B ☐ YES ☐ NO Effective Date: / /
Other Insurance ☐ YES ☐ NO Effective Date: / /

Disenrollment Date: / /

Medicare Number:

Policy Number:

INSURANCE CARRIER:

**PART - SHARE OF COST (SEND DE-701 TO ALTCS LOCAL OFFICE)**

☐ Reduce Share of Cost Due to Death of Member
☐ Other (Specify):

Effective: Month/Year / /

**PART VII - INCOME/RESOURCE CHANGE (SEND DE-701 TO ALTCS LOCAL OFFICE)**

☐ Income ☐ Resources
Source or Type:

Explain the change:

**PART VIII - VENTILATOR STATUS CHANGE/PAS REASSESSMENT REQUEST (SEE FORM INSTRUCTIONS)**

☐ Ventilator Dependent ☐ Non-Ventilator Dependent Effective date:
☐ PAS Reassessment Request – Check Reason for Assessment and provide comment
☐ Improvement in functional abilities or medical condition to the extent that the member may no longer be medically eligible. Explain the change in comments.
☐ Transitional member now in NF; expected to exceed 90 days: (Complete Part II)
☐ Other (Explain):
Comments:

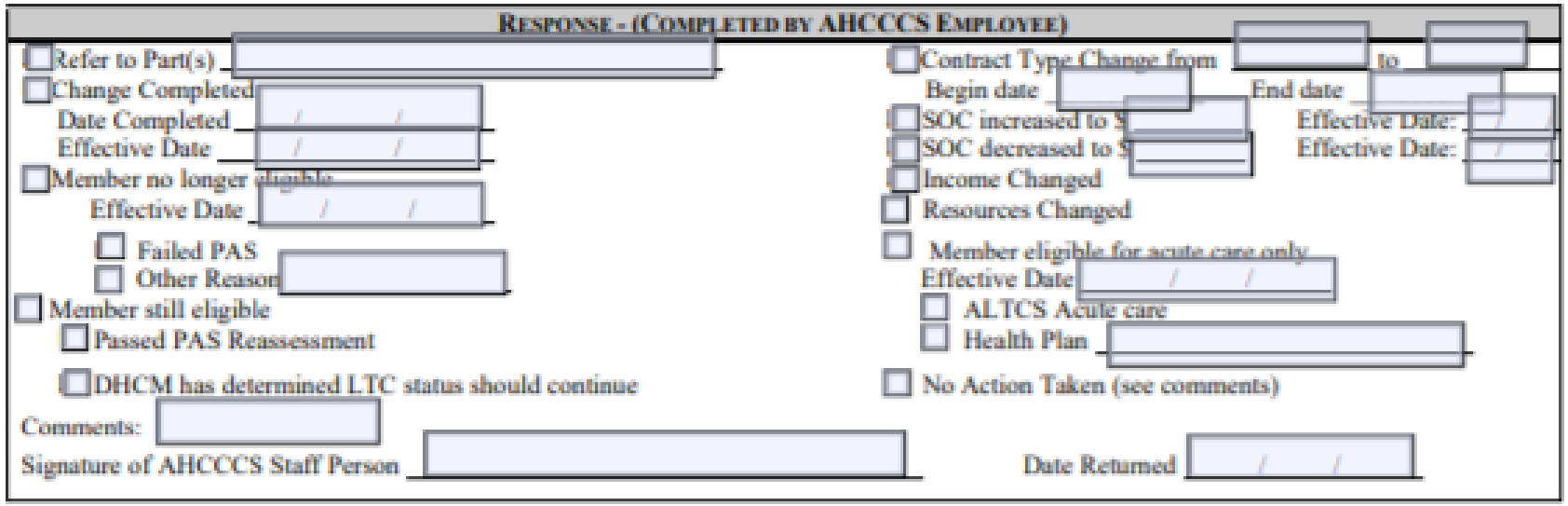
**Exhibit 1620-2 Page 2 of 4**

**Effective Dates:** 07/04, 10/07, 01/01, 01/12, 10/13, 01/16, 10/01/17
**Revision Dates:** 07/04, 10/07, 01/11, 01/12, 05/12, 10/13, 01/16, 07/25/17

# EXHIBIT 1620-2, ALTCS MEMBER CHANGE REPORT Page 3, (top portion).

- **NOTE** – Members who are temporarily out of the Contractor's service area including out of state, may be provided with LTC services if these are available, in the member's best interests and are approved by the contractor. No AHCCCS services may be provided while a member is outside of the United States.

- A hard copy MCR may be needed if, at the time of submission, the member is no longer enrolled with the Contractor that is attempting to send the report.


RESPONSE - (COMPLETED BY AHCCCS EMPLOYEE)

Refer to Part(s) _____

Change Completed

Date Completed ___/___/___

Effective Date ___/___/___

Member no longer eligible

Effective Date ___/___/___

Failed PAS

Other Reason _____

Member still eligible

Passed PAS Reassessment

DHCM has determined LTC status should continue

Comments: _____

Signature of AHCCCS Staff Person _____

Contract Type Change from _____ to _____

Begin date _____ End date _____

SOC increased to $ _____ Effective Date: ___/___/___

SOC decreased to $ _____ Effective Date: ___/___/___

Income Changed

Resources Changed

Member eligible for acute care only

Effective Date ___/___/___

ALTCS Acute care

Health Plan _____

No Action Taken (see comments)

Date Returned ___/___/___

# AHCCCS ELIGIBILITY – LATEST UPDATES

The PHE has impacted the way we process some eMCR's. Below are a few examples of changes.

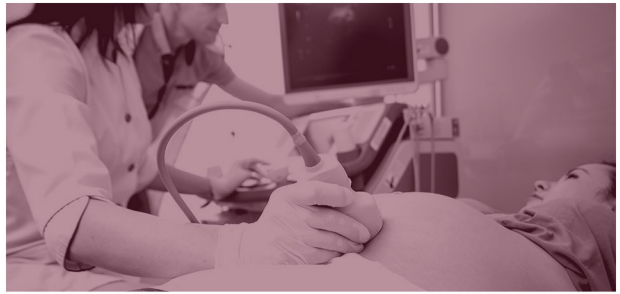
- Cannot discontinue for loss of contact
- Cannot discontinue for moving out of state unless we have an out of state address or we are able to confirm with member they have moved
- Cannot reduce coverage from full ALTCS to acute for any reason, such as refusing HCBS
- If AHCCCS EI receives a report that a customer is over resource or income they are unable to discontinue eligibility.

Staff should be replying to eMCR's to explain when they are unable to make requested changes, that are being put on hold due to the PHE.

# ANY QUESTIONS?






# Vanessa Torrez – Tribal ALTCS Nurse

## PA & CLAIMS PROCESS FOR CUSTOMIZED WHEELCHAIRS

AHCCCS
Arizona Health Care Cost Containment System

# AHCCCS PA & CLAIMS PROCESS
## Customized Wheelchairs

| Medicare/Third Party Primary | Medicaid PA Required | CM Needs 2 Bids | Bill Medicare As Primary | Delivery Ticket | Primary Insurance EOB Required For Medicaid Secondary Payment | AHCCCS RESPONSIBILTIY |
|---|---|---|---|---|---|---|
| DME Covered by Medicare/Third Party | NO | NO | YES | YES | YES | Deductible/Coinsurance |
| DME Not Covered by Medicare/Third Party (Valid Denial Required) SNF Members | YES | NO | YES | YES | YES | Rental is the first option but clinical review can determine purchase. |

| Medicaid Primary | CM Needs 2 Quote Prior To Service Rendered | Medicaid PA (Rental/Purchase) Required Prior To Service Rendered | Payment Made By Medicaid | AHCCCS RESPONSIBILTIY |
|---|---|---|---|---|
| DME Covered by Medicaid (Referrals need to be sent to Tribal ALTCS Case Manager so he/she can start the PA Process) | YES | YES | YES | Rental is the first option but clinical review can determine purchase. |

| POINT OF CONTACT | PHONE | FAX | Email Address |
|---|---|---|---|
| AHCCCS Claims Customer Service | 602-417-7670 | | |
| Fax Medicare/Third Party Payer EOB to: | | 602-417-7670 | |
| Christopher Ray - Claims Operations & Policy Administrator | 602-417-4562 | | christopher.ray@azahcccs.gov |
| Rachel Hunter - Tribal ALTCS Administrator | 602-417-4180 | | Rachel.hunter@azahcccs.gov |
| Medicaid PA Issues - Contact Assigned CM | | | https://www.azahcccs.gov/AmericanIndians/LongTermCareCaseManagement/ |

AHCCCS does not accept the Medicare/Third Party EOB through email. Provider may fax over the EOB including a cover sheet with the denied Medicaid claim number referenced to 602.253.5472. Another option is to submit via mail or TIBCO. Please do not submit the claim again, only the EOB.

**PA Issue**
Request not in Docuware: Tribal CM
Request in Docuware: Tribal ALTCS Nurse

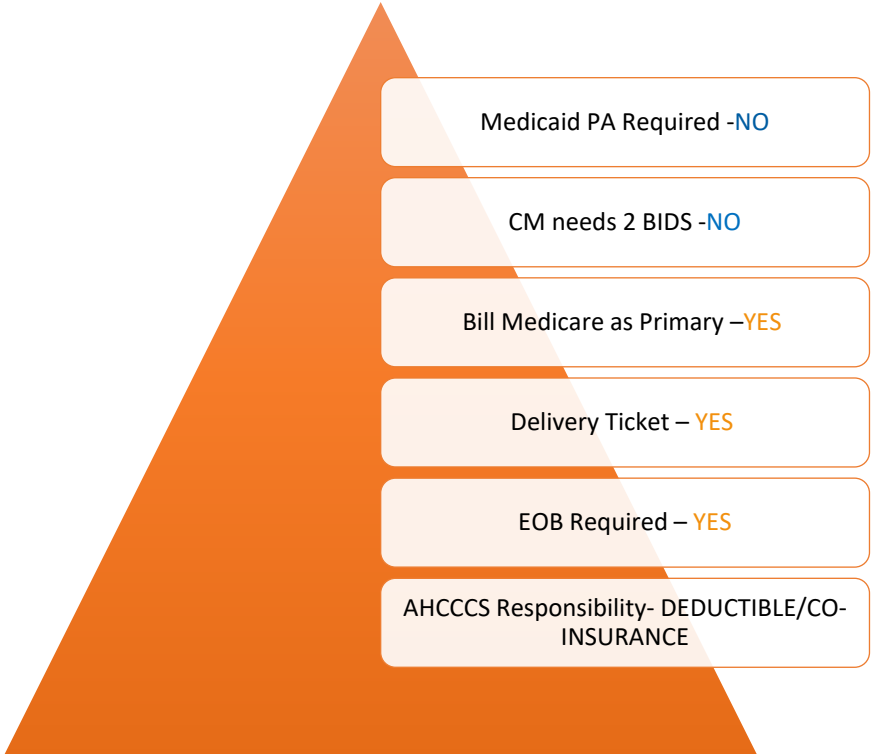
# MEDICARE/THIRD PARTY AS PRIMARY

- DME covered by Medicare/Third Party

**Medicare Approved Setting**

-No Pended PA

-No BID needed



# MEDICARE/THIRD PARTY AS PRIMARY

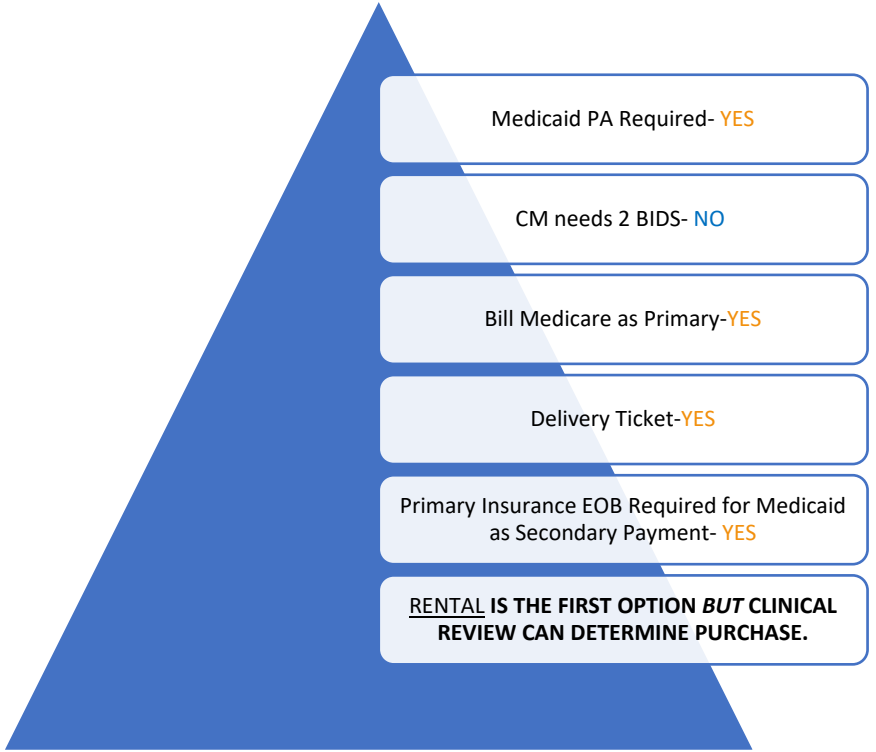
- DME <u>not</u> covered by Medicare/Third Party (Valid Denial Required)

**SNF Members**

-Pended PA

-EOB

-Delivery Ticket



# IHS/Tribal Provider Billing Manual: Chapter 15 Nursing Facility Services

## Items included in the SNF per diem rate:

Wheelchairs
(all non-customized)

# Customized Wheelchairs

Medicaid PA Required - YES

Bill Medicare as Primary- YES

Delivery Ticket- YES

Primary Insurance EOB Required for Medicaid as Secondary Payment- YES

RENTAL **IS THE FIRST OPTION *BUT* CLINICAL REVIEW CAN DETERMINE PURCHASE.**

K0004

K0005

Motorized / Power Wheelchair

# EOB-Medicare Denial Letter

[redacted]

PAYER CONTACT:
PHONE:
EMAIL:

EIN:
NPI:
EFT:
CHECK DATE:
PRODUCTION DATE:

[redacted]

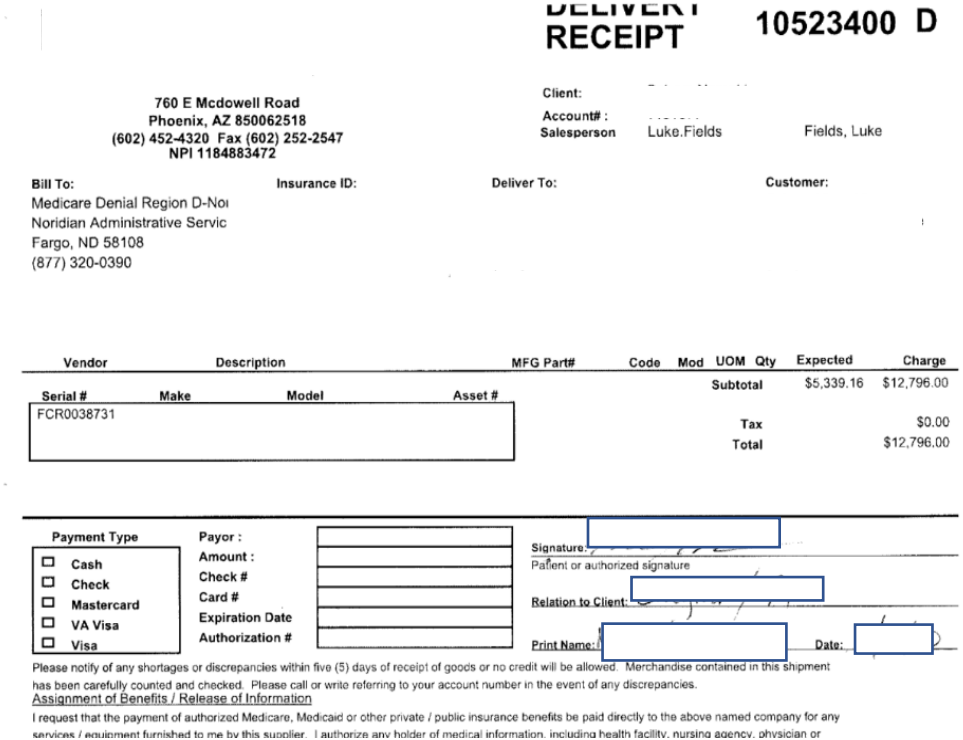
| PROV | SERV DATE | POS | NOS | PROC | MODS | BILLED | ALLOWED | DEDUCT | COINS | GRP/RC-AMT | PROV PD |
|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | | | | | ACNT:50587306 | | ICN:20325829934000 | | | MOA:MA15 MA01 | |
| | 1110 111020 | 31 | 0 | E1161 | RRKHGY | 5550.00 | 5550.00 | 0.00 | 0.00 | PR-96 | 5550.00 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E2231 | NUKUGY | 720.00 | 720.00 | 0.00 | 0.00 | PR-96 | 720.00 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | K0108 | NUGY | 640.00 | 640.00 | 0.00 | 0.00 | PR-5 | 640.00 | 0.00 |
| | | SUB NOS:1 | | | REM: M77 | | | | | | | |
| | 1110 111020 | 31 | 0 | K0040 | NUKUGY | 370.00 | 370.00 | 0.00 | 0.00 | PR-96 | 370.00 | 0.00 |
| | | SUB NOS:2 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E0951 | NUKUGY | 100.00 | 100.00 | 0.00 | 0.00 | PR-96 | 100.00 | 0.00 |
| | | SUB NOS:2 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E0971 | NUKUGY | 280.00 | 280.00 | 0.00 | 0.00 | PR-96 | 280.00 | 0.00 |
| | | SUB NOS:2 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E0978 | NUKUGY | 140.00 | 140.00 | 0.00 | 0.00 | PR-96 | 140.00 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E0960 | NUKUGY | 366.00 | 366.00 | 0.00 | 0.00 | PR-96 | 366.00 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E0955 | NUKUGY | 380.24 | 380.24 | 0.00 | 0.00 | PR-96 | 380.24 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E1028 | NUKUGY | 395.76 | 395.76 | 0.00 | 0.00 | PR-96 | 395.76 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E2613 | NUKUGY | 1110.00 | 1110.00 | 0.00 | 0.00 | PR-96 | 1110.00 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E2203 | NUKUGY | 1210.00 | 1210.00 | 0.00 | 0.00 | PR-96 | 1210.00 | 0.00 |
| | | SUB NOS:1 | | | REM: M18 | | | | | | | |
| | 1110 111020 | 31 | 0 | E0973 | NUKUGY | 590.00 | 590.00 | 0.00 | 0.00 | PR-96 | 590.00 | 0.00 |
| | | SUB NOS:2 | | | REM: M18 | | | | | | | |
| PT RESP 11852.00 | | | | | SUB TOTALS | 11852.00 | 11852.00 | 0.00 | 0.00 | | 11852.00 | 0.00 |
| ADJ TO TOTALS: | | | | | PREV PD 0.00 | INTEREST 0.00 | | LATE FILING CHARGE 0.00 | | | | |
| | | | | | | | | | | | | NET 0.00 |

| TOTALS: | # OF CLAIMS | BILLED AMT | ALLOWED AMT | DEDUCT AMT | COINS AMT | RC-AMT | PROV PAID | PROV ADJ | CHECK AMT |
|---|---|---|---|---|---|---|---|---|---|
| | 1 | 11852.00 | 11852.00 | 0.00 | 0.00 | 11852.00 | 0.00 | -0.09 | 9826.94 |

| PROVIDER ADJ DETAILS: | PLB REASON CODE | FCN / Other Identifier | AMOUNT |
|---|---|---|---|
| | L6 | | -0.09 |

GLOSSARY: Adjustment, Group, Reason, MOA, and Remark codes
PR- Patient Responsibility
96 Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
5 The procedure code/bill type is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Effective 02/01/2018: The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
MA15 Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA01 Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
M18 Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.
M77 Missing/incomplete/invalid/inappropriate place of serivce.
L6 Use this monetary amount for the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I. "Medicare Part A will provide code "IN" in PLB03-2.

# Delivery Ticket



DELIVERY RECEIPT 10523400 D

760 E Mcdowell Road
Phoenix, AZ 850062518
(602) 452-4320 Fax (602) 252-2547
NPI 1184883472

Client:
Account# :
Salesperson Luke.Fields Fields, Luke

Bill To: Insurance ID: Deliver To: Customer:
Medicare Denial Region D-Noi
Noridian Administrative Servic
Fargo, ND 58108
(877) 320-0390

| Vendor | Description | MFG Part# | Code | Mod | UOM | Qty | Expected | Charge |
|---|---|---|---|---|---|---|---|---|
| | | | | | | Subtotal | $5,339.16 | $12,796.00 |
| Serial # | Make | Model | Asset # | | | | | |
| FCR0038731 | | | | | | | | |
| | | | | | | Tax | | $0.00 |
| | | | | | | Total | | $12,796.00 |

Payment Type
- ☐ Cash
- ☐ Check
- ☐ Mastercard
- ☐ VA Visa
- ☐ Visa

Payor :
Amount :
Check #
Card #
Expiration Date
Authorization #

Signature:
Patient or authorized signature
Relation to Client:
Print Name: Date:

Please notify of any shortages or discrepancies within five (5) days of receipt of goods or no credit will be allowed. Merchandise contained in this shipment has been carefully counted and checked. Please call or write referring to your account number in the event of any discrepancies.

Assignment of Benefits / Release of Information

I request that the payment of authorized Medicare, Medicaid or other private / public insurance benefits be paid directly to the above named company for any services / equipment furnished to me by this supplier. I authorize any holder of medical information, including health facility, nursing agency, physician or

# PROVIDER PORTAL

Main | FAQ | Terms Of Use | LogOut |

**Menu**

- AIMH Services Program
- Claim Status
- Claims Submission
- EFT Enrollment
- Member Verification
- Members Supplemental Data
- Newborn Notification
- **Prior Authorization Inquiry**
- Prior Authorization Submission
- Provider Verification
- Targeted Investments Program

**Support and Manuals**

- User Manuals
- Learn More
- Frequently Asked Questions

**Account Information**

- Username: thedmecompan
- User: George Charalambous
- Type: Master
- IP: 72.212.144.184
- National Provider ID: 1750895975
- User Request Stats
- Admin

**Prior Authorization: PA Case Detail**

**Case Status:** A-APPROVED
**Effective Dates:** 05/19/2021 05/31/2021

**Case Detail**

**Case NO:** 001172725
**Case Type:** PRIOR AUTHORIZATION

**Service Provider**

**Provider ID:** 427208
**Provider NPI:** 1750895975
**Provider Name:** DME HEALTHCARE PARTNERS
**Provider Type:** 30 DME SUPPLIER

**Recipient**

Recipient is retroactive Medicare (Types: A,B,C,D). Please submit claims to Medicare.

**AHCCCS ID:** A00252554
**Name:** DELMA, MIRANDA
**Date of Birth:** 05/30/1961
**Gender:** FEMALE

**Event List**

Total events found: 1

Partial text for new unread notes will appear as a blue link.

**Requestor**
PWR W/C- MEDICARE PRIMARY- PENDING EOB

| Seq No | Status | Type | Svc Begin Date | Svc End Da | | Diag Code | Class Cat. | Cmt No. |
|---|---|---|---|---|---|---|---|---|
| 01 | P-PENDED | DM | 05/19/2021 | 05/31/202 | /CMN REQUIRED | G83.4 | | |

**Unread notes for Seq=01**

**Read notes for Seq=01**

No read notes for this event

**Activity List for Seq=01**

No activity data is available for this event

# Pending PA Letter

**From:**

Fax:

Phone Number:

Office:

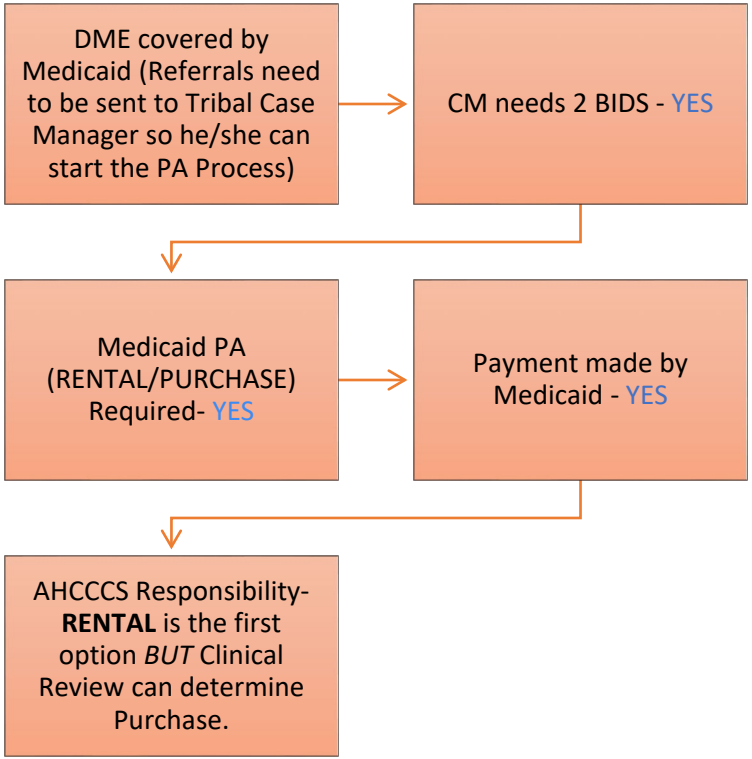
City/State:

---

**Comments:**

CaseManager: HealthPlan:
DME request for member: from Provider:
has been received. The member has Medicare as their Primary payer. Please inform the Provider to submit Directly to Medicare and PA/Authorization is not required to bill AHCCCS as the secondary payer.
PA NUMBER:001172725 has been entered- payment is dependent upon receipt of the Medicare EOB reflecting denial.
**In the event Medicare approves items,Provider will need to notify so Auth can be revoked for Claim to process without difficulty**
Thank you.
Vanessa Torrez
Tribal ALTCS Nurse

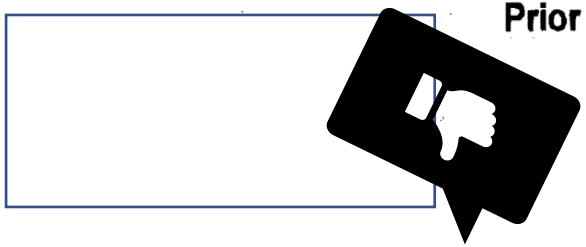
# MEDICAID PRIMARY




** Prior to Service Rendered**

- 2 BIDS

-Prior Authorization



## Prior Authorization

| Date | Quote # |
|---|---|
| 5/18/2021 | 205 |

THIS QUOTE WOULD BE SENT BACK FOR INDIVIDUAL BILLING PRICES FOR UNLISTED CODES

| Item | Description | Qty | Total |
|---|---|---|---|
| Chief 107ZRX K0861 | Chief 107ZRx New Unit, Group III Multi-Option Power Wheelchair<br>Includes Billing Code: K0861, E0960, E1007, E1010, E1028, E2311, E2377, E0955, E0951 (2), E2361 (2), E2313, E2613, E2624, E2301<br>Redman Exclusive: Stand/Recline/Tilt/Independent Leg Elevation/Intrinsic Body Positioning System 90 Degree Low Shear with auto-centron patented gravity balance system.<br>Adjustable Height Desk Length Flip Away Arms<br>Color: BLACK<br>INCLUDES:<br>Trail Link-uneven ground compensation<br>Independent Rear Suspension<br>Independent Frog Leg Big Rig Suspension<br>American made High Torque 4 Pole Motors and Gear Boxes w/quick release freewheeling | 1 | 44,995.00 |

Attn:
Medica
Po Box

Phoenix, AZ 85002

**Diagnosis**

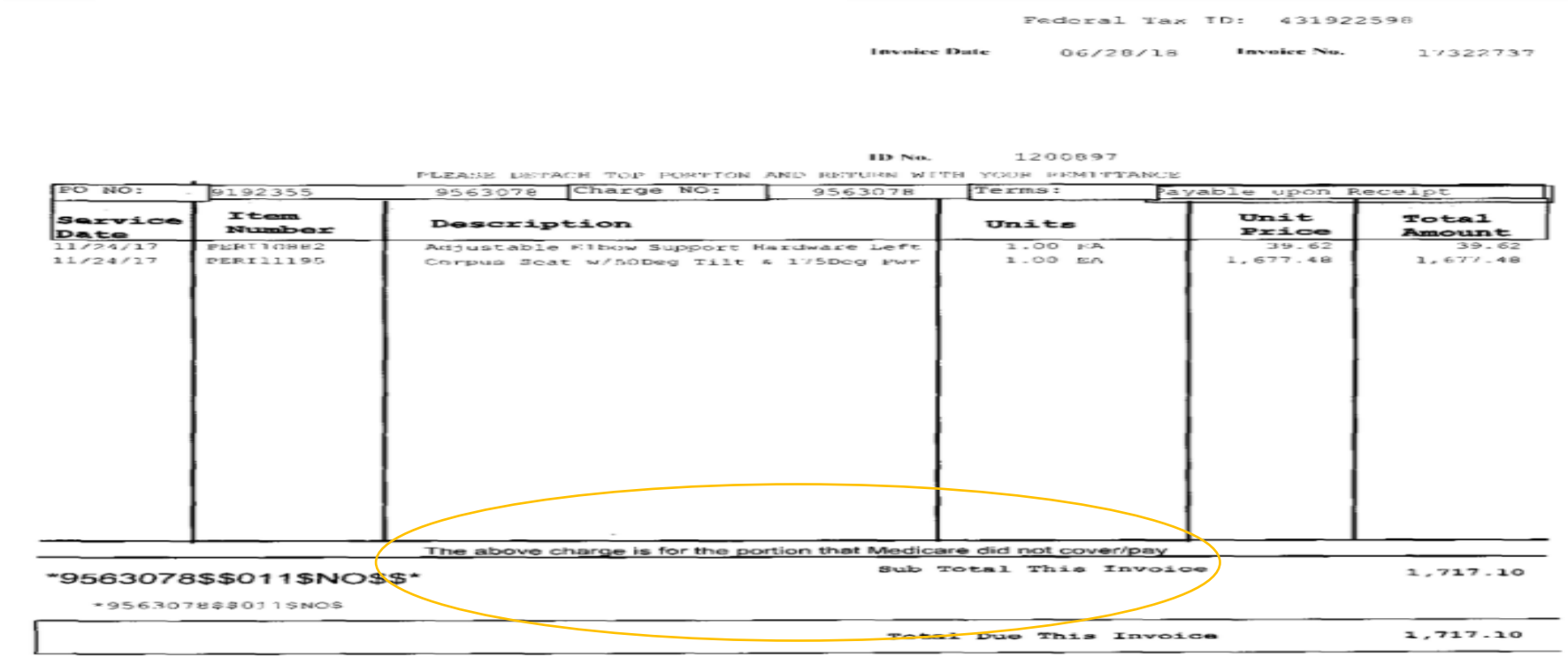
| | |
|---|---|
| **G8252** | Quadriplegia, C1-C4 Incomplete |
| **G629** | Polyneuropathy, Unspecified |
| **N319** | Neuromuscular Dysfunction Of Bladder, |
| **K592** | Neurogenic Bowel, Not Elsewhere Class |

## Quote

YES, EACH BILLING ITEM IS INDIVIDUALLY PRICED

| Vendor | Description | Code | Modifiers | UOM | Qty | Allowable | Charge |
|---|---|---|---|---|---|---|---|
| Pride Mobility Products | Quantum Q6 Edge HD 3SPHD-SS | **K0858** | NU | EA | 1 | **$10,083.65** | $17,190.00 |
| Pride Mobility Products | Tru-Balance 3 HD Tilt | **E1002** | NU | EA | 1 | **$4,843.58** | $19,738.00 |
| Pride Mobility Products | Battery, Intreceptor, Gel 70AH/3HR Group 24 | **E2363** | NU | EA | 2 | **$405.00** | $1,460.00 |
| Pride Mobility Products | Joystick Mounting Bracket, Swing Away | **E1028** | NU | EA | 1 | **$248.58** | $560.00 |
| Pride Mobility Products | Mushroom Handle | **E2323** | NU | EA | 1 | **$103.01** | $170.00 |
| Pride Mobility Products | Tru Comfort 2 Back - 4-Way Stretch Cover - 22W | **E2621** | NU | EA | 1 | **$661.52** | $1,550.00 |
| Pride Mobility Products | 10" Headrest Pad, Comf Plus, Cool Core | **E0955** | NU | EA | 1 | **$243.34** | $334.00 |
| Pride Mobility Products | Unilink Mntg Hdwr Kit, Headrest Mnt, Comf Plus | **E1028** | NU | EA | 1 | **$248.58** | $588.00 |

# Cross Over Claims- Invoice



Federal Tax ID: 431922598

Invoice Date 06/28/18 Invoice No. 17322737

ID No. 1200897

PLEASE DETACH TOP PORTION AND RETURN WITH YOUR REMITTANCE

| PO NO: | 9192355 | 9563078 | Charge NO: | 9563078 | Terms: | Payable upon Receipt |
|---|---|---|---|---|---|---|

| Service Date | Item Number | Description | Units | Unit Price | Total Amount |
|---|---|---|---|---|---|
| 11/24/17 | PERT10HB2 | Adjustable Elbow Support Hardware Left | 1.00 EA | 39.62 | 39.62 |
| 11/24/17 | PERI11195 | Corpus Seat w/50Deg Tilt & 175Deg Pwr | 1.00 EA | 1,677.48 | 1,677.48 |

The above charge is for the portion that Medicare did not cover/pay

*9563078$$011$NO$$*

*9563078$$011$NO$

Sub Total This Invoice 1,717.10

Total Due This Invoice 1,717.10

# CROSSOVER CLAIMS

- Provider are to reach Claims Customer Service, please call **(602) 417-7670** Option 4.
- **www.azahcccs.gov** **(**Provider Portal**)**
- Mail: **Attention Claims PO Box 1700 Phoenix AZ 85002-170**

ANY PA / PROVIDER ISSUES INVOLVING PA OR REQUESTS SUBMITTING TO DOCUWARE PLEASE DIRECT TO:

## Tribal ALTCS Nurse Contact Information:

Vanessa Torrez

(602)-417-4169

Vanessa.Torrez@azahcccs.gov

# ANY QUESTIONS?

# Tribal ALTCS Projects & Initiatives

## Creating a new TAT Report

| Documents | Subtotal |
|---|---|
| >80% | 23 |
| ALF BH | 273 |
| Contractor Change | 4 |
| DME | 811 |
| E1399 | 2 |
| Home Modification | 97 |
| Open Line Request | 451 |
| Out of State Placement | 49 |
| SNF | 343 |

## Total: 2053 Documents

- FAX
- Duplicate Documents
- Missing Information
- Approval Letter
- No PA Required
- Canceled
- Other Comments

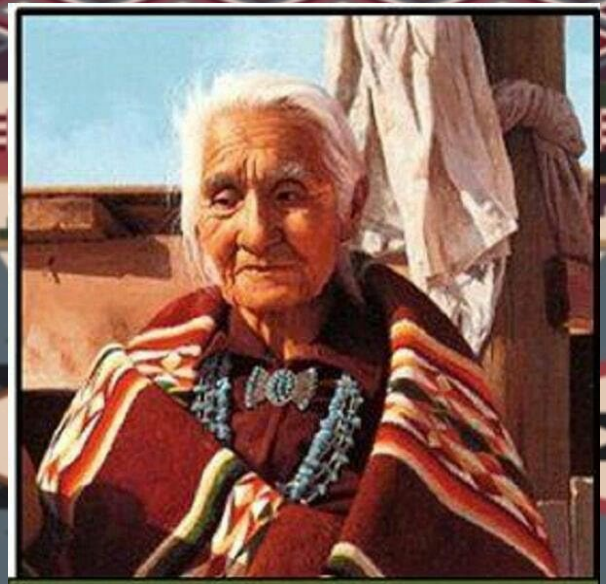
**Create Standized Comments:**

- Incoming FAX (PA Request)
- Saving Approved Request in Docuware:

**Standard comments will help the team identify areas:**

- Need improvement
- Provide additional training
- Number of responses provided (FAX/Email)

# Tribal Plan Recognitions



"Honor your Elders"
For they have the Wisdom to Teach what we have not learned yet.