



P I N A L • C O U N T Y

Wide open opportunity

A Program Contractor for Arizona Long Term Care System (ALTCS)

A Division of Pinal County Health and Human Services

PROVIDER MANUAL

“QUALITY THROUGH COMMITMENT”

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INTRODUCTION

PROGRAM DESCRIPTION

P/GLTC has been an Arizona Long Term Care System (ALTCS) Program Contractor for the Arizona Health Care Cost Containment System (AHCCCS) since October 1990. ALTCS is the AHCCCS program that provides medical and medically related services (Acute, home-based, long-term care, and behavioral health) to frail, elderly, and physically disabled individuals enrolled with Pinal/Gila Long Term Care (P/GLTC). These individuals are determined eligible for ALTCS through one of the State AHCCCS/ALTCS eligibility offices. P/GLTC is a division of Pinal County Health and Human Services Department, and as such, the P/GLTC program is owned and operated by the Pinal County Government. P/GLTC provides ALTCS services in both Pinal and Gila County's. Individuals receiving these services may reside in a nursing home, alternative living facility, or their own home. The administrative office for P/GLTC is in Florence with satellite offices in Globe and Payson to serve Gila County.

INTERPRETATION SERVICES

Pinal/Gila Long Term Care contracts with Language Line™ to provide interpretation services to our members during their healthcare visits. In order to access this free telephone interpretation service, please contact Case Management at 520-866-6775 or toll free at 1-800-831-4213.

CHIEF EXECUTIVE OFFICER (CEO)

The CEO of P/GLTC is responsible for the overall development and administration of P/GLTC including the ALTCS, SMILE, and Family Caregiver Support. The CEO reports to the Pinal County Assistant County Manager for Health and Human Services and to the Gila County Board of Supervisors. The CEO is located in the main P/GLTC administrative office in Florence.

CHIEF MEDICAL OFFICER (CMO)

The Chief Medical Officer of P/GLTC is a licensed physician and is responsible for the development of policies, procedures and standards by which the medical service components of the program operate. Primary responsibilities include the direction of quality management, utilization management, disease management, prior authorization, medical review, credentialing and peer review of licensed medical practitioners, and communication with the medical provider network regarding current P/GLTC and AHCCCS/ALTCS policies and procedures.

ASSOCIATE MEDICAL DIRECTOR

The Associate Medical Director provides back up for the Medical Director, upon request.

FRAUD AND ABUSE

All providers are required to report to P/GLTC, all incidences of suspected Fraud and Abuse by or to members and by service providers. Fraud and abuse includes, but is not limited to, fraud, abuse, neglect, negligence, and exploitation. Providers will also ensure that quality of care issues, which may impact member's health, safety, and well being, are identified and corrected. Suspected incidents should be reported to the Corporate Compliance Office at **(520) 866-6718**.

TITLE VI AND THE AMERICAN WITH DISABILITIES ACT

Title VI, 42 U.S.C. §2000d et seq., was enacted as part of the landmark Civil Rights Act of 1964. It prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance. Accordingly, P/GLTC has the expectation that providers will not discriminate against members and will treat all members with dignity and respect.

P/GLTC also expects providers to comply with the American with Disabilities Act and make reasonable accommodations for members. Title I of the [Americans with Disabilities Act of 1990](#) prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment. The ADA covers employers with 15 or more employees, including state and local governments. It also applies to employment agencies and to labor organizations. The ADA's nondiscrimination standards also apply to federal sector employees under section 501 of the Rehabilitation Act, as amended, and implementing its rules.

CULTURAL COMPETENCY

P/GLTC has laid out the foundation for the implementation of the National Standards of Culturally and Linguistically Appropriate Services (CLAS). This initiative instills the commitment to further the development and progress of cultural and linguistic competence within our service delivery. In striving to assure that P/GLTC members are not discriminated against and are provided accessibility to all covered services without regard to race, color, and national origin, P/GLTC surveys its providers annually. Information related to ethnicity, language fluency, certification, translation and internal cultural competency policies is identified. It is P/GLTC's plan to ensure that ALTCS services are provided effectively to Limited English Proficiency (LEP) members enrolled with P/GLTC. Providers are expected to utilize available resources in meeting the needs of members for whom they provide service. The use of outside resources is encouraged when practical.

Cultural competency training is offered to all P/GLTC contracted providers. For providers encountering difficulties in meeting member's distinct cultural needs, P/GLTC is available and can arrange for services such as translation and other interpretive services through the Language Line™. When possible, providers are asked to arrange for such services far enough in advance to allow for appropriate scheduling. For questions related to cultural competency or translation or interpretive services, please contact Network Development and Management at **(520) 866-6703**.

NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout and organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent (Standards 1-3), Language Access Services (Standards 4-7) and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines and recommendations as follows:

CLAS mandates are current federal requirements for all recipients of federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by federal, state and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1.

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2.

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3.

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4.

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5.

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6.

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7.

Health care organizations must make available easily understood patient-related material and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8.

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9.

Health care organizations should conduct initial and ongoing organizations self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.

Standard 10.

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11.

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12.

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13.

Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complains by patients/consumers.

Standard 14.

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

MEMBER/PROVIDER COUNCILS

P/GLTC developed Member/Provider Councils to enhance the service delivery system throughout Pinal and Gila Counties. To accomplish this, we seek input on policies and programs from both providers and members via member provider councils. There are two councils, one for Pinal County and one for Gila County. The councils are comprised of a cross representation of both providers and members/families/advocacy groups/significant others. We strive for a balance that reflects the diverse population and varied communities we serve. P/GLTC provides orientation and on-going training to council members so they have sufficient information and understanding to fulfill their responsibilities.

P/GLTC submits an annual plan to AHCCCS that outlines the goals of the committee as well as meeting schedules. The Councils meet quarterly and includes light refreshments or lunch. If you are interested in joining a Council or would like more information, please call our Community Relations and Outreach Coordinator at **(520) 866-6761**.

P/GLTC CONTACT INFORMATION

	<u>Florence Office</u>	<u>Globe Office</u>	<u>Payson Office</u>
ADDRESS:	971 N. Jason Lopez Circle, Building D P.O. Box 2140 Florence, AZ 85132	1177 E. Monroe Street Globe, AZ 85502	200 West Frontier Suite # 4 Payson, AZ 85541
TELEPHONE:	(520) 866-6775 or Toll Free: 1-800-831-4213	(928) 425-8105 Toll Free: 1-800-831-4213 TDD: (928) 425-0839	(928) 468-1430 or (928) 468-8006 Toll Free: 1-866-564-9221 TDD: (928) 425-0839
FAX:	(520) 866-4450 – Network Development and Management (520) 866-6720 – Case Management (520) 866-6717 – Prior Auth	(928) 425-3923	(928) 468-0530

<u>Department/Section</u>	<u>Phone Number</u>
Chief Executive Officer	(520) 866-6771
Case Management	(520) 866-6704
Accounting and IS (AIS)	(520) 866-6775
Network Development and Management	(520) 866-6703
SMILE & Family Caregiver Support	(520) 866-6737

**COVERED, NON-
COVERED,
EMERGENCY AND
SERVICE
AUTHORIZATION
SERVICES**

COVERED SERVICES

P/GLTC covers the following services for ALTCS eligible members. These services are described in further detail in Arizona Administrative Code Title 9, Chapter 22, Article 2.

ACUTE CARE

- Audiology
- Ambulatory Surgery
- Anesthesiology
- Behavioral Health
- Dental services for members under 21 include, but are not limited to:
 - Instruction in oral hygiene care
 - Intra-oral examinations
 - Radiology for screening purposes
 - Oral prophylaxis, topical fluorides, and dental sealants.
- Dental Services are not covered for members over the age of 21 except when approved for a major organ transplant. .
- Dialysis
- Early Periodic Screening and Diagnostic Treatment (EPSDT)
- Emergency Services (Triage Screening & Evaluation)
- Eye Examinations/Optomety
- Family Planning – the following are covered without Prior Authorization:
 - Contraceptive counseling, medication and supplies
 - Associated medical and laboratory examinations
 - Treatment of complications resulting from contraceptive use
 - Natural family planning education
 - Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse
 - Pregnancy screening
 - Screening and treatment for sexually transmitted diseases
 - Sterilization for both men and women (prior authorization required)
- Health Risk Assessment & Screening
- Home Infusion Therapy
- Immunizations
- Inpatient Hospital
- Laboratory
- Maternity
- Medical Supplies-Durable Medical Equipment (DME)
- Orthotics and Prosthetic Devices
- Medically Necessary Abortions
- Nutritional Consults
- Organ & Tissue & Related Transplants (deemed medically necessary limited to kidney, cornea, and bone)
- Outpatient Hospital
- Podiatry
- Prescription Medications (as allowed by P/GLTC's drug formulary)
- Primary Care Provider (PCP)

- Respiratory Therapy
- Specialty Consult
- Therapy (PT,OT,ST)
- Transportation (Emergency and Non-Emergency)
- Ventilator Dependent
- X-Ray and Medical Imaging

BEHAVIORAL HEALTH

- Evaluation and Diagnosis
- Inpatient Hospital
- Inpatient Psychiatric Facility
- Institution for Mental Disease
- Alternative Residential Settings
- Individual Therapy/Counseling
- Group/Family Therapy/Counseling
- Psychotropic Medication Monitoring
- Rehabilitation Services-Partial Care
- Emergency Crisis
- Behavior Management

HOME AND COMMUNITY BASED SERVICES (HCBS) - HOME

- Adult Day Health
- Home Health Nursing Aide
- Home Health Nurse
- Homemaker
- Personal Care
- Respite
- Emergency Alert System
- Attendant Care
- Pest Control
- Home Delivered Meals
- Habilitation
- Environmental Modifications
- Hospice

HOME AND COMMUNITY BASED SERVICES (HCBS) - COMMUNITY

- Assisted Living Home
- Assisted Living Home – Dementia Specific
- Assisted Living Center
- Assisted Living Center – Wandering Dementia Pilot Project
- Behavioral Health Level II Facility
- Traumatic Brain Injury Facility

INSTITUTIONAL

- Nursing Home Services which include:
 - Level 1, Level 2, Level 3, Level 3A
 - Behavioral Management
 - Rehabilitation
 - Respiratory/Ventilator Dependent
 - Wandering Dementia

ADDITIONAL SERVICES

For the benefit of P/GLTC members, ALTCS Case Managers will work with members to access other non-AHCCCS covered services. These additional services include:

- General - Application assistance, food stamps, family assistance, home repair and weatherization, utility assistance, rural services for the blind, sight conservation, housing, nutrition, support groups, volunteers, and funding advocacy.
- Disabled Adult and Elder Services - Legal Counseling.
- HIV+ Services - Emergency housing, nutrition therapy, vitamin therapy, dental care, legal counseling, clinical trials, counseling, day care, pet therapy, chiropractic care, medication education, legal counseling, support group, transportation, and alternative therapies.

DRUG FORMULARY

The P/GLTC Drug Formulary is a list of medications evaluated and approved by the P/GLTC Pharmacy and Therapeutics Committee. Only those medications included in the Drug Formulary are routinely available from P/GLTC network pharmacies. The Drug Formulary is intended for use by P/GLTC primary care and specialist physicians, network pharmacies and others involved in the care of P/GLTC Members.

The P/GLTC Drug Formulary applies only to prescription medications for P/GLTC members in home and community based settings (HCBS) and nursing facilities (NF). It does not apply to inpatient medications prescribed for hospitalized members. **The P/GLTC Drug Formulary requires the use of generically equivalent medications when available. Medications listed on the formulary followed by an asterisk (*) must be dispensed using the generic drug. Brand names are listed for all drugs for reference purposes only.** A generically equivalent medication is considered part of the Drug Formulary at the time it is approved by the Food and Drug Administration and is available to Network Pharmacies. All generic medications are considered a part of the formulary.

To be considered for reimbursement, prior authorization is required for ALL medications not listed in the Drug Formulary. All parenterals, except insulin, require authorization.

United Drugs administers the P/GLTC Drug Formulary. Please contact the United Drugs Help Desk at (800) 364-8865 with questions and for assistance with prior authorization.

The formulary is available on the Internet at:

<http://www.uniteddrugs.com/PBM/Documents/PGLTCForm.pdf>.

Any updates to the Drug Formulary will be presented to providers via P/GLTC's quarterly provider newsletter.

NON-COVERED SERVICES

P/GLTC does not cover the following services:

- Drugs and medical supplies not ordered by the member's PCP
- Services from private doctors or hospitals that were not approved by the PCP
- Hearing aids or eye exams for glasses (adults)
- Routine dental visits for adults
- Experimental services and services done primarily for research
- Extended services usually offered by a TBI hospital or psychiatric hospital
- Personal items
- Cosmetic surgery
- Sex change or certain organ transplants
- **Any services provide without required prior authorization**

EMERGENCY SERVICES

P/GLTC monitors Emergency Department (ED) utilization from both a member and PCP prospective. The following definitions are used in reviewing emergency room visits to determine appropriateness:

Emergency Medical Condition - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Emergency Medical Service - covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition.

Post Stabilization Services - medically necessary services, related to an emergency medical condition provided after the member's condition is sufficiently stabilized so that the member could alternatively be safely discharged or transferred to another location. The services must be provided at the site where the member was treated for the emergency medical condition.

Prudent Layperson - a person who, although not a medical professional, possesses an average

knowledge of health and medicine and can reasonably determine that an individual may be suffering from an emergency medical condition.

Once a visit is determined to be potentially inappropriate, P/GLTC utilization staff will:

- Note the day of week and time of day
- Contact the member to determine the reason for presenting to ER
- If the PCP has instructed member to go to ER the PCP's office is contacted to determine why the member was instructed to go to ER instead of given an appointment
- Track the event
- Submit monthly reports regarding inappropriate ER usage appropriate staff for review and follow-up.

SERVICE AUTHORIZATION

HCBS, Institutional and Behavioral Health

All behavioral health, HCBS, and nursing home services for P/GLTC members are arranged for and authorized by the case manager. Case managers contact providers with an authorization number, followed by a written service authorization form. The service authorization number enables providers to obtain payment for services rendered. Payment for these services will not be made without an authorization number issued by P/GLTC.

Detailed information on service authorization for long term care services is provided in the Service Authorization and Prior Authorization policies and procedures found in this manual.

Institutional Providers

In order to obtain a bed hold when members are hospitalized, institutional providers are required to notify the case manager on the day of hospitalization (or the next working day if after hours or on the weekend). Failure to notify the case manager within the specified time frame will result in a bed hold denial.

HCBS Providers

HCBS providers providing Medicare covered skilled care to members must advise the case manager when such services are being provided. Information the case manager will require includes the service, frequency, and duration.

HCBS services must be prior authorized in order for the provider to receive reimbursement. If services are provided to members on an "emergency" basis, the provider must notify the case manager the next working day. The case manager will require information justifying medical necessity. Retro-authorization for such services requires Administrative approval.

Acute Services

All acute care providers should follow the prior authorizations grid found in the Medical Management section of this manual to ensure services rendered are reimbursed appropriately.

ACCOUNTING AND INFORMATION SYSTEMS

ACCOUNTING AND INFORMATION SERVICES SECTION

The Accounting and Information Systems Section (AIS) is responsible for:

- Reviewing and processing provider claims,
- Submission of encounter (claims) data to AHCCCS
- Preparing financial reports, and
- Assisting providers with questions regarding submission of claims and claims payment.

The AIS Section is required to pay clean claims within thirty (30) days of receipt. To assure prompt payment, it is important for providers to submit complete, legible claims on the appropriate forms as outlined in this manual. AIS Section staff is available to train new providers on the intricacies of claim submission time lines, proper billing and claim form completion. Relevant claims information is also regularly presented at the quarterly provider meetings. Claims meeting "clean claim" status are paid in the order received.

AIS claim processing staff are available during regular working hours to answer any questions regarding claims submissions. General claim questions can be directed to the AIS Provider Liaison at **(520) 866-6775**. Questions on specific provisions in a provider contract should be directed to the Network Development and Management Section. Providers may verify eligibility by calling P/GLTC at **(520) 866-6775** or by visiting the website at <http://co.pinal.az.us/LTC>.

CLAIMS SUBMISSION PROCESSING

CLAIMS SUBMISSION TIME LINES

P/GLTC will not honor any claims for payment submitted six (6) months after the date of service. The contractor has an additional six (6) month period to correct any errors on claims submitted within the initial submission deadline (6 month). P/GLTC will not honor any corrected claims that are received twelve (12) months after the date of service. Clean claims are defined as claims that can be processed without obtaining additional information from the provider of the service or from a third party. The Compensation Section of the provider's contract with P/GLTC details methods of payment and provider responsibility for claims submissions. Contact the P/GTLC Network Development and Management Section at **(520) 866-6703** for further contract information.

REQUIRED FORMS

At the end of the Claims Submission Processing section of the provider manual there are samples of forms accepted by P/GLTC for claims submission and instructions for completing the claims. Pharmacy claims submitted by contracted pharmacy providers are submitted electronically by the pharmacy to a Third Party Payor contracted with P/GLTC.

The **CMS 1500 Form** is used for billing the following services:

1. Physician Services
2. Therapies
3. Home and Community Based Services
4. Transportation
5. Durable Medical Equipment

6. Orthotics/Prosthetics Services
7. Infusion

The ADA Claim Form is used for billing all Dental services:

The **UB-04 Form** is used for billing the following services:

1. In-patient Hospitalization
2. Outpatient Hospitalization
3. Institutional Care
4. Dialysis Facility
5. Emergency Room - Facility

CLAIMS MEDICAL REVIEW

Claims requiring medical review are forwarded to the Medical Director and/or nursing staff for review. The claim is reviewed and approved or denied based on criteria given in specific policies and procedures established by P/GLTC. Providers of claims submitted for payment, which have been denied by the medical review process, receive a remittance advice letter stating reasons for the denial and methods for filing a grievance with P/GLTC.

REMITTANCE ADVICE

At the end of this section there is a sample of a remittance advice. As shown, the remittance advice lists the claims processed for payment, along with details of amount paid for each service. The remittance advice also details reasons for denial and other information.

DENIED CLAIMS

If you disagree with our denial for payment, you may resubmit with supporting documentation. Resubmission is recommended as a first course of action. If you continue to be dissatisfied with our decision, you may then file a grievance. A grievance that is related to a claim for payment of covered services must be filed in writing and received within twelve months after the date of service or within sixty (60) days after the date of the denial, whichever is later. Please refer to your contract for more details or contact P/GLTC at **(520) 866-6700**.

POLICIES AND PROCEDURES

For questions or concerns regarding P/GLTC's policies and procedures regarding: Claims Processing, Encounter Submission and tracking, and Coordination of Benefits / Medicare Cost Sharing, please contact us at **(520) 866-6775** and ask to speak with the AIS Section.

ADDRESS FOR SUBMITTING CLAIMS

Claims should be mailed to the following address:

Pinal/Gila Long Term Care
Attn: Claims Department
P.O. Box 2140
Florence, AZ 85132

HEALTH INSURANCE CLAIM FORM CMS 1500 CLAIM INSTRUCTIONS

INTRODUCTION

The CMS 1500 claim form is used to bill for most non-facility services, including professional services, transportation, and durable medical equipment. Ambulatory surgery centers and independent laboratories also must bill for services using the CMS 1500. CMS-1500 (08/05) version became effective 1/1/2007. Effective April 2, 2007, AHCCCS will accept only this revised version. Minor changes have been made to the form in order to accommodate the National Provider Identifier (NPI) as well as current identifiers for a transition period until NPI is implemented. In order to distinguish this version from the previous versions, the 1500 symbol and the date approved.

(08/05) by NUCC has been added to the top margin of the claim form.

- CPT and HCPCS procedure codes must be used to identify all services.
- ICD-9 diagnosis codes are required.
 - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.

COMPLETING THE CMS 1500 CLAIM FOR (VERSION (08/05))

The following instructions explain how to complete the CMS 1500 claim form (08/05) and whether a field is “Required if applicable,” or “Not required.”

NOTE: This chapter applies to paper CMS 1500 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

1. Carrier Block Required

The carrier block is located in the upper right margin of the form.

Check the second box labels “Medicaid.”

<input type="checkbox"/> MEDICARE (Medicare #)	<input checked="" type="checkbox"/> MEDICAID (Medicaid #)	<input type="checkbox"/> CHAMPUS (Sponsor’s SSN)	<input type="checkbox"/> CHAMPVA (VA File #)	<input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID)	<input type="checkbox"/> FECA BLK LUNG (SSN)	<input type="checkbox"/> OTHER (ID)
---	--	---	---	---	---	--

1a. Insured’s ID Number Required

Enter the recipient’s *AHCCCS ID number*. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client’s AHCCCS ID number, *not* the client’s BHS number.

1a. INSURED’S ID NUMBER	(FOR PROGRAM IN ITEM 1)
A12345678	

2. Patient's Name

Required

Enter Recipient's last name, first name, and middle initial as shown on the AHCCCS ID card.

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Smith, John H.
--

3. Patient's Date of Birth and Sex

Required

Enter the recipient's date of birth. Check the appropriate box to indicate the patient's gender.

3. PATIENT'S BIRTH DATE			SEX	
MM	DD	YY	M	F
08	14	1951	<input checked="" type="checkbox"/>	<input type="checkbox"/>

4. Insured's Name

Not required

5. Patient Address

Not required

6. Patient Relationship to Insured

Not required

7. Insured's Address

Not required

8. Patient Status

Not required

9. Other Insured's Name

Required if applicable

If the recipient has no coverage other than AHCCCS, leave this section blank. If other coverage exists, enter the name of the insured. If the other insured is the recipient, enter "Same."

9a. Other Insured's Policy or Group Number

Required if applicable

Enter the group number of the other insurance

9b. Other Insured's Date of Birth and Sex

Required if applicable

If the other insured is not the AHCCCS recipient, enter the month, day, and year (MM/DD/YYYY) of the other insured's birth. Check the appropriate box to indicate gender.

9c. Employer's Name or School Name

Required if applicable

Enter the name of the organization, such as an employer or school, which makes the insurance available to the individual identified in Field 9.

9d. Insurance Plan Name or Program Name

Required if applicable

Enter name of insurance company or program that provides the insurance coverage

10 a-c. Is Patient's Condition Related to:

Required if applicable

Check "YES" or "NO" to indicate whether the patient's condition is related to employment, an auto accident, or other accident. If the patient's condition is the result of an auto accident, enter the two-letter abbreviation of the state in which the person responsible for the accident is insured.

10. IS PATIENT'S CONDITION RELATED TO:		
a. EMPLOYMENT? (CURRENT OR PREVIOUS)		
<input checked="" type="checkbox"/>	YES	<input type="checkbox"/> NO
b. AUTO ACCIDENT?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
		PLACE (State)
		<input type="text"/>
c. OTHER ACCIDENT?		
<input type="checkbox"/>	YES	<input checked="" type="checkbox"/> NO

10 d. Reserved for Local Use

Not required

11. Insured's Group Policy or FECA Number

Required if applicable

11a. Insured's Date of Birth and Sex

Required if applicable

11b. Employer's Name or School Name

Required if applicable

11c. Insurance Plan Name or Program Name

Required if applicable

11d. Is There Another Health Benefit Plan?

Required if applicable

Check the appropriate box to indicate coverage other than AHCCCS. If "Yes" is checked, you must complete Fields 9a-d.

12. Patient or Authorized Person's Signature

Not required

13. Insured's or Authorized Person's Signature

Not required

14. Date of Current Illness/Injury or Pregnancy

Required if applicable

15. Date of Same or Similar Illness

Not required

16. Dates Patient Unable to Work in Current Occupation

Not required

17. Name of Referring Provider or Other Source

Required if applicable

17a. ID Number of Referring Provider

(Required only for podiatry services)

17b. NPI # of Referring Provider (shaded area)

(Required only for podiatry services)

18. Hospitalization Dates Related to Current Services

Required if applicable

19. Reserved for Local Use

Not required

20. Outside Lab? Yes or No and (\$) Charges

Not required

21. Diagnosis Codes

Required

Enter at least one *ICD-9 diagnosis code* describing the recipient’s condition. Behavioral health providers must **not** use DSM-4 diagnosis codes. Up to four diagnosis codes in priority order (primary condition, secondary condition, etc.) may be entered.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24 E BY LINE)

1.	250	.	52	3.	_____	.	_____
2.	_____	.	_____	4.	_____	.	_____

22. Medicaid Resubmission Code

Required if applicable

Enter the appropriate code (“A” or “V”) to indicate whether this claim is a resubmission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the AHCCCS Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled “Original Reference No.” See Chapter 4, General Billing Rules, for information on resubmissions, adjustments, and voids.

22. MEDICAID RESUBMISSION

CODE	ORIGINAL REF. NO.
A	060010004321

23. Prior Authorization Number

Not required

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 8, Authorizations/HIS Referrals, for information on prior authorization.

24 A-I Shaded areas NOT USED)

24 A. Date(s) of Service

Required

Enter the beginning and ending service dates.

24.	A						B	C	D	
DATE(S) OF SERVICE								Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER
From			To							
MM	DD	YY	MM	DD	YY					
	02	15	07	02	15	07				

24 B. Place of Service

Required

Enter the two-digit code that describes the place of service.

- | | | | | | |
|----|------------------------------------|----|--|----|--|
| 03 | School | 22 | Outpatient Hospital | 54 | ICF/Mentally Retarded |
| 04 | Homeless Shelter | 23 | ER – Hospital | 55 | Residential Substance Abuse Treatment Facility |
| 05 | HIS Free-Standing Facility | 24 | ASC | 56 | Psych Residential Treatment Center |
| 06 | HIS Provider-based Facility | 25 | Birth Center | 57 | Non-residential Substance Abuse Treatment Facility |
| 07 | Tribal 638 Free-standing Facility | 26 | Military Treatment Facility | 60 | Mass Immunization Center |
| 08 | Tribal 638 Provider-based Facility | 31 | Skilled Nursing Facility | 61 | Comprehensive Inpatient Rehabilitation Facility |
| 11 | Office | 32 | Nursing Facility | 62 | Comprehensive Outpatient Rehabilitation Facility |
| 12 | Home | 33 | Custodial Care Facility | 65 | ESRD Treatment Facility |
| 13 | Assisted Living Facility | 34 | Hospice | 71 | Public Health Clinic |
| 14 | Group Home | 41 | Ambulance – Land | 72 | Rural Health Clinic |
| 15 | Mobile Unit | 42 | Ambulance – Air or Water | 81 | Independent Laboratory |
| 20 | Urgent Care Facility | 49 | Independent Clinic | 99 | Other Place of Service |
| 21 | Inpatient Hospital | 50 | FQHC | | |
| | | 51 | Inpatient Psych Facility | | |
| | | 52 | Psych Facility – Partial Hospitalization | | |
| | | 53 | Community Mental Health Center | | |

24.	A						B	C	D	
	DATE(S) OF SERVICE						Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
	From				To				CPT/HCPCS	MODIFIER
	MM	DD	YY	MM	DD	YY				
							11			

24 C. EMG – Emergency Indicator

Required if applicable

Mark this box with a “√,” an “X,” or a “Y” if the service was an emergency service, regardless of where it was provided.

24.	A						B	C	D	
	DATE(S) OF SERVICE						Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
	From				To				CPT/HCPCS	MODIFIER
	MM	DD	YY	MM	DD	YY				
							Y			

24 D. Procedures, Services, or Supplies

Required

Enter the CPT or HCPCS procedure code that identifies the service provided. If the same procedure is provided multiple times on the *same date of service*, enter the procedure only once. Use the Units field (Field 24G) to indicate the number of times the service was provided on that date. Unit definitions must be consistent with the HCPCS and CPT manuals.

For some claims billed with CPT/HCPCS codes, procedure modifiers must be used to accurately identify the service provider and avoid delay or denial of payment.

24.	A						B	C	D	
	DATE(S) OF SERVICE						Place of Service	EMG	PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
	From				To				CPT/HCPCS	MODIFIER
	MM	DD	YY	MM	DD	YY				
								71010	26	

24 E. Diagnosis Pointer**Required**

Relate the service provided to the diagnosis code(s) listed in Field 21 by entering the *number* of the appropriate diagnosis. Enter only the reference number from Field 21 (1, 2, 3, or 4), *not* the diagnosis code itself. If more than one number is entered, they should be in descending order of importance.

D		E	F	G	H	
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT FAMILY PLAN
CPT/HCPCS	MODIFIER					
		1, 2				

24 F. \$ Charges**Required**

Enter the total charges for each procedure. If more than one unit of service was provided, enter the total charges for all units. For example, if each unit is billed at \$50.00 and three units were provided, enter \$150.00 here and three units in Field 24G.

D		E	F	G	H	
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT FAMILY PLAN
CPT/HCPCS	MODIFIER					
			179	00		

24 G. Days/Units**Required**

Enter the units of service provided on the date(s) in Field 24A. Bill all units of service provided on a given date on one line. Unit definitions must be consistent with CPT and HCPCS manuals.

D		E	F	G	H	
PROCEDURE, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS	EPSDT FAMILY PLAN
CPT/HCPCS	MODIFIER					
					1	

24 H. EPSDT/Family Planning**Not required****24 I. ID Qualifier****Required if applicable****24 J. (SHADED AREA) – Use for COB INFORMATION****Required if applicable**

Use this **SHADED** field to report Medicare and/or other insurance information. For Medicare, enter the Coinsurance and Deductible amounts. If a recipient's Deductible has been met, enter zero (0) for the Deductible amount.

For recipients and service covered by a third party payer, enter only the amount *paid*.

Always attach a copy of the Medicare or other insurer's EOB to the claim.

If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24J (Shaded area). Leaving this field blank will cause the claim to be denied.

See Chapter 9, Medicare/Other Insurance Liability, for details on billing claims with Medicare and other insurance.

See example below.

24 J. (NON SHADED AREA) – RENDERING PROVIDER ID#

Required

Rendering Provider’s NPI is required for all providers that are mandated to maintain an NPI #.

For atypical provider types, the AHCCCS ID must be used.

E DIAGNOSIS POINTER	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID#
					COB Information

25. Federal Tax ID Number

Required

Enter the tax ID number and check the box labeled “EIN.” If the provider does not have a tax ID, enter the provider’s Social Security Number and check the box labeled “SSN.”

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT ACCOUNT NO.
86-1234567	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

26. Patient Account Number

Required if applicable

This is a number that the provider has assigned to uniquely identify this claim in the provider’s records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS CRN and the provider’s own accounting or tracking system.

27. Accept Assignment

Not required

28. Total Charge

Required

Enter the total for all charges for all lines on the claim.

27. ACCEPT ASSIGNMENT? (For govt claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
<input type="checkbox"/> YES <input type="checkbox"/> NO	\$ 179 00 \$	\$	\$

29. Amount Paid

Required if applicable

Enter the total amount that the provider has been paid for this claim by all sources *other than AHCCCS*. Do *not* enter any amounts expected to be paid by AHCCCS.

30. Balance Due

Not Required

31. Signature of Physician or Supplier, including degrees and credentials and Date

Required

The claim must be signed by the provider or his/her authorized representative. Rubber stamp signatures are acceptable if initialed by the provider representative. Enter the date on which the claim was signed.

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	
SIGNED John Doe	DATE 03/01/07

32. Service Facility Location Information **Required if applicable**

32a. Service Facility NPI# (non-shaded area) **Required if applicable**

32b. Service Facility AHCCCS ID# (Shaded Area) **Required if applicable**

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	
Arizona Hospital	
123 Main Street	
Scottsdale, AZ 85252	
a. NPI	b. AHCCCS ID

33. Billing Provider Name, Address and Phone # **Required**
Enter the provider name, address, and phone number. If a group is billing, enter the group biller's name, address, and phone number.

33a. Billing Provider NPI # (non-shaded area) **Required if applicable**

33b. Other ID – AHCCCS ID # (Shaded Area) **Required if applicable**

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
Doc Holliday	
123 OK Corral Drive	
Tombstone, AZ 85999	
a. NPI	b. AHCCCS ID

** Note – NPI is required for all providers that are mandated to maintain an NPI number.

For atypical provider types, box 33b must be completed.

UB 04 Claim Form Sample

1		2		3a PAT CNTL #		4 TYPE OF BILL	
				b. MED REC #			
				5 FED TAX NO		6 STATEMENT COVERS PERIOD FROM	
						7 THROUGH	
8 PATIENT NAME a				9 PATIENT ADDRESS a			
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION HR	
				14 TYPE		15 SPO	
		16 DHR		17 S STAT		18	
		19		20		21	
		22		23		24	
		25		26		27	
		28		29 ACCT STATE		30	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 CODE		36 CODE		37 CODE		38 CODE	
				39 OCCURRENCE SPAN FROM		40 OCCURRENCE SPAN THROUGH	
				41 CODE		42 CODE	
				43 VALUE CODES AMOUNT		44 VALUE CODES AMOUNT	
				45 CODE		46 CODE	
				47 VALUE CODES AMOUNT		48 VALUE CODES AMOUNT	
				49 CODE		50 CODE	
42 REV CD		43 DESCRIPTION		44 HCPCS / RATE / HPPS CODE		45 SERV DATE	
						46 SERV UNITS	
						47 TOTAL CHARGES	
						48 NON-COVERED CHARGES	
						49	
1						1	
2						2	
3						3	
4						4	
5						5	
6						6	
7						7	
8						8	
9						9	
10						10	
11						11	
12						12	
13						13	
14						14	
15						15	
16						16	
17						17	
18						18	
19						19	
20						20	
21						21	
22						22	
23						23	
PAGE		OF		CREATION DATE		TOTALS	
A		B		C		D	
51 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 PRIOR PAYMENTS	
				54 BEN		55 EST. AMOUNT DUE	
						56 NPI	
						57 OTHER PRV ID	
A		B		C		D	
58 INSURED'S NAME		59 P/FEL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
						62 INSURANCE GROUP NO.	
A		B		C		D	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A		B		C			
B		C		D			
C		D		E			
66		67		68		69	
DX		A		B		C	
I		J		K		L	
M		N		O		P	
Q		R		S		T	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
		a		b		c	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 QUAL	
				LAST		FIRST	
74 OTHER PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 OPERATING NPI		77 QUAL	
				LAST		FIRST	
80 REMARKS		81CC a		78 OTHER NPI		79 QUAL	
		b		LAST		FIRST	
		c		79 OTHER NPI		80 QUAL	
		d		LAST		FIRST	

UB-04 CLAIM INSTRUCTIONS

INTRODUCTION

Beginning **May 23, 2007**, the **UB-04** claim form is to be used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services also are billed on the UB-04. The UB-092 version will no longer be accepted after this date.

- Revenue codes are used to bill line-item services provided in a facility.
- Revenue codes must be valid for the service provided.
- Revenue codes also must be valid for the bill type on the claim.
 - ✓ For example, hospice revenue codes 651, 652, 655, 656 can only be billed on a UB-04 with a bill type 81X-82X (Special Facility Hospice).
 - ✓ If those revenue codes are billed with a regular inpatient bill type (11X – 12X), the claim will be denied.
- ICD-9 diagnosis codes are required.
 - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.
- ICD-9 procedure codes must be used to identify surgical procedures billed on the UB-04.

COMPLETING THE UB-04 CLAIM FORM

The following instructions explain how to complete the UB-04 claim form and whether a field is “Required,” “Required if applicable,” or “Not required.” The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04*.

NOTE: This chapter applies to paper UB-04 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS web site at www.azahcccs.gov. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

1. Billing Provider Data

Required

Enter the billing provider name, address and telephone number.

Arizona Hospital 123 Main Street Phoenix, AZ
--

1. **(Cont.) NOTES:** The billing provider address **MUST** be a street address. PO Box or Lock Box addresses are to be entered in the Pay-To Address field of the form.

2. Pay-To Name and Address

Required

The address that the provider submitting the bill intends payment to be sent **IF** different than that of the Billing Provider (see #1).

3a. Patient Control Number

Required if applicable

This is a patient’s unique (alphanumeric) number assigned by the provider to facilitate

retrieval of the individual's account of services (accounts receivable) containing the financial billing records and any postings of payments. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility's accounting or tracking system.

3b. Patient Control Number **Required if applicable**

This is the number assigned to the patient's medical/health record by the provider.

4. Type of Bill **Required**

This code indicates the specific type of bill. The first digit is a leading zero (do not include leading zero on electronic claims). Facility type (2nd digit), bill classification (3rd digit), and frequency (4th digit). See *UB-04 Manual* for codes.

2. PAY TO NAME AND ADDRESS	3a. PATIENT CONTROL NO.	4. TYPE OF BILL
	3b. MEDICAL/HEALTH RECORD NO.	111

5. Federal Tax Number **Required**

Enter the facility's federal tax identification number.

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
86-1234567			

6. Statement Covers Period **Required**

Enter the beginning and ending service dates of the period included on this bill. **NOTES:** the "Form" date should not be confused with the Admission Date (see #12).

5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH	7. COV D
	02/15/07	02/20/07	

7. Reserved **Not Required**

8. Patient Name/Identifier **Required**

Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer.

9. Patient Address **Required**

The mailing address of the patient.

10. Patient Birth Date **Required**

11. Patient Sex **Required**

12. Admission/Start of Care Date **Required**

The start Date for this episode of care. For inpatient services, this is the date of admission. For other (home health) services, it is the date the episode of care began.

12. ADMISSION/START OF CARE	13. ADMISSION HOUR

- 13. Admission Hour** **Required if applicable**
 The code referring to the hour during which the patient was admitted for inpatient or outpatient care.
- 14. Priority (Type) of Visit** **Required**
 A code indicating the priority of this admission/visit. *See UB-04 Manual for codes.*
- 15. Source of Referral for Admission or Visit** **Required**
 A code indicating the source of the referral for this admission or visit. *See UB-04 Manual for codes.*
- 16. Discharge Hour** **Required if applicable**
 Code indicating discharge hour of the patient from *inpatient care*.
- 17. Patient Discharge Status** **Required**
 A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (as reported in FL6, Statement covers Period). *See UB-04 Manual for codes.*
- 18-28. Condition Codes** **Required if applicable**
 A code(s) used to identify conditions or events relating to this bill that may affect processing. *See UB-04 Manual for codes.*
- 29. Accident State** **Required if applicable**
 The accident state field contains the two-digit state abbreviation where the accident occurred. Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code. *See UB-04 Manual for codes.*
- 30. Reserved** **Not Required**
 Not currently used.
- 31-34. Occurrence Codes and Dates** **Required if applicable**
 The code and associated date defining a significant event relating to this bill that may affect payer processing. *See UB-04 Manual for codes.*
- 35-36. Occurrence Spans Codes and Dates** **Required if applicable**
 A code a related dates that identify an event that related to the payment of the claim. *See UB-04 Manual for codes.*
- 37. Reserved** **Not Required**
 Not currently used.
- 38. Responsible Party Name and Address** **Required if applicable**
 The name and address of the party responsible for the bill.
- 39-41. Value Codes and Amounts** **Required if applicable**
 A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. *See UB-04 Manual for codes.*

- 42. Revenue Codes** **Required**
Codes that identify specific accommodation, ancillary service or unique billing calculations or arrangements. Revenue Code categories are four digits. *See UB-04 Manual for codes.*
- 43. Revenue Description** **Required**
The standard abbreviated description of the related revenue code categories included on the bill. The description should correspond with the Revenue Codes as defined by the NUBC. *See UB-04 Manual for descriptions.*
- 44. HCPCS/Accommodation Rates** **Required if applicable**
Enter the Healthcare Common Procedure Coding System (HCPCS) applicable to the ancillary service and outpatient bills. Enter the accommodation rate for inpatient bills. (when associated revenue code is 0100-0219).
- 45. Service Date (Outpatient)** **Required if applicable**
The date (MMDDYY) the *outpatient* service was provided.
- 46. Service Units** **Required**
A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, pints of blood, renal dialysis treatments, etc.
- 47. Total Charges** **Required**
Total charges pertaining to the related revenue code for the current billing period is entered in the statement covers period. Total Charges includes both covered and non-covered charges.
- 48. Non-covered Charges** **Required if applicable**
Reflect the non-covered charges for the payer as it pertains to the related revenue code.
- 49. Reserved** **Not required**
Currently not used.
- 50. Payer Name** **Required**
Name of the payer that the provider might expect payment for the bill.
- 51. Health Plan Identification Number** **Required**
This is a number used by the health plan to identify itself.
- 52. Release of Information Certification Indicator** **Required**
Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.
- 53. Assignment of Benefits Certification Indicator** **Required**
Code indicates the provider has a signed for authorizing the third party payer to remit payment directly to the provider.
- 54. Prior Payments – Payer** **Required if applicable**
The amount the provider has received (to date) by the health plan toward payment of this bill.

- 55. Estimated Amount Due – Payer** **Not required**
The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).
- 56. National Provider Identifier (NPI) – Billing Provider** **Required**
The unique identification number assigned to the provider submitting the bill; NPI is the national provider identifier.
- 57. Other (Billing) Provider Identifier** **Required if applicable**
A unique identification number assigned to the provider submitting the bill by the health plan.
- 58. Insured’s Name** **Not required**
The name of the individual under whose name the insurance benefit is carried.
- 59. Patient’s Relationship to Insured** **Not required**
Code indicating the relationship of the patient to the identified insured.
- 60. Insured’s Unique Identifier** **Not required**
The unique number assigned to the health plan to the insured. AHCCCS does not require.
- 61. Insured’s Group Number** **Not required**
The group or plan name through which the insurance is provided to the insured. AHCCCS does not require.
- 62. Insured’s Group Number** **Not required**
The identification number, control number, or code assigned by the carrier or administrator to identify the group number under which the individual is covered. AHCCCS does not require.
- 63. Treatment Authorization Code** **Not required**
A number or other indicator that designates that the treatment indicated on this bill has been authorized by the payor. You may include the AHCCCS Prior Authorization Number but AHCCCS does not require that you provide the number on the claim. If there is a Prior Authorization approved within the AHCCCS Claims system, the claim will validate the presence of the Authorization during processing.
- 64. Document Control Number (DCN)** **Required if applicable**
The claim Reference Number (CRN) assigned to the original bill by AHCCCS. Required when claim is a replacement or void to a previously adjudicated claim and the Bill Type (FL 04) indicates a Void or Replacement.
- 65. Employer Name (of the Insured)** **Not required**
The name of the employer that provides health care coverage for the insured individual. AHCCCS does not require.
- 66. Diagnosis and Procedure Code Qualifier (ICD)** **Required**
The qualifier that denotes the version of International Classification of Diseases (ICD) reported. AHCCCS currently uses “9” – Ninth Revision.

- 67 A-Q. Principal and Other Diagnosis Codes and POA Indicator** **Required**
 Enter the principal and other ICD-9 diagnosis code. Behavioral Health providers must NOT use DSM-4 diagnosis codes. Present on Admission (POA) Indicator is also required by AHCCCS. The POA Indicator applies to the diagnosis codes for claims involving inpatient admissions. Refer to the UB-04 Manual for usage guidelines.
- 68. Reserved** **Not Required**
 Not currently used.
- 69. Admitting Diagnosis** **Required**
 Required for **inpatient** bills. Enter the ICD-9 diagnosis code that represents the significant reason for admission.
- 70 A-C. Patient's Reason for Visit (Outpatient only)** **Not required**
 AHCCCS does not require this field to be populated.
- 71. Prospective Payment System (PPS) Code** **Not required**
 AHCCCS does not require this field to be populated.
- 72 A-C. External Cause of Injury (ECI) Code** **Required if applicable**
 The ICD-9 diagnosis codes pertaining to external cause of injuries, poisoning, or adverse effect.
- 73. Reserved** **Not required**
 Currently not used.
- 74 A-E. Principal and Other Procedure Codes and Dates** **Required if applicable**
 Required on INPATIENT claims when a procedure was performed. Not required on Outpatient claims. Enter the ICD-9 code that identifies the inpatient procedure performed at the claim level during the period covered by the bill and the corresponding date. Enter date as MMDDYY.
- 75. Reserved** **Not required**
 Currently not used.
- 76. Attending Provider Name and Identifiers** **Required if applicable**
 The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Required on INPATIENT claims and to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.
- 77. Operating Physician Name and Identifiers (NPI)** **Required if applicable**
 The name and identification number of the individual with the primary responsibility for performing surgical procedures. Required if a surgical procedure code is listed on the claim.
- 78-79. Other Provider (Individual) Names and Identifiers** **Not required**
 The name and NPI number of the individual corresponding to the Provider Type category indicated in this section of the claim. *Refer to UB-04 for usage guidelines.*

80. Remarks Field

Required if applicable

Area to capture additional information necessary to adjudicate the claim – provider’s discretion.

81. Code – Code Field

Required if applicable

To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by NUBC. *Refer to UB-04 for usage guidelines.*

ADA DENTAL CLAIM FORM INSTRUCTIONS

ADA Claim Form Block Number/Description	
Block 1 - Dentist's pretreatment estimate or statement of actual services and identification of specialty	By checking the appropriate box, the form will be processed more quickly and with less chance of error. We do not require identification of specialty at this time.
Block 2 - Medicaid claim, EPSDT, prior authorization number	Include appropriate information for government funded benefit programs as necessary.
Blocks 3-7 - Carrier name and address zip	Indicates where the claim is to be sent.
Blocks 8-11, 16 - Patient name and address	Include patient's <i>legal</i> name for proper identification purposes.
Block 12 - Patient date of birth	Required in order to determine eligibility.
Block 13 - Patient ID number	Not required to process claim. A dental office assigned number.
Block 14 - Sex	Required for identification purposes and statistical analysis.
Block 15 - Patient phone number	Patient's phone number.
Block 17 - Relationship to subscriber/employee	Employee refers to the insured person and their relationship to the patient, which may affect the patient's eligibility, as well as level of benefits available.
Block 18 - Employer/School name and address	Eligibility of the dependent patient may be affected if the patient is over a certain age (specified in the benefits policy) and is still a full-time student.
Block 19 - Subscriber/Employee ID or Social Security Number	The employee's social security number (SSN) is commonly used for an identification number, but some plans use an identification number that is different from the SSN.
Block 20 - Employer	The subscriber's employer name.
Block 21 - Group number	Refers to the contract policy number assigned to the employer group.
Blocks 22-30 - Subscriber/Employee information	Refers to the insured person, not necessarily the patient.
Block 31 - Is patient covered by another plan?	This information identifies multiple coverage and helps determine which other carriers, if any, have primary liability for treatment provided.
Block 32 - Policy number	Refers to the policy number assigned to the employer group.
Blocks 33-35 - Other subscriber information	Refers to employee with policy number in Block 32.
Block 36 - Plan/Program name	Identifies national programs, such as Champus.
Block 37 - Employee/School	Refers to person in Block 33. Necessary for eligibility requirements and coordination of benefits.
Block 38 - Employer/Employer status	Refers to person in Block 22. Necessary for eligibility requirements and coordination of benefits.
Block 39 - Patient signature	The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For communication of information and consent, this term may also include the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
Block 40 - Employer/School	Refers to person in Block 22; needed for coordination of benefits.
Block 41 - Employee/Subscriber	Must be completed if the patient and/or the dentist wish to have benefits paid directly to the dentist. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
Blocks 42-43, 46, 50-52 - Information for billing dentist or dental entity	The individual dentist's name or the name of the group practice/corporation responsible for billing. This may differ from the actual treating dentist's name. This is the name that should appear on any payments or correspondence that will be remitted to the billing dentist.

Block 44 - Provider ID #	Not required for claim processing at this time.
Block 45 - Dentist Social Security number or TIN	Refers to dentist or dental entity in Block 42. Report the corporation or individual's tax ID number.
Block 47 - Dentist license number	This is the license number of the billing dentist. This may differ from that of the treating dentists, which appears in the dentist's signature block at the bottom of the form.
Block 48 - First visit date current series	Important to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
Block 49 - Place of treatment	Depending on where treatment is rendered, medical and/or hospital coverage (including dental benefits) may be applied. ECF stands for "extended care facility."
Block 53 - Radiographs or models enclosed	Indicates whether diagnostic materials were submitted. Assists in return of proper number of materials to dentist.
Block 54 - Is treatment for orthodontics?	Enter yes or no.
Block 55 - If prosthesis for a crown, bridge or denture, is this initial placement?	Most dental contracts have specific limitations on replacement of dentures, partials, crowns, and bridges. This is used to determine eligibility.
Block 56 - Is treatment result of occupational illness or injury?	Refers to possible application of Workers' Compensation, which would alter coverage available and carrier involved. Important for coordination of benefits and accurate claims processing.
Block 57 - Is treatment the result of an auto accident?	Will affect reimbursement in no-fault auto cases. Indicates whether another party's insurance may be responsible. Also important for coordination of benefits.
Block 58 - Diagnosis Code Index	We do not require at this time.
Block 59 - Examination and treatment plan	Refer to the American Dental Association's Current Dental Terminology (CDT-3) for appropriate procedure codes. We do not require diagnosis codes at this time.
Block 60 - Identify all missing teeth	Identify missing teeth with an 'X'.
Block 61 - Remarks for unusual services	Indicate information that may be helpful in determining the benefits for the treatment. If space is inadequate, use unused portion of Block 59, or attach a separate page.
Block 62 - Dentist's signature block	The treating dentist's signature and license number.
Block 63-66 - Address where treatment was performed	Complete this section if treatment was performed at a different location than indicated in Blocks 46, 50-52.
Payment itemization:	Optional area for some carriers to calculate payments.
For administrative use only:	Area where carrier calculates benefits.



P I N A L • C O U N T Y

Wide open opportunity

P.O. Box 2140 Florence, Arizona 85232 (520) 866-6775

**Explanation Of Payments
20050517**

Vendor

Tax ID:

Date of Service	Proc. Code	Description	Mod	Units	Billed Charges	Payment Method	Amount Paid	EOB
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Services rendered by:

Payable to:

Claim ID:	Member Name:	Patient#:	Invoice #:
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Claim Total:

Provider Totals:

Vendor Totals	Cap Amount	FFS Amount	Adjustments	Total Payments
Payable to:				

EOB Descriptions

- 072 Paid Patient Responsibility.**
- 075 Medicare COB information not received.**

NETWORK DEVELOPMENT & MANAGEMENT SECTION

NETWORK DEVELOPMENT AND MANAGEMENT SECTION

The Network Development and Management Section of P/GLTC is responsible for developing, educating, maintaining, and monitoring P/GLTC's network of medical, in-home, long-term and behavioral health providers to ensure the full array of ALTCS services is available to members. Once contracts are finalized, the Provider Relations Representatives will serve as the primary contact between P/GLTC and providers. Problems requiring mediation or intervention should be directed to the Network Development and Management Section for resolution.

The Network Development and Management Section of P/GLTC are responsible for the following areas:

- Developing, procuring, awarding and monitoring contracts
- Rate negotiations
- Disseminating updated information to both contracted and non-contracted providers
- Furnishing technical assistance to providers as needed or requested
- Scheduling new provider orientation and ongoing education with appropriate P/GLTC staff
- Coordinating quarterly provider meetings
- Updating and distributing provider directories
- Assistance with claim problems not resolved with the P/GLTC Accounting and Information System Section
- Developing, updating and distributing the provider manual
- Coordinating all provider communication including new and terminated contracts, newsletters, etc.
- Coordinating Peer Review and Pharmacy & Therapeutic (P&T) Committees
- Credentialing of practitioners
- Provider claim disputes and member appeals

Whether you are a new or existing provider, Network Development and Management staff is available to furnish training and education on topics such as your contract, ALTCS requirements, credentialing, referrals and billing. Network Development and Management regularly sends out information related to contract requirements, policy updates and other process changes. Such information may be provided through direct mailings, provider newsletters, e-mails or website updates.

If you have any questions regarding your contract, or have any other provider issues, please contact Network Development and Management at **(520) 866-6703**.

CLAIM DISPUTE, APPEAL AND REQUEST FOR HEARING

Claim disputes, member appeals and requests for State Fair Hearings are managed by the Network Development and Management Section of P/GLTC. Any member or provider who believes their rights have been violated may file an appeal, claim dispute and/or Request for State Fair Hearing. The dispute, appeal and request for hearing policies and procedures are available in both English and Spanish and are available by contacting P/GLTC at **(520) 866-6775**. Contracted and non-contracted providers who need assistance understanding or following the dispute, appeal and request for hearing process should contact a Provider Relations Representative at **(520) 866-6703**.

Providers may also file appeals on behalf of members with the member's written consent. P/GLTC encourages providers advocating on behalf of members. Should you have any questions, please do not hesitate in contacting your member's Case Manager at **(520) 866-6775**.

FALSE CLAIMS ACT

The False Claims Act (31 U.S.C. §3729 et seq.), also called the "Lincoln Law" is an American federal law which allows people, whether affiliated with the government or not, to file actions against federal contractors claiming fraud against the government. The act of filing such action is informally called "whistle-blowing". Persons filing under the Act stand to receive a portion (usually about 15-25 percent) of any recovered damages.

The Act provides a legal tool to counteract fraudulent billings turned into the federal government. Claims under the law have been filed by persons with insider knowledge of false claims, which have typically involved health care, military or other government spending programs.

The Act establishes liability when any person or entity improperly receives from or avoids payment to the federal government, with the exception of tax fraud. Briefly, the Act prohibits:

- Knowingly presenting, or causing to be presented to the government, a false claim for payment;
- Knowingly making, using or causing to be made or used, a false record or statement to get a false claim paid or approved by the government;
- Conspiring to defraud the government by getting a false claim allowed or paid;
- Falsely certifying the type or amount of property to be used by the government;
- Certifying receipt of property on a document without completely knowing that the information is true;
- Knowingly buying government property from an unauthorized officer of the government, and;
- Knowingly making, using or causing to be made or used, a false record to avoid, or decrease an obligation to pay or transmit property to the government.

As a healthcare provider, P/GLTC requires that you educate staff on the provisions of the False Claims Act. P/GLTC will be monitoring for this requirement. An online training is available at:

<http://www.azahcccs.gov/DRA/DRAtraining/default.html>

P/GLTC encourages you to use the website as a training tool for staff.

Should you have any questions, please contact your Provider Relations Representative or Network Development and Management at **(520) 866-6703**.

PROVIDER RIGHTS

As a P/GLTC Provider, you have the right to:

- Prompt, professional and courteous treatment by all P/GLTC employees
- Be treated with respect by P/GLTC members

- Be compensated fairly, promptly and accurately for services rendered
- Open, timely and necessary communication

PROVIDER RESPONSIBILITIES

As a P/GLTC Provider, you have the responsibility to:

- Treat all P/GLTC employees professionally and courteously
- Treat P/GLTC members with dignity and respect, with sensitivity to cultural differences and without regard to race, color, age religion, sex, national origin, disability or sexual orientation
- Communicate openly and honestly with P/GLTC
- Bill promptly and accurately for services rendered

P/GLTC contracted providers provide high quality services to eligible members. Contracted providers are expected to abide by all terms specified in their contract with P/GLTC. The contract includes general and special provisions, reimbursement rates, claim submission requirements and work statements detailing service delivery. When providers determine that the terms of their contract contradict the delivery of appropriate care, the provider should discuss this issue with their assigned Provider Relations Representative.

Non-contracted providers are expected to be registered as AHCCCS providers to be eligible for payment of services provided to P/GLTC members. Non-contracted providers are only used in instances when there are no contracted P/GLTC providers available. Non-contracted providers are reimbursed at the AHCCCS fee-for-service rates, cost-to-charge ratios or hospital tiered per diem as established by AHCCCS for the provider service type and facility classification. Non-contracted providers are expected to comply with all AHCCCS rules and regulations pertaining to their category of service. Non-contracted providers should contact the P/GLTC Network Development and Management Section for questions related to service delivery and conflicts.

Prior to providing services to members, providers will verify each member's stated identification and eligibility. This can be done by calling P/GLTC directly at **(520) 866-6775** or by visiting P/GLTC's website at: <http://pinalcountyz.gov/Departments/LongTermCare/Pages> and clicking on the Claims Status/Member Eligibility link. Services provided to persons misrepresenting their identities will not be reimbursed.

Providers shall work with Case Managers to resolve member issues prior to requesting reassignment of the member. Providers shall utilize Case Managers to coordinate medical and other appropriate care and participate in care conferences as requested.

Primary Care Physicians (PCP) will serve as a gatekeeper and coordinator in referring the member for specialty medical and behavioral health services. Coordinator of medical care and acting as a gatekeeper includes but is not limited to the following responsibilities:

- Initiate and coordinate all medically necessary and appropriate referrals to contracted providers. When appropriate and necessary, refer members to an out-of-network provider in order to obtain services
- Oversee drug regimens to prevent negative interactive effects
- Follow-up for all emergency services
- Coordinate inpatient care

- Maintain continuity of care for each assigned member
- Maintain the member's medical record, which incorporated documentation of all services provided to the member by the Contractor as well as any services rendered by other providers

For PCPs, adequate coverage and accessibility during regularly scheduled working hours must provide:

- Routine care appointments within twenty-one (21) days
- Urgent care appointments within two (2) days
- Emergency appointments within the same day, or within twenty-four (24) hours of the member's phone call or other information

PCPs will strive to ensure that the member's office wait time for scheduled appointments does not exceed forty-five (45) minutes. PCPs will provide member referrals to specialists or therapists when medically necessary and medically appropriate.

For specialty referrals, the provider will provide:

- Routine care appointments will be scheduled within forty-five (45) days of referrals
- Urgent care appointments will be scheduled within three (3) days of referral
- Emergency appointments will be scheduled within twenty-four (24) hours of referral

For behavioral health services, the provider will provide:

- Routine appointments within thirty (30) days of referral
- Emergency appointments within twenty-four (24) hours of referral

For maternity care, the provider will provide initial prenatal care appointments for enrolled pregnant members as follows:

- First trimester – within fourteen (14) days of request
- Second trimester – within seven (7) days of request
- Third trimester – within three (3) days of request
- High-risk pregnancies – within three (3) days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

For a listing of current AHCCCS covered services, please visit:

<http://www.azahcccs.gov/reporting/legislation/sessions/2010/BenefitChanges.aspx>

MEMBER ADVOCACY

P/GLTC does not prohibit or otherwise restrict healthcare providers from advising or advocating on behalf of a member regarding the following: the member's health status, medical care or treatment options, including any alternative treatment that may be self-administered; any information the member needs in order to decide among all relevant treatment options; the risks, benefits and consequences of treatment or non-treatment options; the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment

and to express preferences about future treatment decisions. Should you require additional information on this topic, please contact Network Development and Management at **(520) 866-6703**.

BEHAVIORAL HEALTH SERVICES

P/GLTC covers the following behavioral health services for enrolled members regardless of age:

- Evaluation and screening
- Individual/group/family therapy and counseling
- Behavioral health case management services (limited)
- Psychotropic medicine
- Psychotropic medicine adjustment and monitoring
- Respite care (with limitations)
- Therapeutic foster care
- Behavior management (behavioral health personal assistance, family support and peer support)
- Psycho-social rehabilitation (living skills training; health promotion; pre-job training; education and development; job coaching and employment support)
- Emergency and non-emergency transportation
- Emergency/crisis behavioral health services
- Lab and x-ray services for psychotropic medicine regulation and diagnosis
- Inpatient services
- Inpatient psychiatric facilities (residential treatment centers and sub-acute facilities)
- Partial care (supervised, therapeutic and medical day programs)
- Substance abuse services

Case Managers are responsible for identifying a member's need for and prior authorizing these services. The Case Manager must consult with P/GLTC's in-house Qualified Behavioral Health Professional (QBHP) within three (3) days of identification or notification of the member's need for services. The Behavioral Health Coordinator is responsible for approval of services and assisting the Case Manager in locating an appropriate behavioral health provider. Once authorized, the service must be provided within thirty (30) days for a routine need and twenty-four (24) hours for an emergency. The Case Manager incorporates the member's behavioral health needs and goals into the care plan.

Members receiving ongoing behavioral health services are reviewed at least every three (3) months by the Case Manager and the Behavioral Health Coordinator to assure that the member is making progress and that the services remain appropriate to meet the member's current needs. The Case Manager is also responsible for coordination of behavioral health services between the provider of the service and the member's PCP.

Providers may also identify a need for behavioral health services and notify the Case Manager for appropriate action. For more information about covered behavioral health services and providers, please call P/GLTC's Behavioral Health Coordinator at **(520) 866-6792**.

EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of twenty-one (21). The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment and follow-up care of physical and behavioral health problems for AHCCCS members less than twenty-one (21) years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary, mandatory and optional services listed in federal law 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness does not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and “*such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) state plan.*” This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions and illnesses discovered by the screening process when those services fall within one of the twenty-eight (28) optional and mandatory categories of “Medical Assistance” as defined in the Medicaid Act. Services covered under EPSDT include all twenty-eight (28) categories of services in the federal law even when they are not listed as covered services in the AHCCCS state plan, AHCCCS statutes, rules or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation and family planning services. EPSDT also includes diagnostic, screening preventive and rehabilitative services. However, EPSDT services do not include services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

EPSDT DEFINITIONS

Early – in the case of a child already enrolled with an AHCCCS contractor as early as possible in the child’s life, or in other cases, as soon as after the member’s eligibility for AHCCCS services has been established.

Periodic – at intervals established by AHCCCS Administration for screening to assure that a condition, illness, or injury is not incipient or present.

Screening – regularly scheduled examinations and evaluations of the general physical and

behavioral health, growth, development and nutrition status of infants, children and youth, and the identification of those in need of more definitive evaluation. For the purpose of the AHCCCS EPSDT program, screening and diagnosis are not synonymous.

Diagnostic – the determination of the nature or cause of a condition, illness or injury through the combined use of health history, physical, developmental and psychological examination, laboratory tests, and x-rays when appropriate.

Treatment – any of the 28 mandatory or optional services described in federal law 42 USC 1396d(a), even if the service is not covered under the AHCCCS State Plan, when necessary to correct or ameliorate defects and physical and mental illnesses and conditions detected by screening or diagnostic procedures.

EPSDT REQUIREMENTS

Comprehensive periodic screenings must be performed by a clinician according to the time frames identified in the AHCCCS EPSDT periodicity schedule, the AHCCCS Dental Periodicity Schedule and inter-periodic screenings as appropriate for each member. The AHCCCS periodicity schedule is intended to meet reasonable and prevailing standards of medical and dental practice and specifies screening services as each stage of the child's life and is based on recommendations by the Arizona Medical Association and is closely aligned with guidelines of the American Academy of Pediatrics. The Periodic Schedules specify screening services at each stage of the child's life. The service intervals represent minimum requirements, and any services determined by a primary care provider to be medically necessary must be provided, regardless of the interval.

EPSDT focuses on continuum of care by: assessing health needs, providing preventive screening, initiating needed referrals, and completing recommended medical treatment and appropriate follow up. EPSDT screenings must include the following:

- A comprehensive health and developmental history, including growth and development screening (including physical, nutritional and behavioral health assessments). **As of January 1, 2006**, the Parent's Evaluation of Development Status (PEDS) developmental screening tool should be utilized for developmental screening by all participating primary care providers (PCPs) who care for EPSDT-age members admitted to the Neonatal Intensive Care (NICU) following birth. The PEDS screening should be completed for NICU-discharged EPSDT members from birth through eight (8) years of age.

The PEDS tool may be obtained from www.pedstest.com or www.forepath.org.

- A comprehensive unclothed physical examination
- Appropriate immunizations according to age and health history
- Laboratory tests including: blood lead screening assessment and blood lead testing appropriate to age and risk, anemia testing and diagnostic testing for sickle cell trait if a child has not been previously tested with sickle cell preparation or a hemoglobin solubility test
- Health education
- Appropriate oral health screening, intended to identify oral pathology, including tooth decay and/or oral lesions, conducted by a physician, physician's assistant or nurse practitioner

- Appropriate vision, hearing and speech testing and diagnosis, as well as treatments for defects in vision and hearing, including provision of eyeglasses and hearing aids. Appropriate medically necessary therapies, including speech therapy are also covered under EPSDT
- All hospitals/birthing centers must screen newborns using a physiological hearing screening method as early as possible prior to initial discharge
- All hospitals/birthing centers should provide out-patient re-screening for babies who were missed or are referred from the initial screen. Outpatient screening must be scheduled at time of initial discharge and completed between two (2) and six (6) weeks of age.
- Refer families to a medical home for appropriate assessment when there is an indication that a newborn or infant may have a hearing loss or congenital disorder.
- All infants with confirmed hearing loss receive services before turning six (6) months of age.
- Tuberculin skin testing as appropriate to age and risk. Children at increased risk of tuberculosis (TB) include those who have contact with persons:
 - a. Confirmed or suspected as having TB
 - b. In jail or prison during the last five years
 - c. Living in a household with an HIV-infected person or the child is infected with HIV, and
 - d. Traveling/emigrating from, or having significant contact with persons indigenous to endemic countries

EPSDT services must be provided according to community standards of practice and the AHCCCS EPSDT and Dental Periodicity Schedules. The AHCCCS EPSDT Tracking Forms (<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf>) must be used to document services provided and compliance with AHCCCS standards. The tracking forms must be signed by the clinician who performs the screening.

EPSDT providers must adhere to the following specific standards and requirements:

1. **Immunizations** – EPSDT covers all child and adolescent immunizations as specified in the AHCCCS EPSDT Periodicity Schedule. All appropriate immunizations must be provided to establish and maintain up-to-date immunization status for each EPSDT member (<http://pinalcountyz.gov/Departments/LongTermCare/NetworkDevelopment/Documents/EPSTDPeiodicitySchedule.pdf>) Effective December 1, 2006, AHCCCS will cover the human papilloma virus (HPV) vaccine for female EPSDT members per the Advisory Committee on Immunization Practices recommended schedule. Providers must coordinate with the Arizona Department of Health and Human Services Vaccines for Children (VFC) program in the delivery of immunization services. Immunizations must be provided according to the Advisory Committee on Immunization Practices Recommended Schedule: (<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf> (exhibit 430-2)). Contractors must ensure providers enroll and re-enroll annually with the VFC program in accordance with AHCCCS Contract requirements. The Contractor shall not utilize AHCCCS funding to purchase FVC vaccines for members younger than 19 years of age. Contractors must ensure providers document each EPSDT member's immunization in the Arizona State Immunization Information System (ASIIS) and maintain the ASIIS immunization records of each EPSDT member in ASIIS in accordance with A.R.S. Title 36, Section 135.

2. **Eye Examinations and Prescriptive Lenses** – EPSDT covers eye examinations as appropriate to age according to the AHCCCS EPSDT Periodicity Schedule and as medically necessary using standardized visual tools. Prescriptive lenses are provided to correct or ameliorate defects, physical illness and conditions discovered by EPSDT screenings, subject to medical necessity.
3. **Blood Lead Screening** – EPSDT covers blood lead screening. All children are considered at risk and must be screened for lead poisoning. All children must receive a screening blood lead test at twelve (12) months and twenty-four (24) months of age. Children between the ages of thirty-six (36) months and seventy-two (72) months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test result equal to or greater than ten (10) micrograms of lead per deciliter of whole blood obtained by capillary specimen or finger stick must be confirmed using a venous blood sample. A verbal blood screening risk assessment must be completed at each EPSDT visit for children ages six months through seventy-two (72) months (6 years) to assist in determining risk. Providers must report blood lead levels equal to or greater than ten (10) micrograms of lead per deciliter of whole blood to the Arizona Department of Health Services.
4. **Organ and Tissue Transplantation Services** – EPSDT covers medically necessary solid organ and tissue transplants approved for reimbursement in accordance with respective transplant policies. Covered transplants must not be experimental or provided primarily for the purpose of research.
5. **Tuberculosis Screening** – EPSDT covers TB screening.
6. **Nutritional Assessment and Nutritional Therapy:**

Nutritional Assessments: Nutritional assessments are conducted to assist EPSDT members whose health status may improve with nutrition intervention. AHCCCS covers the assessment of nutritional status provided by the member's primary care provider (PCP) as a part of the EPSDT screenings specified in the AHCCCS EPSDT Periodicity Schedule, and on an inter-periodic basis as determined necessary by the member's PCP. AHCCCS also covers nutritional assessments provided by a registered dietitian when ordered by the member's PCP. This includes EPSDT eligible members who are under or overweight. To initiate the referral for a nutritional assessment, the PCP must use the Contractor referral form in accordance with Contractor protocols. Prior authorization (PA) is not required when the assessment is ordered by the PCP. If an AHCCCS covered member qualifies for nutritional therapy due to a medical condition as described in this section, then AHCCCS Contractors are the primary payor for:

- a. WIC-eligible infant formulas
- b. Medical foods
- c. Parenteral feedings
- d. Enteral feedings

Nutritional Therapy: AHCCCS covers nutritional therapy for EPSDT-eligible members on an enteral, parenteral or oral basis when determined medically necessary to provide either complete daily dietary requirements, or to supplement a member's daily nutritional and caloric intake. AHCCCS Contractors are the primary payor for parenteral

and enteral feedings.

- a. **Enteral nutritional therapy:** Provides liquid nourishment directly to the digestive tract of a member who cannot ingest an appropriate amount of calories to maintain an acceptable nutritional status. Enteral nutrition is commonly provided by jejunostomy tube (J-tube), gastrostomy tube (G-tube) or nasogastric (N/G) tube.
- b. **Parenteral nutritional therapy:** Provides nourishment through the venous system to members with server pathology of the alimentary tract, which does not allow absorption of sufficient nutrients to maintain weight and strength.
- c. **Commercial oral supplemental nutritional feedings:** Provides nourishment and increases caloric intake as a supplement to the member's intake of age appropriate foods, or as the sole source of nutrition for the member. Nourishment is taken orally and is generally provided through commercial nutritional supplements available without prescription.
 1. PA is required for commercial oral nutritional supplements unless the member is also currently receiving nutrition through enteral or parenteral feedings. PA is not required for the first thirty (30) days if the member required commercial oral nutritional supplements on a temporary basis due to an emergent condition.
 2. Medical necessity for commercial oral nutritional supplements must be determined on an individual basis by the member's PCP or attending physician, using at least the criteria specified in this policy. An example of nutritional supplement is an amino acid-based formula used by a member for eosinophilic gastrointestinal disorder. The PCP or attending physician must use the AHCCCS approved form, "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements" to obtain PA from the Contractor.
 3. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must document that the PCP or attending physician has provided nutritional counseling as a part of the EPSDT services provided to the member. The documentation must specify alternative that were tried in an effort to boost caloric intake and/or change food consistencies before considering commercially available nutritional supplements for oral feedings, or to supplement feedings.
- d. The Certificate of Medical Necessity for Commercial Oral Nutritional Supplements must indicate which criteria were met when assessing the medical necessity of providing commercial oral nutritional supplements. At least two of the following criteria must be met:
 1. The member is at or below the 10th percentile on the appropriate growth chart for their age and gender for three months or more
 2. The member has reached a plateau in growth and/or nutritional status for more than six months (prepubescent)
 3. The member has already demonstrated a medically significant decline in weight within the past three months (prior to the assessment)
 4. The member is able to consume/eat no more than 25% of his/her nutritional requirements from age-appropriate food sources

5. Absorption problems as evidenced by emesis, diarrhea, dehydration, and/or weight loss and intolerance to milk or formula products has been ruled out
 6. The member requires nutritional supplements on a temporary basis due to an emergent condition; i.e. post-hospitalization (PA is not required for the first thirty (30) days) or
 7. The member is at high risk for regression due to chronic disease or condition and there are no alternatives for adequate nutrition.
7. **Oral Health Services** – As part of the physical examination, the physician, physician’s assistant or nurse practitioner must perform an oral health screening. A screening is intended to identify gross dental or oral lesions, but is not a thorough clinical examination and does not involve making a clinical diagnosis resulting in a treatment plan. Depending on the results of the oral health screening, referral to a dentist should be made as outlined below:

Category	Recommendation for Next Dental Visit
Emergent	Within twenty-four (24) hours of request
Urgent	Within three (3) days of request
Routine	Within forty-five (45) days of request

An oral health screening must be part of an EPSDT screening conducted by a PCP; however it does not substitute for examination through direct referral to a dentist. PCPs are expected to refer EPSDT members for appropriate services based on needs identified through the screening process and for routine dental care based on the AHCCCS EPSDT Periodicity Schedule. Evidence of this referral should be documented on the EPSDT form.

Note: Although the AHCCCS Dental Periodicity Schedule identifies when routine referrals begin, PCPs may refer EPSDT members for a dental assessment at an earlier age if their oral health screening reveals potential carious lesions or other conditions requiring assessment and/or treatment by a dental professional. In addition to PCP referrals, EPSDT members are allowed self-referral to a dentist who is included in the P/GLTC provider network.

EPSDT covers the following dental services:

- a. Emergency dental services including:
 1. Treatment for pain, infection, swelling and/or injury
 2. Extraction of symptomatic, infected and non-restorable primary and permanent teeth, as well as retained primary teeth, and
 3. General anesthesia, conscious sedation or anxiolysis (minimal sedation, patients respond normally to verbal commands) when local anesthesia is contraindicated or when management of the patient requires it. (see #9 of this section regarding conscious sedation policy)
- b. Preventive dental services provided as specified in the AHCCCS EPSDT Periodicity Schedule, including, but not limited to:

1. Diagnostic services including comprehensive and periodic examinations; two oral examinations and two oral prophylaxis and fluoride treatments per member per year (i.e., one every six months) for members aged twelve months through twenty (20) years
 2. Radiology services which are screening in nature for diagnosis of dental abnormalities and/or pathology, including panography or full-mouth x-rays, supplemental bitewing x-rays and occlusal or periapical films as needed
 3. Preventive services which include:
 - a) Oral prophylaxis performed by a dentist or dental hygienist which includes self-care oral hygiene instructions to member, if able, or to the parent/legal guardian
 - b) Application of topical fluorides. Use of a prophylaxis past containing fluoride and fluoride mouth rinses are not considered separate fluoride treatments (fluoride varnish in the PCP office is not a covered service)
 - c) For members under age 16, dental sealants on all non-carious permanent first and second molars and second primary molars, and
 - d) Space maintainers when posterior primary teeth are lost permanently
- c. All therapeutic dental services will be covered when they are considered medically necessary and cost effective but may be subject to PA. These services include but are not limited to:
1. Periodontal procedures, scaling/root planning, curettage, gingivectomy, osseous surgery
 2. Crowns
 - a) When appropriate, stainless steel crowns may be used for both primary and permanent posterior teeth; composite, prefabricated stainless steel crowns with a resin window or esthetic coating should be used for anterior primary teeth, or
 - b) Precious or case semi-precious crowns may be used on functional permanent endodontically treated teeth, except third molars, for members who are eighteen (18) through twenty (20) years old.
 3. Endodontic services including pulp therapy for permanent and primary teeth, except third molars unless it is functioning in place of a missing molar
 4. Restoration of carious permanent and primary teeth with accepted dental materials other than cast or porcelain restorations unless the member is eighteen (18) through twenty (20) years of age and has had endodontic treatment, and
 5. Removable dental prosthetics including complete dentures and removable partial dentures
 6. Orthodontic services and orthognathic surgery are covered only when these services are medically necessary to treat a handicapping malocclusion. Services must be medically necessary and determined to be the primary treatment of choice or an essential part of an overall treatment plan developed by both the PCP and the dentist in consultation with each other. Orthodontic services are not covered when the primary purpose is

cosmetic. Examples of conditions that may require orthodontic treatment include the following:

- a) Congenital craniofacial or dentofacial malformations, requiring reconstructive surgical correction in addition to orthodontic services, or
- b) Trauma requiring surgical treatment in addition to orthodontic services, or
- c) Skeletal discrepancy involving maxillary and/or mandibular structures

Services or items furnished solely for cosmetic purposes are excluded from AHCCCS coverage (9 A.A.C. 22, Article 2).

AHCCCS covers dental hygiene services provided by Arizona licensed dental hygienists subject to the terms of the written affiliated practice agreement entered into between a dentist and a dental hygienist. Each affiliated dental hygienist, when practicing under an affiliated practice relationship may perform only those duties specified within the terms of the affiliated practice relationship and they must maintain an appropriate level of contact, communication and consultation with the affiliated practice dentist.

In addition to the requirements in A.R.S. §32-1281 & §32-1289, AHCCCS requires the following:

1. Both the dental hygienist and the dentist in the affiliated practice relationship must be registered AHCCCS providers.
 2. The affiliated practice dental hygienist must maintain individual patient records of AHCCCS members in accordance with the Arizona State Dental Practice Act. At a minimum this must include member identification, parent/guardian identification, signed authorization (parental consent) for services, patient medical history and documentation of services rendered.
 3. When practicing under the scope of an affiliated practice dental hygienist, the affiliated practice dental hygienist must register with AHCCCS and must be identified as the treating provider under his/her individual AHCCCS provider identification number and NPI number. In addition, if the services are to be billed to an AHCCCS contractor, the affiliated practice dental hygienist and the dentist with whom she/he is affiliated must be a credentialed network provider of the Contractor.
 4. The affiliated practice dental hygienist will only be reimbursed for providing services in accordance with state statute and regulations, AHCCCS policy and provider agreement, and their affiliated practice agreement.
 5. AHCCCS reimbursement for dental radiographs is restricted to providers who are qualified to perform both the exposure and the interpretation of dental radiographs.
8. **Cochlear Implantation** – Cochlear implantation provides an awareness and identification of sounds and facilitates communication for persons who have profound, sensorineural hearing loss (nerve deafness). Deafness may be prelingual/perilingual or postlingual. AHCCCS covers medically necessary services for cochlear implantation. Criteria for medical necessity of cochlear implants include, but are not limited to, the following instances:

- a. Have a diagnosis of bilateral profound sensorineural deafness (using age-appropriate standard testing), with little or no benefit from a hearing (or vibrotactile) aid, as established by audiologic and medical evaluation
- b. Presence of an accessible cochlear lumen structurally suited to implantation, with no lesions in the auditory nerve and acoustic areas of the central nervous system, as demonstrated by CT scan or other appropriate radiologic evaluation
- c. No known contraindications to surgery
- d. Demonstrated age appropriate cognitive ability to use auditory clues, and
- e. The device must be used in accordance with the FDA approved labeling.

Cochlear implantation requires PA from the P/GLTC Medical Director.

9. **Conscious Sedation** – AHCCCS covers conscious sedation for members receiving EPSDT services. Conscious sedation provides a state of consciousness that allows the member to tolerate an unpleasant procedure while remaining able to continuously maintain adequate cardiovascular and respiratory function as well as the ability to respond purposely to verbal command and/or tactile stimulation.

Coverage is limited to the following procedures:

- a. Bone marrow biopsy with needle or trocar
- b. Bone marrow aspiration
- c. Intravenous chemotherapy administration, push technique
- d. Chemotherapy administration into central nervous system by spinal puncture
- e. Diagnostic lumbar spinal puncture, and
- f. Therapeutic spinal puncture for drainage of cerebrospinal fluid

Additional applications of conscious sedation for members receiving EPSDT services will be considered on a case by case basis and require medical review and prior authorization by the P/GLTC Medical Director.

10. **Behavioral Health Services** – EPSDT behavioral health services include the services listed in Federal Law 42 USC 1396d(a) necessary to correct or ameliorate mental illnesses and conditions discovered by the screening services whether or not the services are covered under the AHCCCS State Plan. AHCCCS covers behavioral health services for members eligible for EPSDT services as outlined below:

- a. Behavioral health therapeutic home care services
- b. Behavior management
- c. Case management
- d. Emergency behavioral health care
- e. Evaluation and assessment
- f. Inpatient services (including inpatient hospitals and inpatient psychiatric facilities)
- g. Laboratory, radiology and medical imaging services for diagnosis and psychotropic medicine regulation
- h. Medications (psychotropic)
- i. Partial care (supervised day program, therapeutic day program and medical day program)

- j. Professional services (therapy and counseling, including electroconvulsive therapy)
- k. Psychosocial rehabilitation services (skills training and development, behavioral health promotion/education, psycho-educational services, ongoing support to maintain employment and cognitive rehabilitation)
- l. Respite care
- m. Screening services
- n. Transportation (including emergency and non-emergency)
- o. Institution for mental disease, with limitations

For the diagnosis of attention deficit disorder/attention deficit hyperactivity disorder, depression (including post natal depression), and/or anxiety disorders, there are clinical guidelines that include assessment tools and algorithms. The clinical guidelines are to be used by the PCPs as an aide in treatment decisions. The guidelines can be found at the following locations:

- Child ADHD – http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixE_C_hildADHD.pdf
- Child Anxiety – http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixE_C_hildAnxiety.pdf
- Child Depression - http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixE_C_hildDepression.pdf

- 11. **Religious Non-Medical Health Care Institution Services** – AHCCCS covers religious non-medical health care institution services for members eligible for EPSDT services.
- 12. **Case Management Services** – AHCCCS covers case management services as appropriate for members eligible for EPSDT services. In EPSDT, case management involves identifying the health needs of a child, ensuring necessary referrals are made, maintaining health history, and initiating further evaluation/diagnosis and treatment when necessary.
- 13. **Chiropractic Services** – AHCCCS covers chiropractic services to members eligible for EPSDT services when prescribed by the member’s PCP and approved by P/GLTC in order to ameliorate the member’s medical condition.
- 14. **Personal Care Services** – AHCCCS covers personal care services, as appropriate, for members eligible for EPSDT services.
- 15. **Incontinence Briefs** – Incontinence briefs, including pull-ups, are covered in order to prevent skin breakdown and to enable participation in social, community, therapeutic and educational activities under the following circumstances:
 - a. The member is over three (3) year and under twenty-one (21) years old
 - b. The member is incontinent due to a documented disability that causes incontinence of bowel and/or bladder

- c. The PCP or attending physician has issued a prescription ordering the incontinence briefs
- d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder
- e. The member obtains incontinence briefs from providers in the Contractor's network
- f. Prior authorization has been obtained as required by the Administration, Contractor or Contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every twelve (12) months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit.

Prior authorization will be permitted to ascertain that:

- 1. the member is over age three (3) and under age twenty-one (21);
 - 2. The member has a disability that causes incontinence of bladder and/or bowel;
 - 3. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the Contractor; and
 - 4. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.
16. **Medically Necessary Therapies** – AHCCCS covers medically necessary therapies including physical therapy, occupational therapy and speech therapy necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Therapies are covered under both an inpatient and outpatient basis when medically necessary.

POLICIES AND PROCEDURES

For questions or concerns regarding P/GLTC's policies and procedures regarding: the Member Appeal System, Network Management Procedures, the Provider Claims Dispute System, Credentialing / Re-Credentialing and Provider Non-discrimination and Member Advocacy, please contact us at **(520) 866-6703**.

**CASE
MANAGEMENT &
MEMBER
SERVICES**

CASE MANAGEMENT SECTION

The Case Management Section is responsible for both case management and member services for all members enrolled with P/GLTC. A brief description of these two services is given below.

Case Management is the section that assigns Case Managers and provides case management services for ALTCS members enrolled with P/GLTC. The Case Manager is the person with whom the member has his or her initial contact. During this phone call, the Case Manager:

- Assesses for special needs (i.e., translation services, bilingual case manager, etc.),
- Assesses for high risk conditions needing immediate intervention
- Identifies all third party liability insurances
- Assists members with the selection of a primary care physician (PCP)

The Case Manager is responsible for informing new members or their family of the following:

- Enrollment
- Prior Period Coverage (PPC)
- Share of Cost (if applicable)
- Acute care coverage
- PCP coverage
- Prescription drug coverage
- Medical supply coverage
- Transportation
- How to obtain emergency medical care
- Nursing facility coverage and network
- Availability and coverage of ALF's
- Available home-based services

Upon enrollment with P/GLTC, a Case Manager conducts a thorough assessment of each member's functional levels, needs and requests, develops a care plan and arranges for the delivery of services mutually agreed upon between the Case Manager and the member. The Case Manager's role is that of a service planner, coordinator, facilitator and member advocate. The Case Manager assists the member with selecting the appropriate level of service including in-home, assisted living facility or nursing home services.

A Case Manager is available to provide assistance to providers and members during regular business hour from 8:00am-5: pm at 1-800-831-8312 or (520) 866-6755 and after hours at 1-800-831-8312.

For Case Management questions specific to a member, the assigned Case Manager should be contacted. If a Case Manager is out of the office and you need assistance or have a question that needs immediate attention, you can always speak to the Backup Case Manager. You can reach the Backup Case Manager by calling 1-800-831-4213 or (520) 866-6775. Ask to speak to the Backup Case Manager when the receptionist answers. If the Back up Case Manager is unavailable, the Case Management Supervisor or Case Management Director should be contacted.

Member Services is the unit within the Case Management Section responsible for receiving and processing member enrollments and disenrollment's, assigning case managers to members, assigning members to Primary Care Provider's (PCP), assisting members and providers with information and issue resolution, entering member information into the P/GLTC databases, including prior period coverage (PPC) screens, and informing providers of members eligibility for PPC services.

A Member Services Representative (MSR) is available each working day, and may be reached at 1-800-831-4213 or (520)866-6755. If the MSR is unavailable and immediate attention is

needed, the Back up Case Manager, Case Management Supervisor, or the Case Management Director can help.

LONG TERM CARE SERVICES

The P/GLTC Case Manager is responsible for prior authorizing most of the covered long term care services for members. They include:

1. **Nursing homes**
2. **Home and Community Based Services:**
 - Adult Day Health
 - Behavior Management
 - Group Respite
 - Habilitation
 - Home Health Services
 - Personal Care
 - Hospice
 - Attendant Care and Self Directed Attendant Care
 - Emergency Alert System
 - Home Modifications
 - Home Delivered Meals
 - Homemaker Services
 - Respite
 - Pest Control
3. **Alternative residential settings:**
 - Adult Foster Care
 - Assisted Living Center
 - Behavioral Health facility
 - Assisted Living Home
 - Alzheimer's Treatment Assisted Living Facility
 - Traumatic Brain Injury facility

The member's independence and right to make decisions for him or herself are very important to P/GLTC. The member/ representative work as partners with the Case Manager and the Primary Care Provider to come up with a plan for services which will keep the member as independent as possible. The Case Manager arranges for and authorizes most of the care needed. Providers need to call the member's assigned Case Manager.

To ensure payment by P/GLTC, the Case Manager must prior authorize services before they are delivered. If services are arranged without the Case Manager's help, they may not be paid for by P/GLTC.

POLICIES AND PROCEDURES

For questions or concerns regarding P/GLTC's policies and procedures regarding: Primary Care Physician (PCP) Assignment, Advanced Directives, Family Planning Services and Program Contractor Change Requests (PCCR) and Transition Process from ALTCS to Acute Care Plan or to New Program Contractors, please contact us at **(520) 866-6775** and ask to speak with the Case Management Section.

QUALITY and MEDICAL MANAGEMENT

QUALITY and MEDICAL MANAGEMENT SECTION

The Quality and Medical Management Section is responsible for assuring that P/GLTC members receive quality medical and medically related services of an appropriate level and duration according to industry established standards. In addition, Medical Management provides for preventive care and monitors certain diseases through the P/GLTC Disease Management Program.

Quality Management (QM) is the function responsible for monitoring the quality of healthcare services delivered to P/GLTC members. Performance Improvement Projects (PIPs) are established by AHCCCS and P/GLTC. QM is responsible for the monitoring, collaborating with providers to design and implement interventions to improve performance, and reporting of these PIPs.

Medical Management (MM) is the function that provides administrative oversight of the level and type of service delivered by providers to P/GLTC members. The MM Program of P/GLTC is designed to provide a comprehensive, integrated process that ensures that all P/GLTC members receive timely, safe, and appropriate services in the most efficient and cost-effective manner. The UM nurse works directly with the P/GLTC Chief Medical Officer to determine appropriate utilization of medical and medically related services. The four primary functions of Medical Management are briefly described below:

PRIOR AUTHORIZATION

The Prior Authorization (PA) process provides for a review and service authorization for selected types of services. These service types are disseminated to all P/GLTC providers on the P/GLTC Web Site, in Provider Directories, and are cited on the PA Grid. Members may also have access to the PA criteria. PA criteria are reviewed on an annual basis and are revised as indicated.

Requests for PA are submitted by providers. Pre-Service authorizations are prioritized based on the urgency of the care the member needs to receive. These requests should be classified as “Expedited” or “Standard” priority. Decisions related to expedited requests for service are made within 3 business days. “Standard” service requests are reviewed, with decisions made within 14 days of receipt. “Expedited” priority is used for requests in which the provider or P/GLTC determines that using the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain or regain maximum function. An extension of up to 14 day extension may be added to the regular time frame if requested by the member or provider. P/GLTC may apply the same extension if additional information is needed to make a decision on the referral and the delay is in the member’s best interest.

Determinations for pre-service authorization requests are made in a timely manner and are based on established criteria. Decisions related to the pre-service authorization request are made by authorized, competent professionals. The evidence-based and / or regulatory driven decision criteria are applied consistently and in a timely manner. These decisions are communicated to providers and members, ensuring member rights.

P/GLTC has established a five-day a week (Monday-Friday) prior authorization system to review and respond to requests for authorization of all non-emergency acute care services. No prior authorization is required for the provision of emergency care and services. After hours and

weekend prior authorization for urgent service requests may be accessed by calling the Case Manager of Call. An after hours fax based notification system for emergency services, inpatient admissions, and non-emergency transportation is available to providers and members at all times during weekends, holidays and after normal working hours.

CONCURRENT REVIEW (CR)

CR is the process of assessing whether or not a members medical condition meets standard medical criteria for the current level of care they are receiving or for continued inpatient hospitalization. P/GLTC focuses the Concurrent Review process on those members that have P/GLTC as their primary payer source. The Nurses providing CR collaborate with the hospital and professional providers to ensure appropriate care delivery. The CR Nurses notify the hospital and providers when:

- a. Members do not meet the standard medical criteria for continued inpatient hospitalization
- b. Members do not meet the criteria for the current level of care they are receiving.

Approval of the level of care and services provided is directly related to compensation for hospital care. Once the level of care has been denied, the options may be to lower the rate of payment to one that reflects the members' needs and / or transfer the members to an appropriate site for their care (e.g. skilled nursing facility, home, etc.)

DISEASE MANAGEMENT (DM)

The Focus of the P/GLTC DM program is to develop, implement and monitor the effectiveness of selected disease management initiatives, resulting in increased member self care and provider adherence with evidence-based disease management program processes and outcomes. P/GLTC continues to evaluate the effectiveness of existing P/GLTC Diabetes and Preventive Screening program(s), including the associated processes, barriers, and outcomes. Based on these evaluations, strategies for improvement are developed.

CLINICAL PRACTICE GUIDELINES

P/GLTC has developed and/or adopted clinical performance measures that are based on practice guidelines relevant to the members served. As such, the goals for the adoption and dissemination of practice guidelines focus on supporting the review, development and / or endorsement and dissemination of evidence-based Practice Guidelines, enhancing the access of P/GLTC providers, clinicians, and members to evidence-based practice; ensuring alignment with disease management programs; supporting adherence to evidence-based practice; and impacting the potential for positive population-based outcomes. Specifically, P/GLTC will provide and utilize standardized processes for the annual review of evidence-based Practice Guidelines and monitor adherence with and integrate positive incentives to providers for use of key elements of selected, high profile Practice Guidelines [e.g. diabetes, preventive care]

P/GLTC reviews and evaluates practice guidelines through Peer Review Committee, MM/UM Committee, Quality Management Committee, and Pharmacy Benefit Manager Meetings as appropriate to the subject matter. For questions or more information regarding the Clinical Practice Guidelines, please call us at (520) 866-6775.

PRIOR AUTHORIZATION REQUIREMENTS

**NOTE: Contracted providers must be used except where indicated.
Use of any non- contracted provider must be prior authorized**

<u>SERVICE</u>	AUTH NEEDED PRIOR TO DELIVERY OF SERVICE?	KEYNOTES
* Audiology (member's age is under 21)	No	
* Audiology (member's age is 21 and over)	Yes	
Cardiac Rehab	Yes	
Dental (preventive – member's age is under 21)	No	<p><u>Preventive Dental Care</u> - These services include but are not limited to: instruction in oral hygiene care, intra-oral examinations, radiology for screening purposes, oral prophylaxis, topical fluorides, and dental sealants.</p> <p>*The only exception for member over the age of 21 is when they are approved for a major organ transplant or essential services required prior to treatment for cancer of the jaw or neck.</p>
Dental (preventive – member's age is 21 and over)	Yes, limited*	
Dental (therapeutic – member's age is under 21)	Yes	<p><u>Therapeutic Dental Care</u> – These services are aimed at resolving a dental problem. Reviews are performed to ensure medical necessity and cost containment.</p>
Dental (therapeutic – member's age is 21 and over)	Not Covered	
Dental (emergency dental care - member's age is under 21)	No	<p><u>Emergency Dental Care</u> - Medically necessary emergency dental care and extractions are covered for all members who have a malady that meets the AHCCCS definition of emergency care (i.e. a condition which manifest itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.</p> <p>*Dental services provided to members age 21 and over are limited to those that a physician can provide, e.g. radiographs, antibiotics, and / or pain medications.</p>
Dental (emergency dental care - member's age is 21 and over)	No*	
Dialysis – Initial	Yes	
Dialysis – all subsequent treatments	Yes	
DME	Yes	See limitation for Podiatric DME
Elective Surgeries, Non-Office Procedures and Admissions	Yes	
Emergency Department (any hospital may be used – contracted and non-contracted)	No	
Enteral Feedings	Yes	
Home Infusion	Yes	
Inpatient care – (emergency or direct admit contracted and non-contracted hospitals may be used)	No	Hospital to notify P/GLTC by the next business day
Inpatient care – elective and scheduled surgeries	Yes	Notify P/GLTC within 12 hours of admit with admission review.
Labs – (all facilities may be used to include procedures such as type/cross and blood infusions)	No	No Prior Auth required for routine laboratory tests. Genetic testing is limited to the AHCCCS benefit design
* Optometry (member's age is under	No	

<u>SERVICE</u>	AUTH NEEDED PRIOR TO DELIVERY OF SERVICE?	KEYNOTES
21)		
* Optometry (member's age is 21 and over)	No auth required for member's with diabetes in their health history. If member does not have diabetes then auth is required	
Ophthalmology – Cataract Surgery	Yes	Requires PA as an elective surgery
Ophthalmology – Office visits	No	No PA for Contracted Provider
Outpatient surgery/procedure	Yes	
Radiology (CAT Scans and procedures under \$500/test)	No	AHCCCS FFS rates are used to determine cost of test.
Radiology (over \$500/test and all MRI's and PET scans)	Yes	AHCCCS FFS rates are used to determine cost of test.
* Psychologist/Psychiatrist	No	
Specialist – contracted (except those indicated by *)	No auth required for in-office visits	No PA is required for most office visits to contracted specialists. All visits to non-contracted specialists must be authorized
Specialist – non-contracted	Yes	
* Podiatrist – office visit <21 Years of Age –	Yes	
Podiatrist – office visit 21 Years of Age and Over –	21 Years of Age and Over: see notes	Podiatry benefit has been terminated for P/GLTC members ages 21 and over may Those members with Medicare and other insurance coverage may receive podiatry services based on the benefit design of those plans. P/GLTC will pay the co-pay for podiatry benefits only for the members who are QMB status at the time of the service provision. NOTE: QMB status applies to those members with Medicare A & B and are at or below 100% of the Federal Poverty Level.
* Podiatrist –durable medical equipment (DME)	Yes, subject to same restrictions as Podiatry Office Visit	See above
Transportation - emergency	No	
Transportation – non-emergency ambulance transports	Yes	
Transportation – Dependable Medical Transportation Services (DMTS)	No	
Transportation – Air Evac	No for Emergent Use	Any pre-scheduled use of air ambulance services. Emergency utilization will be subject to a retrospective review
Therapy Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)	Yes	Outpatient Physical Therapy is limited to 15 visits per contract year. An exception applies to P/GLTC members with QMB, who may be authorized for more that 15 visits.

Revised 10/26/2010

MEDICAL MANAGEMENT CARE TEAMS

BACKGROUND

Care Teams consist of a Care Team Manager, a Medical Management Coordinator (RN), Case Managers, a Behavioral Health Lead, a Member Services Representative and a Provider Relations Representative. The Team concept is used to more thoroughly and efficiently meet the needs of the P/GLTC members. Each team will be responsible for the members who are assigned to the team's Case Managers and meets regularly to exchange information and solve problems as the conditions and needs of P/GLTC members change. These interdisciplinary teams, by blending staff with diverse backgrounds, expertise, experience and perspectives, resulting in a more holistic and member-centered approach to the whole program. This approach empowers all those involved and allows more information to be available at the critical points when decisions are made.

GOAL

The Care Team, through creative teamwork, will facilitate quality choices that will empower people to live as independently as possible while maintaining maximum cost effectiveness. The Care Team will serve individuals with complex needs, considering all aspects of each person's life in order to best meet their needs.

ESSENTIAL ELEMENTS

- Teamwork is the heart of the interdisciplinary team.
- All members of the team count.
- Team members are encouraged to look at each situation as unique and individual to deal with tough issues.
- Team members are encouraged to explore a variety of treatments and options for and with a member.
- The interdisciplinary team is the member's partner; each with responsibilities, but the ultimate decisions on health lies with the member.

TEAM DUTIES & RESPONSIBILITIES

Each Care Team as a whole is responsible for the following:

- Needs assessment
- Planning and coordination of the delivery of services, including acute and chronic
- Development of care plans and their revision as needed
- Initiation of all services in a timely manner
- Disease Management
- Support the evaluation and measurement of all member outcomes
- Adherence to all AHCCCS/ALTCS standards, regulations and guidelines
- Utilization management
- Member transitions
- Referrals for Multi-Disciplinary Staffings (MDS)

DISEASE MANAGEMENT

The P/GLTC Disease Management Program goals for CYE2011 are focused on the development, implementation and monitoring of the effectiveness of selected disease management initiatives. The behavioral and / or practice changes associated with these programs will, over time, result in increased member self care and provider adherence with evidence-based disease management program processes and outcomes. Specifically, the program goals are as follows:

- Continue to evaluate the effectiveness of existing P/GLTC Disease Management program(s), including the associated processes, barriers, and outcomes
- Based on the evaluation, revise and / or develop strategies for improvement
- Identify potential gaps in Disease Management program availability, utilizing national, regional, and Plan-specific data related to prevalence, cost, and opportunity.
- Based on identified gaps, develop, begin implementation, monitor, and measure the effectiveness / potential return on investment of additional programs and delivery systems such as the Medical Home.

The CYE2010 focus of the P/GLTC Disease Management Program was diabetes. Members with this condition have the potential to benefit from a coordinated and monitored program that is aimed at member self-management and the practice patterns of providers. A substantial number of P/GLTC members have a diagnosis of diabetes. Please note that details are cited in the MM/UM Work Plan Evaluation for CYE2010.

The diabetes disease process was originally chosen because of its high prevalence, its alignment with other quality and utilization activities, its evidence based practice guidelines, and existing opportunities for self-management and education. The Program will continue during CYE2011.

Elements of the Diabetes Disease Management program include supporting collaboration among the Member, Provider, Plan, and Community Resources to improve care delivery. We seek to meet the educational needs of our staff, members, and providers related to diabetes and its management. We encourage members to discuss the management of their disease with their Primary Care Physicians (PCP).

QUALITY MANAGEMENT

The Quality Management Program Goals for CYE 2011 are as follows:

- Evaluate effectiveness of activities related to Performance Measures and revise associated structure and processes to promote achievement of Performance Measure goals.
- Evaluate Quality of Care (QOC) Referral and Review processes and improve associated structure and processes to improve quality of care and services provided to P/GLTC members and ensure quality, consistency, and compliance with regulatory requirements.
- Ensure coordination of care efforts between medical and behavioral healthcare providers.
- Support quality of care and services through the effective use of the credentialing and peer review processes to address professional and organizational provider issues related to clinical competence, service delivery, and/or conduct.

Quality Management activities supporting these goals are:

- Acute care admission reviews (i.e. ER visits and in-patient admissions) – monitor the providers ability to manage changes of condition
- Mortality reviews
- Pressure Sore and other skin impairment – the early recognition and securing timely and appropriate treatment
- Member Safety Initiatives
- Concern/Complaints – miscellaneous quality of care issues
- Compliance rate of Pneumovax and Flu vaccine
- Compliance rate of Diabetic Screens
- Compliance rate of Osteoporosis Prevention Program

POLICIES AND PROCEDURES

For questions or concerns regarding P/GLTC's polices and procedures regarding: Peer Review, Practice Guidelines, Reporting Provider and Member Fraud & Abuse, Hospital Inpatient Concurrent Review and Discharge Planning and Maternity Care Services, please contact us at **(520) 866-6775** and ask to speak with the Medical/Quality Management Section.

COMMUNITY PROGRAMS, RELATIONS & OUTREACH

COMMUNITY PROGRAMS

The Community Programs Section of P/GLTC administers two case management programs.

SMILE Case Management - provides in-home case management services to the elderly, and/or disabled adult population in Pinal County and southwest Gila County who are not ALTCS eligible. Eligible individuals may receive home and community based services such as home delivered meals, personal care, group respite, in-home respite and housekeeping services. Services are provided through the following funding sources: The Older Americans Act, Pinal-Gila Council for Senior Citizens Area Agency on Aging Region V and Pinal/Gila Long Term Care. Particular attention is paid to advocating for and assisting individuals/families with the ALTCS application process.

Family Caregiver Support Program - works with the caregivers of elderly and physically disabled adults, as well as family caregivers to ALTCS members. Staff provides information, advocacy and assistance in gaining access to services, in-home and group respite, as well as education on topics relating to caregiver duties. Services are funded through The Older Americans Act, Pinal-Gila Council for Senior Citizens Area Agency on Aging Region V and Pinal/Gila Long Term Care. Particular attention is paid to advocating for and assisting individuals/families with the ALTCS application process.

Community Programs staff - provides consistent representation at seven Pinal County Triad meetings. In joint collaboration with the Community Relations and Outreach Coordinator, staff also participates as vendors at numerous health fairs and other community events throughout Pinal and Southwest Gila Counties. Community Programs staff provides information and education on eligibility and benefits of the ALTCS program, SMILE Case Management and Family Caregiver Support Program. Staff also disseminates general information on aging issues, other available community services and resources targeted at the elderly and physically disabled populations.

COMMUNITY RELATIONS & OUTREACH

The Community Relations & Outreach Coordinator is responsible for attending agency and community meetings to provide information regarding the ALTCS program including eligibility and benefits. There is joint collaboration between this position and the Community Programs staff to provide representation as a vendor at appropriate health fairs in both Pinal and Gila counties, as well as participation at key community events that directly impact P/GLTC's member base.

The Community Relations & Outreach Coordinator consistently represents P/GLTC at the following meetings:

- Casa Grande Mayor's Task Force on Disabilities
- Pinal County Networking Group
- Southern Gila Networking Group
- Pinal County Domestic Violence Coalition
- Sizzling Seniors
- Elder Abuse Task Force
- Pinal County Diabetes Coalition
- Payson Inter-Agency/Continuum of Care Group

- Pinal County CARE Team Group
- Pinal Hispanic Council

In addition to representation and information dissemination at community health fairs, the Community Relations and Outreach Coordinator played a key role in the event planning for:

- 2009 Halloween Dance and Costume Event for Casa Grande Citizen's with Disabilities
- 2009 Pinal County "A Day For Diabetes and Wellness Fair"
- 2009 Pinal County Domestic Violence Conference
- 2010 Elder Abuse Conference

EPSDT FORMS

For copies of the Early Periodic Screening and Diagnosis Tracking forms, please visit:

<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf>

For copies of referrals, please contact P/GLTC Network Development and Management at (520) 866-6703.

GLOSSARY

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ADHS is the Arizona Department of Health Services; the state agency mandated to serve the public health needs of all Arizona citizens and is responsible for licensing a variety of health care facilities.

AHCCCS is the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to eligible persons, as defined in ARS §36-2902, et seq.

AHCCCSA is the Arizona Health Care Cost Containment System Administration.

ALF is an assisted living facility. Residential care institutions that provide supervisory care services, personal care services or directed care services on a continuous basis. All ALTCS approved residential settings in this category are required to meet ADHS licensing criteria. Of these facilities, AHCCCS has approved three as covered settings; adult foster care homes, assisted living homes and assisted living centers.

ALTCS is the Arizona Long Term Care System, a program under AHCCCS that delivers long term, acute, behavioral health, and case management services to members, as defined in A.R.S. §36-2932.

ARS is the Arizona Revised Statutes, the laws of the State of Arizona

Assignment is the process in which a provider agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Capitation is a method of payment in which a Provider agrees in advance to provide a predefined set of covered services to P/GLTC members for a fixed payment per member per month (PMPM).

Case Manager is the P/GLTC employee designated to develop, coordinate, and monitor the overall service plan for a member's care.

Clean Claim is a claim that may be processed without obtaining additional information from the Provider or from a third party, but does not include claims under investigation for fraud or abuse.

CMS is the Center for Medicare and Medicaid Services (formerly Health Care Financing Administration or HCFA), an organization within the U.S. Department of Health and Human Services, which administers the Medicare and Medicaid programs and the State Children's Health Insurance Program (known as KidsCare in Arizona).

Coinsurance is a percentage co-payment and is the portion of reimbursable medical expenses, after subtraction of any deductible, which Medicare or other Third Party Insurance does not pay.

Concurrent Review is the process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care.

Co-payment is the amount that is the patient responsibility.

Covered Services are health care services to be delivered by a program contractor to eligible members.

Deductible is the amount a beneficiary is responsible for, before Medicare or other Third Party Insurance begins paying; or the initial specific dollar amount for which the beneficiary is responsible.

DES is the Department of Economic Security.

Director is the Director of P/GLTC.

Discharge Planning is the process by which a member's needs are identified and service is coordinated after discharge from an inpatient facility.

Disenrollment is the termination of a member's eligibility to receive covered services through a program contractor.

Dual Eligible is a member who is eligible for both Medicare and Medicaid.

Elective is a surgical procedure that is not considered medically necessary to maintain life or health.

Encounter is a record of health care related service rendered by a provider to a member who is eligible for services.

Explanation of Benefits (EOB) is the written remittance advice submitted to the provider by Medicare or a third party payer that will explain how claims for services billed to that entity were processed.

Explanation of Payment (EOP) is the written remittance advice submitted to the provider by P/GLTC that will explain how claims for services billed to P/GLTC were processed.

Fee-For-Service (FFS) is a method of payment to registered Providers on an amount per service basis.

Formulary is a written list of approved and prescription and non-prescription pharmaceuticals. A formulary is intended for use by physicians, pharmacists, nurse practitioners, and other health care professionals. P/GLTC has developed its own formulary of approved drugs that are available to the authorized providers for the purpose of prescribing medications to P/GLTC members.

HIPAA is the Health Insurance Portability and Accountability Act of 1997.

Inpatient is a patient admitted to a medical facility, such as a hospital, for longer than twenty-four (24) hours.

Length of Stay (LOS) is the total number of days for which a patient is hospitalized as inpatient, per episode, either in total or in a unit or level of care. The date of discharge is not counted as a day of service, unless the member expires.

Medicaid is a Federal program under Title XIX of the Social Security Act that provides health insurance for financially eligible individuals.

Medical Director is the person designated by P/GLTC to supervise the medical care provided to all members.

Medically Necessary is a covered service provided by a physician or other licensed practitioner within the scope of practice under state law to prevent disease, disability, and other adverse health conditions or their progression; or prolong life.

Medicare is a federal program under Title XVIII of the Social Security Act which provides health insurance for person aged sixty-five (65) or older and for other specified groups. Part A of Medicare covers hospitalization and is mandatory. Part B of the program covers outpatient services and is voluntary.

Member As defined in A.R.S. §§ 36-2901.01, 36-2931 and 36-2981, individuals eligible for AHCCCS services, based on their income and resources, citizenship, Arizona residency and/or medical condition, who are enrolled with an AHCCCS Contractor or are FFS.

Out of Area Care is care or services received by a member when the member is outside the program contractor's geographic territory.

Outpatient is a patient who receives services from a licensed health care institution or a facility, however, does not occupy an inpatient bed for greater than twenty-four (24) hours.

P/GLTC is Pinal/Gila Long Term Care.

Pharmaceutical Service is the medically necessary drug prescribed by a primary care provider, physician assistant, a nurse practitioner, other physician or dentist upon referral by a primary care provider and dispensed in accordance with Arizona law.

PMPM is per member per month.

Primary Care Provider (PCP) An individual who meets the requirements of A.R.S. §36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as a person licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a nurse practitioner licensed under A.R.S. Title 32, Chapter 15

Prior Authorization Process by which AHCCCS DFSM/PA or Contractors approve a service subject to medical review later for appropriateness and coverage for payment. Prior authorization is not a guarantee of payment. Refer to 9 A.A.C. 22, Article 1. A written approval given to the Provider by P/GLTC to provide covered services to members, as requested by the case manager, prior to the services being performed or delivered.

Prior Period Coverage (PPC) is the period of time prior to the member's enrollment during which a member is eligible for covered services. The timeframe is from the effective day of eligibility to the day a member is enrolled with a Contractor. Refer to 9 A.A.C. 22, Article 1.

Program Contractor is the health plan contracted with AHCCCSA to provide long-term care services in an assigned geographic service area to members.

Provider Grievance is a complaint concerning an adverse action, decision, or policy by a contractor, subcontractor, non-contracted provider, non-provider, County or Administration, presented by an individual or entity, AAC §R9-22-101 (49). Inquiries, requests for information or correspondence not designated and reasonably identifiable as a grievance are not grievances.

Provider is any person or entity that contracts with P/GLTC and agrees to furnish covered health care services to members according to the provisions in A.R.S. §36-2901.

Qualified Medical Staff is appropriately licensed, certified, or registered personnel who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for patients.

Qualified Medicare Beneficiary (QMB) is deemed eligible as a Qualified Medicare Beneficiary (QMB) and is entitled to the following benefits and services: payment of Medicare Part A premiums, coinsurance, and deductibles; payment of Medicare Part B premiums, coinsurance and deductibles; and Medicare-covered services.

Quality Management (QM) is a function performed under P/GLTC'S Medical Management Unit. And is the assessment of the degree of a provider's conformance to established medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organization components and committees

Referral is when your PCP requests other services not provided in their office.

Retrospective Review is a clinical review after the fact. Used often with respect to utilization management, as with approval or denial of emergency room services.

Room and Board is the amount paid for food and/or shelter in an assisted living facility. Medicaid funds cannot be spent on room and board when a member resides in an assisted living facility. A member who is placed in an assisted living facility is required to contribute to the cost of their room and board provided in that facility. The provider is responsible for collecting the member's room and board contribution at the beginning of each month.

Specialist is a board certified or eligible physician who practices a specific medical specialty.

Subcontractor is any provider who contracts directly with P/GLTC to provide services, equipment, or supplies.

Therapy is a treatment concerned with improving or restoring functions that have been impaired by illness or injury. Therapies include physical, occupational, or speech therapy. The goal of therapy treatment is to improve an individual's ability to perform tasks required for independent functioning.

Third Party Payer is an individual, entity, or program that is or may be liable to pay all or part of the medical expenses incurred by a member.

Title 19 or Title XIX is the Section of Social Security Act that describes the Medicaid

program's coverage for eligible persons.

Utilization Management (UM) is a clinical review that identifies the usage of medical care resources and evaluates for quality, appropriateness, necessity, and cost effectiveness. Reviews involve analysis of authorized services including, but not limited to, specialist visits, emergency room service, and high cost health care services.

Well Child Visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and Dental Periodicity Schedules.

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