Any conflict in the interpretation of the policies and procedures included within this Provider Handbook and the Provider Agreement shall be resolved in accordance with federal and state laws and regulations, including the Payer Contract and payer memos, notices and provider manuals. The Payer Contract takes precedence over any language in this Provider Handbook. This Provider Handbook, revisions, and amendments to it are part of Provider Network Provider Agreement.
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Section 1: Introduction

About Magellan Complete Care of Arizona

Magellan Complete Care of Arizona (MCC of AZ) is an integrated health plan designed for the total care of individuals, including medical and behavioral health needs. Our clinical and operational model of care (clinical, quality and population health programs) enables us to offer our members access to high-quality, clinically appropriate, affordable healthcare that is tailored to each individual’s needs. Our ultimate goal is to improve healthcare outcomes and the overall quality of life for our members and their families.

MCC of AZ is a division of Magellan Healthcare, Inc., a healthcare management company that focuses on fast-growing, complex and high-cost areas of healthcare, with an emphasis on special population management.

MCC of AZ entered into a contract with the Arizona Health Care Cost Containment System (hereinafter referred to as “AHCCCS”) for the provision of Medicaid managed care to individuals enrolled in the Department’s AHCCCS Complete Care Program. Pursuant to the program requirements, MCC of AZ will provide the full scope of services and deliverables through an integrated and coordinated system of care as required, described, and detailed herein, consistent with all applicable laws and regulations, and in compliance with service and delivery timelines as specified by AHCCCS and within the MCC of AZ clinical, quality, and population health program documents.

MCC of AZ complies with AHCCCS and applicable federal requirements, in addition to applicable accreditation standards.

Model of Care

MCC of AZ delivers a fully integrated model of care (MOC) specially designed for members of the AHCCCS Complete Care Program.

Our MOC functions as the foundation for improving the health status of Arizonians by using person-centered and population-based care management, which is delivered through Integrated Health Neighborhood (IHN) teams, to integrate community resources and non-traditional services within local health systems. We ensure that natural and peer supports, housing, and employment are in place, in addition to traditional behavioral and medical treatment.

Our providers are the key to our success in delivering population-based, person-centered care. The level of support and coordination provided is dependent on each individual member’s needs, which may be outlined within an individualized Service Plan (SP). MCC of AZ’s Interdisciplinary Care Team (ICT) is comprised of the member and/or a designated representative and individuals engaged in the member’s life, who represent the continuum of physical and behavioral health and social delivery...
systems and is based on their relationship and knowledge of the member. This ICT model ensures a collaborative approach to care management based on the level of service the member requires.

The composition of the ICT varies based on the member’s needs and includes, at a minimum, the member or caregiver, primary and specialist providers, a care coordinator/care manager (CM) with both behavioral and physical health clinical expertise, peer support specialists, support staff care coordinators, and a health guide. The health guide and support staff care coordinators help the member navigate the physical and behavioral health delivery systems and ensure the member receives all necessary behavioral and physical health services in order to live independently in the community.

MCC of AZ brings the same commitment to the provider community in Arizona as we have in other parts of the country for the last 25 years. Together, we can leverage our strength, experience and expertise to improve outcomes for individuals in need of comprehensive care.

**Integrated Health Neighborhood Teams**

MCC of AZ’s goal to improve members’ care and health outcomes can only be achieved within the context of where the members live—within their neighborhoods and communities. Our model builds an infrastructure with the health and social services system called the Integrated Health Neighborhood (IHN), which customizes the delivery of care by region and supports and enhances the relationship between members and their providers.

Because our team members live and work within the communities where our members reside, these team members have firsthand knowledge of community strengths, resources, services, and service gaps. IHN team members include care coordinator/care managers, health guides, peer specialists and navigators, and community outreach specialists supported by housing specialists, employment specialists, clinical pharmacists, medical directors, and others.

The IHN is MCC of AZ’s mechanism to facilitate close collaboration with community partners, enhancing our ability to provide person-centered care to our members. This network naturally bridges language and cultural barriers, and more effectively and efficiently facilitates access to services to support our members and families where they live, work and play.

**Continuity of Care and Transition of Care Requirements**

MCC of AZ understands the importance of a seamless transition of services to prevent any fragmentation or duplication of care and to help ensure member safety. MCC of AZ works with AHCCCS to help ensure that services delivered during periods of transition are not reduced, modified, or terminated in the absence of an updated assessment and service plan.
During transitions of care, we adhere to the following three primary focus areas:

- Ensure members have no disruption of service
- Ensure providers are paid in a timely and accurate manner
- Implement healthcare delivery and service improvements to improve clinical and quality outcomes and deliver cost savings for the state of Arizona.

All aspects of our care management program and other MCC of AZ services (such as pharmacy services) are available and accessible to the members. We collaborate with members, providers, community partners, state agencies, and other key stakeholders to fully integrate the delivery and provision of services. We actively participate in community reinvestment by offering care and service programs to assist in promoting safe, high-quality and cost-effective care approaches.

Section 2: Quick Reference Information

Service Areas

MCC of AZ services the Central Geographic Service Area (GSA) of Arizona, including Maricopa, Gila and Pinal counties.

Contact Telephone Numbers and Websites

Our Call Center is available Monday-Friday from 8:00 am - 6:00 pm Arizona time, at 1-800-424-5891. A listing of frequently utilized department contacts mentioned throughout the manual is provided below, for quick reference. Providers may reach us at any time via the following options:

<table>
<thead>
<tr>
<th>Department</th>
<th>Email (non-urgent issues only)</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service</td>
<td><a href="mailto:MCCAZCustomerService@magellanhealth.com">MCCAZCustomerService@magellanhealth.com</a></td>
<td>N/A</td>
</tr>
<tr>
<td>Provider Disputes</td>
<td><a href="mailto:MCCAZProviderDisputes@magellanhealth.com">MCCAZProviderDisputes@magellanhealth.com</a></td>
<td>888-656-7504</td>
</tr>
<tr>
<td>Network Provider Services</td>
<td><a href="mailto:MCCAZProvider@magellanhealth.com">MCCAZProvider@magellanhealth.com</a></td>
<td>888-656-0369</td>
</tr>
<tr>
<td>UM Requests/ Prior Authorization</td>
<td><a href="mailto:MCCAZUMRequests@magellanhealth.com">MCCAZUMRequests@magellanhealth.com</a></td>
<td>888-656-7501</td>
</tr>
<tr>
<td>Health Services (General)</td>
<td><a href="mailto:MCCAZHealthServices@magellanhealth.com">MCCAZHealthServices@magellanhealth.com</a></td>
<td>888-656-7503</td>
</tr>
<tr>
<td>Grievance/Appeals</td>
<td><a href="mailto:MCCofAZAppealsandGrievances@magellanhealth.com">MCCofAZAppealsandGrievances@magellanhealth.com</a></td>
<td>888-656-7505</td>
</tr>
<tr>
<td>Quality of Care (QOC)</td>
<td><a href="mailto:MCCAZQOC@magellanhealth.com">MCCAZQOC@magellanhealth.com</a></td>
<td>888-656-7510</td>
</tr>
</tbody>
</table>
Specialty Areas: Contact Numbers

<table>
<thead>
<tr>
<th>Specialty Service</th>
<th>Contact Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>1-800-964-7811</td>
</tr>
<tr>
<td>Vision</td>
<td>1-800-877-7195</td>
</tr>
<tr>
<td>Lab services</td>
<td>1-888-522-2677</td>
</tr>
<tr>
<td>Transportation</td>
<td>1-877-790-9472</td>
</tr>
<tr>
<td>Dialysis</td>
<td>1-800-424-5891</td>
</tr>
<tr>
<td>DME</td>
<td>1-800-424-5891</td>
</tr>
<tr>
<td>Orthotics/Prosthetics</td>
<td>1-800-424-5891</td>
</tr>
<tr>
<td>Radiology</td>
<td>1-800-424-5891</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1-800-424-5891</td>
</tr>
</tbody>
</table>

Member Eligibility and Sample ID Card

MCC of AZ requires that our members keep their ID cards with them at all times. If a member loses their ID card, please have them contact MCC of AZ Customer Service toll free at 1-800-424-5891 (TTY 711). MCC of AZ will send them a replacement ID card within five business days.

Please note that a member ID card is not a guarantee of payment for services rendered. The provider’s office is responsible for verifying eligibility at the time of each office visit. The provider can access the following methods to verify eligibility:

- The 24-hour eligibility line at 1-800-424-5891.
- Online at [www.MCCofAZ.com](http://www.MCCofAZ.com).
Section 3: Provider Services, Support and Training

Provider Services

Our Provider Support Representatives and Network Management teams are committed to our providers and work to establish a positive experience with MCC of AZ by:

- Providing MCC of AZ plan orientation
- Providing education and support to facilitate best practices and cultural competency
- Assisting with strategies related to the development and management of the MCC of AZ provider network
- Supporting the processes that lead to resolution of operational short-falls (e.g. claims payment issues)
- Implementing provider practice-based quality initiatives— (e.g. patient registries, pay-for-performance (P4P) programs, provider scorecards)
- Distributing and reviewing various MCC of AZ clinical and administrative reports

Provider inquiries and requests for information will be acknowledged within three business days of receipt, and addressed within 30 days. The provider support team can be reached via the following methods:

- Phone: 1-800-424-5891
- Email: MCCAZProvider@MagellanHealth.com
- Fax: 1-888-656-0369

MCC of AZ’s provider support team can assist with:

- Notifying the plan of changes to your practice
- Demographic changes (service location, phone number, contacts, etc.)
- Staff/roster changes
- Completion of provider forms
- Assistance in locating another provider or specialists
- Retirement/Termination from practice
- Credentialing or Contract Status

Provider Support Specialists/Provider Relations

Our provider support approach delivers an integrated, high-touch provider relations team. This model fosters healthcare integration at the systems- and service-level by ensuring superior collaboration and communication with all providers across the continuum of care.

Provider support teams include a regionally-based network contract manager, provider network specialists, and a contract network coordinator responsible for all Arizona providers. Each provider support team facilitates contracting, provides technical assistance, conducts site visits, and educates network providers about the AHCCCS program. The provider support team provides ongoing technical
support, engages and updates providers whenever programmatic changes are made, ensuring that providers understand the changes.

Provider support specialists are licensed clinicians, who are experienced in Medicaid/Medicare. These professionals will support primary care providers, behavioral and community-based providers who deliver related services. Working with providers at their locations, these professionals simplify programmatic changes by conducting analyses of provider needs, review workflows to identify opportunities for improving services, and identify the potential for creating additional network access for members. These professionals also work to improve quality and outcomes, and they support adoption of evidence-based practices; facilitate relationships between physical, behavioral, and ancillary providers; transform data into actionable information; and support value-based payment initiatives.

Our field-based provider support staff are the core of our provider engagement strategy offering assistance to ensure issues are quickly resolved. They also assist providers with the appeals process, if necessary.

In addition to the provider orientation noted below, a full range of AHCCCS Complete Care Program, physical and behavioral health trainings are available to our network providers through the Relias Learning Management platform. All AHCCCS Complete Care (ACC)/ Regional Behavioral Health Authority (RBHA) Behavioral Health (BH) providers must have access to Relias Learning. Contracted provider agencies must manage and maintain their individual Relias Learning portal. This includes activating and deactivating users as well as enrollment and disenrollment of courses/events.

**Provider Orientation and Education**

The purpose of this section is to outline training and education program requirements, documentation standards and available resources to ensure effective training and education of employees and providers who support MCC of AZ’s AHCCCS Complete Care Program. Magellan will conduct a provider orientation and offer ongoing provider education and training activities regarding the AHCCCS Complete Care Program and all applicable federal and state requirements as deemed necessary by MCC of AZ or the AHCCCS to ensure compliance with the AHCCCS Complete Care Program contract.

**Provider Orientation**

MCC of AZ is responsible for ensuring appropriate training, education, technical assistance and workforce development opportunities as outlined in section 400 of the AHCCCS Contractors Operations Manual (ACOM) and AHCCCS Medical Policy Manual (AMPM). A comprehensive provider orientation introduces the provider to the AHCCCS Complete Care Program and the special needs of our members. Orientation topics include, but are not limited to:

- AHCCCS Complete Care Program covered services, access to services, including enhanced and carved-out services;
- Policies and procedures (e.g., claims submission standards, process, service authorizations);
- Eligibility criteria and eligibility verification;
• Special needs of members that may affect access to and delivery of services (e.g., transportation needs);
• Member’s rights and responsibilities;
• Involvement of member and family in decision-making and service planning;
• Physician/Provider responsibilities;
• Early and Periodic Screening, Diagnostic and Treatment (EPSDT) developmental screening tools;
• Appointment access and availability standards;
• Identification and handling of quality of care/service concerns and serious incidents;
• Grievance and appeals procedures;
• Procedures for reporting fraud, waste and abuse;
• References to Medicaid manuals, memoranda, and other related AHCCCS Complete Care Program documents;
• Billing instructions which are in compliance with AHCCCS encounter data submission requirements;
• Cultural competency, diversity and understanding specialty populations;
• The provider handbook;
• When and how to contact network staff; and
• Provider resources and online capabilities.

Responsibilities Regarding Compliance and Fraud, Waste, and Abuse (FWA) Training

MCC of AZ understands that to fully implement an effective compliance program, adequate staffing and resources must be devoted to training and education for MCC of AZ’s officers; governing body; managers; employees; first tier, downstream and related entities; and other individuals working in the AHCCCS Complete Care Program. All participating staff and organizations must be knowledgeable about MCC of AZ’s compliance program, its written standards of conduct, policies and procedures, and all applicable statutory and regulatory requirements. Compliance expectations are communicated through distribution of standards of conduct and/or compliance policies and procedures to First Tier, Downstream or Related Entity’s (FDR) employees. Distribution will be accomplished through provider guides, business associate agreements or participation manuals, etc.

MCC of AZ maintains compliance and fraud, waste, and abuse (FWA) training programs as required by Centers for Medicare & Medicaid Services (CMS) and provides said educational and training information annually.

Provider’s Responsibilities for General Compliance Program Training and Education

MCC of AZ must ensure that providers have implemented general compliance program training. Providers must ensure that their employees are knowledgeable about all applicable Medicaid requirements related to their job functions. MCC of AZ will conduct audits and other reviews to ensure providers meet compliance program training requirements. Proof of training may be required by MCC of AZ. Providers must be able to demonstrate that employees have completed necessary training. Requirements can be satisfied through online or classroom training. Compliance program training must be completed within 90 days of initial contracting with MCC of AZ and annually thereafter. Examples of
proof of training can include copies of sign-in sheets, employee attestations or electronic certifications for each employee. The attestation verifies that employees have read and received MCC of AZ standards of conduct and compliance program policies and procedures.

Compliance program training should include, but not be limited to:
- Medicaid compliance plan
- General compliance and program integrity
- Fraud, waste, and abuse
- Privacy and security
- Cultural competence

Trainings may occur in the following instances:
- Upon hire and/or appointment to a new job function
- When requirements change
- When employees are found to be noncompliant
- As a corrective action to address a noncompliance issue
- When an employee works in an area implicated in past fraud, waste or abuse.

**General Compliance Training**

General compliance training may include topics such as:
- Identification of the compliance officer
- Description of the compliance program
- Compliance policy and procedures
- Standards of conduct
- Commitment to business ethics and Medicare/Medicaid program requirements
- How to report noncompliance
- Anonymous reporting - 24-hour hotline: 1-800-424-5891
- Non-retaliation for reporting compliance issues
- Disciplinary actions.

**Fraud, Waste and Abuse Training**

FWA training programs may include topics such as:
- Definition of fraud, waste and abuse
- How to identify fraud
- Upcoding
- Unbundling
- Member fraud
- Anonymous reporting
- No retribution rule
- False Claims Act
- Anti-Kickback
- HIPAA/HITECH
- How to report suspected fraud
- Consequences for noncompliance.

MCC of AZ is committed to conducting health plan management administrative services in a manner that is consistent with recognized compliance standards. Additionally, CMS has developed a general compliance and FWA training. The module is available through the CMS Medicare Learning Network at: http://www.cms.gov/MLNProducts.

**Continuing Education for Providers**

Magellan Complete Care of Arizona’s Workforce Development Administrator partners with the Arizona Workforce Development Alliance, a collaboration of all seven AHCCCS Complete Care Plans dedicated to ensuring comprehensive training is available to our shared provider network. Provider training is primarily delivered via online platform as required by AHCCCS, depending on the topics however, other training modalities may be available such as in person training. The Workforce Development Alliance has created an initial training curriculum for all new employees hired into the provider network, as well an annual training curriculum that is mandatory for all integrated health providers. These trainings are made available via the Relias Learning Management System platform.

All integrated and behavioral health providers contracted with Magellan Complete Care of Arizona are required to have access to the Relias Learning Management System (Relias). The Relias platform is contracted to each of the AHCCCS Complete Care plans via the Arizona Association of Health Plans (AzAHP). All agencies must manage and maintain their Relias Learning portal, including:
- Activating and deactivating users
- Enrollment and disenrollment of courses/events.

**Workforce Development**

MCC of AZ is committed to maintaining a provider network that consists of a sufficient number of qualified workers, who serve members in the most interpersonally, clinically, culturally, and technically capable manner possible. In the AHCCCS system, the provider is responsible for acquiring, developing, deploying and managing a qualified and competent workforce.

The provider shall collaborate with MCC of AZ to collect workforce data, analyze workforce trends, strategize and mobilize the human, educational and community resources needed to both attract and prepare qualified workers to deliver contracted services.

**Section 4: Provider Roles and Responsibilities**

**Primary Care Provider (PCP) Role**

The primary care provider (PCP), with the support of the Interdisciplinary Care Team (ICT), is responsible for the overall care of the member. This responsibility includes providing direct care,
referring members for behavioral health, specialty or ancillary care, and coordinating care with the
health plan and these providers for greater clinical outcomes.

A primary care physician (PCP) must be:
- Currently licensed by the State of Arizona;
- A family practice, internal medicine, general practice, OB/GYN, or geriatrics practitioner; or
- A specialist who receives prior approval from MCC of AZ and performs primary care functions in
locations that include, but are not limited to, Federally Qualified Health Centers, Rural Health
Clinics, Health Departments and other similar community clinics; and
- In good standing with the federal and federal/state Medicaid (AHCCCS) program.

PCP Assignment for Non-Dual Eligible Members

MCC of AZ assigns all non-dual eligible members to a PCP at the date of the member’s enrollment.
Members may select a different in-network PCP at any time if they choose. When we call the member
to schedule an initial assessment, we offer the member the opportunity to change their PCP
assignment.

Our experience shows that members often require highly specialized primary care services to address
their complex needs, along with related services and supports. We prioritize PCP assignment with
Federally Qualified Health Centers and Integrated Clinics, so members can receive primary care
services at a location that best meets their needs.

PCP Assignment for Dual Eligible Members

For dual eligible members, we utilize all AHCCCS and Medicare information provided to us to identify
the member’s PCP and enhance our care management efforts. We assist the member in finding or
changing a PCP, including contacting the individual’s Medicare health plan case manager when
necessary.

We work with PCPs to coordinate care and invite the individual to participate in ICTs. We inform dual
eligible members about their right to access Medicare providers, regardless of whether the provider is
in our network, and without having to obtain prior approval.

PCP Medication Management Services

PCPs may provide treat behavioral health conditions within the scope of their practice. PCPs who treat
behavioral health conditions may provide medication management including prescriptions, laboratory
and other diagnostic tests necessary for diagnosis and treatment. Conversely, behavioral health
providers may provide physical health care services if, and when, they are licensed to do so within the
scope of their practice.

Behavioral Health Providers are required to submit demographic data via online portal for
Demographics, Social Determinants and Outcomes on the AHCCCS site at
https://www.azahcccs.gov/PlansProviders/Demographics/.
MCC of AZ urges behavioral health providers to pay attention to communicating with the member’s PCPs at the time of discharge from a behavioral health inpatient stay and/or whenever there is a significant change in the member’s treatment plan, status or symptomology. We recommend faxing the discharge instruction sheet or a letter summarizing the hospital stay, including prescribed behavioral health medications, to the PCP. Any changes that may impact the member’s treatment plan should be noted. The PCP is also encouraged to share changes in the treatment plan and summary of hospitalization with the behavioral health providers.

Fostering a culture of collaboration and cooperation helps maintain a seamless continuum of care between medical and behavioral health, and positively impacts member outcomes. If a member’s medical or behavioral health condition or medication regimen changes, we expect that both PCPs and behavioral health providers will communicate those changes to each other. The ICT and CC/CM are available to help maintain continuity of care and coordination of members with complex needs by supporting communication between behavioral health and medical providers.

The Specialist Role

A specialist is any licensed provider providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain a prior authorization from MCC of AZ before performing specific procedures or when referring members to non-contracted providers.

Please refer to our website at www.MCCofAZ.com for services that require prior authorization. Providers can review prior authorization requirements in the Summary of Benefits or the Evidence of Coverage or call Member/Provider Services at 1-800-424-5891.

The specialist should:

- Communicate the member’s condition and recommendations for treatment or follow-up with the PCP.
- Include in the PCP communication: medical findings, test results assessments, treatment plan and any other pertinent information.
- Understand that, if a specialist needs to refer a member to another provider, the referral should be to another MCC of AZ participating provider.
- Be aware that any referral to a non-participating provider will require a prior authorization from MCC of AZ.

Specialist as PCP

With prior approval from MCC of AZ, a specialist may act as the PCP for a member. This role modification is often beneficial for members who have a life-threatening, degenerative and/or disabling condition, or a disease requiring prolonged specialized medical care. The member’s PCP is responsible for requesting that a specialist assume the PCP function. Such requests should be made to the Utilization/care management department and approved by the medical director.
Provider Rights and Responsibilities

MCC of AZ is dedicated to selecting healthcare professionals, groups, agencies and facilities to provide member care and treatment across a range of covered services as defined by Arizona Health Care Cost Containment System (AHCCCS).

Network Provider Participation

To be a network provider of healthcare services with MCC of AZ under the AHCCCS Complete Care Program, each provider must be credentialed and contracted according to MCC of AZ and AHCCCS standards. All providers are subject to applicable licensing requirements.

As an MCC of AZ network provider of healthcare services, each provider’s responsibilities include:

1. Providing medically necessary covered services to members whose care is managed by MCC of AZ;
2. Following the policies and procedures outlined in this handbook, any applicable supplements and the provider participation agreement(s) as well as AHCCCS policies and regulations;
3. Providing services in accordance with applicable State of AZ and federal laws and licensing and certification bodies. Contracted providers for the AHCCCS Complete Care Program network are required to abide by AHCCCS regulations and manuals and maintain active licensure for their contracted provider type and specialty at each service location. AHCCCS regulations and manuals can be found online at https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html;
4. Providing covered services to MCC of AZ members as outlined in this handbook, applicable supplements and provider agreement(s), as well as AHCCCS policies and regulations without exclusion or restriction on the basis of religious or moral objections.
5. Agreeing to cooperate and participate with all system of care management, quality improvement, outcomes measurement, peer review, and appeal and grievance procedures;
6. Making sure only providers currently credentialed with MCC of AZ render services to MCC of AZ members; and
7. Following MCC of AZ’s credentialing and recredentialing policies and procedures.

MCC of AZ’s responsibility is to:

1. Offer assistance with a provider’s administrative questions during normal business hours, Monday through Friday;
2. Not prohibit, or otherwise restrict health care providers acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider’s patient, for the member’s health status, medical care, or treatment options, including any alternative treatments that may be self-administered, any information the member may need in order to decide among all relevant treatment options, the risks, benefits, and consequences of treatment or nontreatment. And not prohibit nor restrict the member’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.

3. Assist providers in understanding and adhering to our policies and procedures, the payer’s applicable policies and procedures, and other requirements including but not limited to those of the National Committee for Quality Assurance (NCQA); and

4. Maintain a credentialing and recredentialing process to evaluate and select network providers that does not discriminate based on a member’s benefit plan coverage, race, color, creed, religion, gender, sexual orientation, marital status, age, national origin, ancestry, citizenship, physical disability or other status protected by applicable law.

**Continuity and Coordination of Care**

When MCC of AZ receives a newly enrolled member or when a member chooses a different health plan or payer, we make every effort to ensure the member’s care and services continue without disruption. Pregnant women, who transition to MCC of AZ within their last trimester of their expected date of delivery, will be allowed the option of continuing to receive services from their established physician and anticipated delivery site. We collaborate with the member’s PCP and other providers to ensure a seamless continuity of care experience for members who are transferring to or from a different health plan or payer.

Members have the right to continue to receive needed services, even if the member may no longer be able to receive them from the same provider. MCC of AZ strives to provide members with services that are rendered by in-network providers whenever possible; however, care and services will not be denied due to the member having a non-network provider.

Medical supply, equipment and medication providers will be reviewed to ensure continuity of provision, payment and quality.

As soon as MCC of AZ is notified of a newly enrolled member or a member who is disenrolling from a non-MCC of AZ health plan, the MCC of AZ care management team will, at minimum, carry out the following:

1. Obtain appropriate consent from the member to obtain and share demographic and healthcare information.

2. Collaborate with the member, the PCP, other providers, and the receiving or sending health plan to obtain/provide member information related to the respective program assessments and service plan/care plan information. Our care management team will complete the respective health risk assessment, which includes continuity of care questions once the member is enrolled, followed by the use of other branching assessments, ICT meetings, and individualized Service Plan (SP) creation based on member need. The most current assessment and SP will be requested/shared with documentation of same.

3. Assist members in finding in-network providers whenever possible.

4. Assist nursing facility-confined members in exploring the possibility of returning to the community.

5. Scan/enter clinical information, including assessments and SP, and/or other information into MCC of AZ’s clinical documentation system.
Access and Availability Standards

24-Hour Coverage

All providers must provide coverage 24-hours a day / 7-days a week. Regular hours of operation must be clearly defined and communicated to the members, including arranging for on-call and after-hours coverage. Such coverage must consist of an answering service, call forwarding, provider call coverage or other customary means approved by MCC of AZ. The after-hours coverage must be accessible using the medical office’s daytime telephone number and the call must be returned within 30 minutes of the initial contact.

Coverage During Absence

The provider must arrange for coverage of services during absences due to vacation, illness, or other situations that require the provider to be unable to provide services. An MCC of AZ participating provider must provide coverage.

Appointment Wait Time Requirement

The provider must offer appointments to our members in accordance with the State standards to timely access to care and services taking into account the urgency of the need for services and within the timeframes outlined below.

Providers shall ensure that the provider’s office staff is aware of and follows the standards as described in this Provider Handbook. MCC of AZ monitors appointment availability standards of its providers on a routine basis to ensure that the provider’s offices are compliant with these requirements as stipulated below and in accordance with AHCCCS ACOM Policy 417.

Additional information can be found online at: https://tst.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/417_Appointment_Availability_Monitoring_and_Reporting.pdf

General Appointment Wait Time Standards:

- Emergency care services are available same day of member request.

Primary Care Provider Appointments:

- Urgent care appointments are available as expeditiously as the member’s health condition requires, but no later than two (2) business days of request.
- Routine sick care (non-urgent) appointments are available within one week of request.
- Routine care appointments are available within twenty-one (21) calendar days of request. (This standard does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or for routine specialty services like dermatology, allergy care, etc.).
Specialty Provider Appointments:
- Urgent care appointments are available as expeditiously as the member’s health condition requires, but no later than two (2) business days of request.
- Routine care (non-urgent) appointments are available within forty-five (45) calendar days of request.

Dental Provider Appointments:
- Urgent care appointments are available as expeditiously as the member’s health condition requires, but no later than three (3) business days of request.
- Routine care (non-urgent) appointments are available within forty-five (45) calendar days of request.

Maternity Care Provider Appointments:
- Initial prenatal care appointments for enrolled pregnant members shall be provided as follows:
  - First trimester—Within fourteen (14) calendar days of request.
  - Second trimester—Within seven (7) calendar days of request.
  - Third trimester—Within three (3) business days of request.
  - High Risk Pregnancy—As expeditiously as the member’s health condition requires, but no later than within three (3) business days of identification of high risk by MCC of AZ or by maternity care provider or immediately if an emergency exists.
- Emergency care services are available same day of member request.

Behavioral Health Provider Appointments:
- Urgent care appointments are available as expeditiously as the member’s health condition requires, but no later than twenty-four (24) hours of request.
- Routine care (non-urgent) appointments:
  - Initial assessment within seven (7) calendar days of referral or request for service.
  - The first behavioral health service following the initial assessment: as expeditiously as the member’s health condition requires, but no later than twenty-three (23) calendar days after initial assessment.
  - All subsequent behavioral health services: As expeditiously as the member’s health condition requires, but no later than forty-five (45) calendar days from identification of need.

For Psychotropic Medications:
- Assess the urgency of the need immediately.
- Provide an appointment, if clinically indicated, with a behavioral health medical professional within a time frame that ensures the member
  - (a) Does not run out of needed medications
  - (b) Does not decline in his/her behavioral health condition prior to starting medication, but no later than thirty (30) calendar days from the identification of need.

Timely Medical Evaluation
The provider will ensure that all patients have a professional evaluation within one hour of their scheduled appointment time. If a delay is unavoidable, the patient will be informed and provided an alternative.

**Member Panel**

A PCP panel may hold up to 1500 members. MCC of AZ monitors PCP panel size regular to ensure that panels do not go over the 1500 limit. If a PCP wishes to close their panel prior to reaching 1500, the PCP should reach out to their Provider Relations Representative.

PCP and Specialty Care Providers understand the importance of maintaining open accessibility of MCC of AZ members to appropriate and covered health care services and agree to notify MCC of AZ immediately in the event that a PCP or Specialty Care Provider is no longer able to accept new Medicaid members in the practice.

**Member Eligibility/Enrollment/Disenrollment**

The AHCCCS Complete Care Program provides integrated care addressing physical health and behavioral health needs for the following Title XIX/XXI populations:

1. Adults who are not determined to have a Serious Mental Illness excluding DES/DDD enrolled members,
2. Children, including those with special health care needs; excluding DES/DDD and DCS/CMDP enrolled members, and
3. Members determined to have SMI who opt to transfer to the Contractor for the provision of physical health services as outlined in ACOM Policy 442.

**Eligibility Groups**

AHCCCS Complete Care Program is made up of multiple groups, each with distinct eligibility/enrollment requirements and benefits:

**Title XIX**

1. Parents/Caretaker Relatives: Eligible individuals under the 1931 provision of the Social Security Act, with income at or below 106% of the FPL.
2. SSI Cash: Eligible individuals receiving Supplemental Security Income through Federal cash assistance programs under Title XVI of the Social Security Act who are aged, blind or who have a disability and have income at or below 100% of the Federal Benefit Rate (FBR).
3. SSI Medical Assistance Only (SSI MAO) and Related Groups: Eligible individuals who are aged, blind or who have a disability and have household income levels at or below 100% of the FPL.
4. Freedom to Work (Ticket to Work): Eligible individuals under the Title XIX program that extends eligibility to individuals 16 through 64 years old who meet SSI disability criteria, and whose earned income after allowable deductions is at or below 250% of the FPL, and who are not eligible for any other Medicaid program. These members must pay a premium to AHCCCS, depending on income.
5. Pregnant Women: Eligible pregnant women, with income at or below 156% of the FPL,
6. Children: Eligible children with incomes ranging from below 133% to 147% of the FPL, depending on the age of the child.
7. Breast and Cervical Cancer Treatment Program (BCCTP): Eligible individuals under the Title XIX expansion program for women with incomes at or below 250% of the FPL, who are diagnosed with and need treatment for breast and/or cervical cancer or cervical lesions and are not eligible for other Title XIX programs. Eligible members cannot have other creditable health insurance coverage, including Medicare.
8. Title IV-E Foster Care and Adoption Subsidy: Children who are in State foster care or are receiving federally funded adoption subsidy payments.
9. Young Adult Transitional Insurance (YATI): Transitional medical care for individuals age 18 through age 25 who were enrolled in the foster care program under jurisdiction of the Department of Child Safety in Arizona on their 18th birthday
10. Adult Group at or below 106% FPL: Adults aged 19-64, without Medicare, with income at or below 106% of the Federal Poverty Level (Adults <= 106%).
11. Adult Group above 106% FPL: Adults aged 19-64, without Medicare, with income above 106% through 133% of the Federal Poverty Level (Adults > 106%).

Title XXI
1. **KidsCare**: Federal and State Children’s Health Insurance Program (Title XXI – CHIP) administered by AHCCCS. The KidsCare program offers comprehensive medical, preventive, treatment services, and behavioral health care services statewide to eligible children under the age of 19, in households with income between 133% and 200% of the Federal Poverty Level (FPL)

State-Only Transplants
1. Working directly with an MCC of AZ designated Transplant Coordinator, Title XIX individuals, for whom medical necessity for a transplant has been established and who subsequently lose Title XIX eligibility under a category other than Adult Group may become eligible for and select one of two extended eligibility options as specified in A.R.S. §36-2907.10 and A.R.S. §36-2907.11. The extended eligibility is authorized only for those individuals who have met all of the following conditions:
   - The individual has been determined ineligible for Title XIX due to excess income,
   - The individual had been placed on a donor waiting list before eligibility expired, and
   - The individual has entered into a contractual arrangement with the transplant facility to pay the amount of income which is in excess of the eligibility income standards (referred to as transplant share of cost).

2. The following options for extended eligibility are available to these members:
   - Option 1: Extended eligibility is for one 12-month period immediately following the loss of AHCCCS eligibility. The member is eligible for all AHCCCS covered services as long as they continue to be medically eligible for a transplant. If determined medically ineligible for a transplant at any time during the period, eligibility will terminate at the end of the calendar month in which the determination is made.
   - Option 2: The member loses AHCCCS eligibility but maintains transplant candidacy
status as long as medical eligibility for a transplant is maintained. At the time that the transplant is scheduled to be performed the transplant candidate will reapply and will be re-enrolled with his/her previous Contractor to receive all covered transplant services. Option 2-eligible individuals are not eligible for any non-transplant related health care services from AHCCCS

**Disenrollment from Current MCO**

An AHCCCS member may request disenrollment at the following times:
1. For cause at any time, which includes: poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in addressing the member’s care needs;
2. Without cause 90 days after initial enrollment or during the 90 days following notification of enrollment, whichever is later;
3. Without cause at least once every 12 months;
4. Without cause upon reenrollment if a temporary loss of enrollment has caused the member to miss the annual disenrollment period.

When a member requests disenrollment for cause, the member must use the MCC of AZ’s Grievance and Appeal System process for the request and MCC of AZ shall issue a decision no later than 30 days from the date of the request. If MCC of AZ approves the disenrollment, AHCCCS is not required to make a determination.

The effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the member or MCC of AZ files the request.

AHCCCS will disenroll the member from MCC of AZ:
1. When the member becomes ineligible for the AHCCCS program,
2. In certain situations when the member moves out of the Contractor’s service area,
3. When the member changes Contractors during the member’s open enrollment and annual enrollment choice period,
4. When the Contractor does not, because of moral or religious objections, cover the service the member seeks unless the Contractor offered a solution that was accepted by AHCCCS in accordance with the requirements in Section D, Paragraph 9, Scope of Services,
5. When the member is approved for a Contractor change through ACOM Policy 401,
6. When the member is eligible to transition to another AHCCCS Program,
7. When the member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member’s primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk, or for cause.

**Americans with Disabilities Act Requirements**

The provider must ensure that the programs and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities.
Specifically, providers shall comply with the ADA (28 CFR § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 USC § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its members by:

1. Providing flexibility in scheduling to accommodate the needs of members;
2. Providing interpreters or translators for members who are deaf and hard of hearing and those who do not speak English;
3. Ensuring that individuals with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the individual, and include but are not limited to:
   a. Ensuring safe and appropriate physical access to buildings, services and equipment;
   b. Ensuring providers allow extra time for members to dress and undress, transfer to examination tables, and extra time with the practitioner in order to ensure that the individual is fully participating and understands the information; and,

**Prohibition against Discrimination**

In accordance with the provider’s agreement, as a participating provider, the provider is prohibited from discriminating against a member based on color, race, creed, age, gender, sexual orientation, disability, and place of origin, source of payment or type of illness or condition. A contracted provider must provide services to members in the same manner as the provider provides those services to all non-Medicaid members. Additionally, in accordance with 42 CFR § 438.206, the provider must offer hours of operation that are no less than the hours of operation offered to commercial members or other Arizona Medicaid programs, if the provider serves only Medicaid members.

**Second Opinion**

Members have the right to a second medical opinion. If a second opinion cannot be provided from an MCC of AZ Participating Provider, arrangements can be made for a second opinion outside the network. Please contact our Health Services department at 1-800-424-5891 for a prior authorization request.

**Referrals**

Consistent with our model of care, MCC of AZ has established a referral policy which promotes care management, integration, and access. MCC of AZ does not require in-network referrals to be approved by MCC of AZ; however, the provider’s records are expected to include evidence that care has been coordinated among the member’s treating providers.

Specifically, a PCP should refer the member for specialty care and send their National Provider Identification (NPI) number, clinical records and other relevant information to the specialist at the time of the referral, in advance of the appointment. Specialists are expected to provide a written report to the primary care provider after seeing the member.
All providers are expected to maintain medical records that reflect this coordination. If coordination is oral, the providers’ records should include documentation of the communication. We require specialists to include the primary care provider’s NPI number in field 17b on claims for office-based services. Exceptions to this requirement include:

1. Provider is in the same provider group, or has the same tax ID or type II NPI, as the referring physician
2. Services were provided after hours (99050)
3. Emergency services (services performed in place of service 23)
4. Obstetrics/gynecology claims
5. Billing or referring physician is from any of the following:
   a. Federally Qualified Health Center
   b. Urgent Care Center
   c. County Health Departments
6. Self-referrals—members may self-refer for certain services, including:
   a. Family planning services
   b. Annual eye exams by optometrist
   c. Some chiropractic, podiatric, and dermatologic services
   d. Well-woman examinations
   e. Behavioral health services.

For these excluded services, MCC of AZ requests provider assistance in communicating and coordinating the care of members. However, we pay for direct-access services without completion of field 17b.

If medically necessary care cannot be provided by in-network providers, care can be provided by an out-of-network provider. In these exceptional cases, MCC of AZ requires a prior authorization be obtained by the provider.

**Provision of Assessment and Counseling Services**

**Initial Assessment**

The PCP must conduct a health assessment of all new members within 90 days of the effective date of enrollment. The PCP is responsible for notifying MCC of AZ if unable to contact the member to arrange the initial assessment within 90 days.

**Pregnancy**

The MCC of AZ Maternal and Infant program approach includes intensive coordination of care and services provided to pregnant enrollees who have multiple health care needs including pregnancy, substance use, and/or co-occurring and/or co-morbid conditions, and/or lifestyle risks requiring extensive and prolonged use of resources.

MCC of AZ has developed care management structures to manage pregnant and post-partum populations with histories of or current substance use, focusing on planning strategies to facilitate a
recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches. Due to the complexities of pregnancy combined with substance use and related treatments, these pregnant enrollees are considered high risk.

Members who transition to MCC of AZ and become enrolled during their third trimester will be allowed to complete their maternity care with their current AHCCCS registered provider, regardless of the provider’s contractual status with MCC of AZ, to ensure continuity of care.

We expect providers to do the following when caring for this population.

1. **Pregnancy Identification**: The provider is responsible for notifying MCC of AZ when they identify a pregnant member at 1-800-424-5891. If notification is faxed, it should include the member’s name, ID number, and due date. Pregnancy notifications can be faxed to our Maternity Team at 888-656-7541.

2. **Referrals to Healthy Start and WIC**: The MCC of AZ care coordinator will make referrals to and coordinate care with the Health Start program, immunization programs, and referral to the Special Supplemental Nutrition Program for Women, Infants and Children.

3. **HIV Counseling for Pregnant Women**: The provider agrees to provide counseling and offer the recommended anti-retroviral regimen to all pregnant women who are HIV-positive and to refer them and their infants to Healthy Start programs, regardless of their screening scores.

4. **Hepatitis B Screening for Pregnant Women**: The provider agrees to offer screening for Hepatitis B surface antigen to all women receiving prenatal care. If they test positive, the provider agrees to refer them to Healthy Start regardless of their screening score and to provide Hepatitis B Immune Globulin and the Hepatitis B vaccine series to children born to such mothers.

**Network Development**

MCC of AZ is dedicated to recruiting and retaining individual providers, groups, agencies and facilities with the healthcare credentials to provide care and treatment across a range of products and services to members in the AHCCCS Complete Care Program statewide.

**Types of Providers**

MCC of AZ refers members to credentialed and contracted providers in private practice, practitioners in a group practice, and provider organizations including facilities and agencies.

MCC of AZ refers members to credentialed and contracted providers in the following categories:

- **Individual Practitioner**: A professional provider who is licensed by the Arizona Department of Health Professions and who provides healthcare services and bills under his or her own Taxpayer Identification Number. Individual practitioners must meet MCC of AZ credentialing criteria (see the next section on Credentialing and Recredentialing) and have a fully executed provider agreement with MCC of AZ.

- **Group Practice**: A provider practice contracted with MCC of AZ as a group entity, and as such,
bills as a group entity for the services performed by its MCC of AZ-credentialed practitioners. Practitioners affiliated with the group must complete the individual credentialing process, and the group must have at least one active/credentialed group member in order to be eligible to receive referrals from MCC of AZ.

- **Organization:** A facility or agency licensed and/or certified in Arizona to provide healthcare or ancillary services and have a fully executed provider agreement with MCC of AZ
- **Ancillary provider:** A freestanding or facility-based provider with a specialty to supplement the professional provider and facility network.

A Provider’s responsibility is to:

- Provide MCC of AZ with a complete Form W-9 for the contracting entity to facilitate contracting and claims processing;
- Notify MCC of AZ and complete a new Form W-9 if the contracted entity changes;
- Notify MCC of AZ of any changes to the list of practitioners in the provider’s group within 10 business days;
- Notify MCC of AZ of changes in the provider’s service location, mailing and/or financial address information, using the contact methods described in Section 3: Provider Services;
- Notify AHCCCS of any changes in the provider’s service location or mailing address, online at: [https://www.azahcccs.gov/PlansProviders/CurrentProviders/AHCCCSonline.html](https://www.azahcccs.gov/PlansProviders/CurrentProviders/AHCCCSonline.html); and
- Adhere to credentialing policies outlined in this manual.

MCC of AZ’s responsibility is to:

- Review providers and prospective providers for network participation without regard for race, color, creed, religion, gender, sexual orientation, marital status, age, ethnic/national identity, ancestry, citizenship, physical disability, disabled veteran, or veteran of the Vietnam Era status, or other status protected by applicable law;
- Develop and implement recruitment activities to solicit quality healthcare providers to participate in the AHCCCS Complete Care Program;
- Not make credentialing or recredentialing decisions based solely on the type of procedure or patient type in which the practitioner specializes; selection and retention criteria do not discriminate against providers who serve high-risk populations or specialize in the treatment of costly conditions; and

**Credentialing, Recredentialing and Organizational Assessment**

MCC of AZ is committed to promoting quality care for its members. In support of this commitment, practitioners and organizational (facility or agency) providers must meet and maintain a minimum set of credentials in order to be able to provide services to members. MCC of AZ credentials practitioners and assesses organizational providers in accordance with criteria established by MCC of AZ and in compliance with applicable regulatory requirements and nationally recognized accreditation standards.

Magellan credentials acute, primary, behavioral and substance use providers in compliance with federal standards at 42 CFR § 438.214, the most recent NCQA standards, and state standards.
MCC of AZ partners with the Arizona Association of Health Plans (AzAHP) to ensure all primary source verification of credentialing is completed. Practitioners are required to utilize the online universal credentialing process offered by the Council for Affordable Quality Healthcare (CAQH). Providers are reminded to give MCC of AZ access to the provider’s application information, to review and attest to its accuracy and completeness, and to call the CAQH Help Desk at 1-888-599-1771 or email providerhelp@proview.caqh.org for answers to any questions related to the CAQH application or website.

Throughout the credentialing process, providers have the right to review information submitted to support their application for credentialing, and to correct erroneous information. Please note: MCC of AZ is not required to make certain information available including references, recommendations and peer review protected information. Corrections should be submitted within 30 days of notification to the Magellan Provider Network department at MCCAZProvider@MagellanHealth.com.

Upon request, providers have the right receive the status of their credentialing/recredentialing application. Requests for application status can be directed to MCC of AZ’s Provider Services staff at MCCAZProvider@MagellanHealth.com.

MCC of AZ’s credentialing committee utilizes a peer review process to evaluate appropriateness for inclusion in the provider network. The credentialing committee reviews provider credentialing information, including, but not limited to:

- Licensure for independent practice that is unrestricted, unencumbered, and without other terms, conditions and/or limitations, including probationary status through an appropriate licensing agency;
- Board certification, or residency training, or professional education, where applicable;
- Hospital privileges in good standing or alternate admitting arrangements, where applicable;
- Current valid federal Drug Enforcement Administration (DEA) certificate and state Controlled Dangerous Substance (CDS) registration (as applicable);
- State and federal exclusion/sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General) and applicable state Medicaid Exclusions List(s).
- Current liability insurance in compliance with minimum limits set by MCC of AZ’s provider agreement;
- Malpractice settlements made on behalf of the provider; and
- Member need and access, subject to applicable state laws.

The credentialing committee reviews organizational provider assessment information, including, but not limited to:

- Confirmation of good standing with state and federal regulatory bodies, typically evidenced via licensure.
- Appropriate current accreditation from an MCC of AZ-accepted accrediting body.
- If not accredited, successfully complete a Magellan-performed site visit upon request; or
- If Magellan has approved the state licensure or Centers for Medicare & Medicaid Services (CMS) criteria as meeting standards, a CMS or state licensing/certification site review may be substituted in lieu of a site visit by MCC of AZ.
• Compliance with MCC of AZ’s minimum requirements for professional and general liability insurance coverage, as outlined in the Provider Participation Agreement.
• State and federal exclusion/sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General) and applicable state Medicaid Exclusions List(s).

Organizational providers must attest to their compliance with Provider Participation Requirements as defined in applicable Arizona Health Care Cost Containment System (AHCCCS) Provider Manual(s).

MCC of AZ will notify providers of the outcome of the initial credentialing process. MCC of AZ also may notify providers of successful recredentialing; however, if no notification is received, successful recredentialing can be assumed.

MCC of AZ network providers are required to undergo recredentialing/reassessment at least every 36-months. Recredentialing review includes evaluation of provider performance in the MCC of AZ network including, but not limited to: clinical care, service and outcomes, member service, and adherence to MCC of AZ policies and procedures.

Appealing Decisions that Affect Network Participation Status

Participating providers have a right to appeal MCC of AZ quality review actions that are based on issues of quality of care or service that affect the conditions of the provider’s participation in the network. Customer requirements and applicable federal and state laws may impact the appeals process; therefore, MCC of AZ outlines the process for appeal in the written notification that details the changes in the conditions of the provider’s participation.

MCC of AZ offers participating providers an opportunity for a formal appeal hearing when MCC of AZ takes action to terminate network participation due to quality concerns. Providers receive notice in writing of the action. Specifics of the appeal and notification processes are subject to customer, state or federal requirements. Notification includes: the reason(s) for the action, the right to request an appeal, the process to initiate a request for appeal, summary of the appeal process, and that such request must be made within 33 calendar days from the date of MCC of AZ’s written notification.

Providers must follow the instructions outlined in the notification letter if requesting an appeal. Providers may participate in the appeal hearing either telephonically or in-person and may be represented by an attorney or another person of the provider’s choice. Providers are notified in writing of the appeal decision within 30 calendar days of completion of the formal appeal hearing.

Providers whose network participation is terminated due to license sanctions or disciplinary action, or exclusion from participation in Medicare, Medicaid or other federal healthcare programs, no longer meet MCC of AZ’s network participation criteria and are offered an internal administrative review unless otherwise required by customer, state or federal requirements. Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to an internal administrative review. Providers are permitted no more than 33 calendar days from the date of MCC of AZ’s written notification to request an administrative review if they disagree with the reasons for the termination. The provider is notified in writing of the outcome within 30 calendar days of the administrative review.
Termination from the Network

MCC of AZ’s philosophy is to maintain a diverse, quality network of providers to meet the needs of our members. In addition, we believe providers should advocate on behalf of members in obtaining care. Network providers will not be terminated from the network for any of the following reasons:

- Provider advocating on behalf of a member;
- Provider filing a complaint against MCC of AZ;
- Provider appealing a decision of MCC of AZ;
- Provider requesting a review of or challenging a termination decision of MCC of AZ;
- Provider has a practice that includes a substantial number of patients with expensive medical conditions;
- Objection to the provision of or refusal to provide a health care service on moral or religious grounds; or
- Any refusal to refer a patient for health care services when the refusal of the provider is based on moral or religious grounds and the provider has made adequate information available to the members in the provider’s practice.

Network providers may be terminated from the network for the following reasons, including, but not limited to:

- Failure to submit materials for recredentialing within required timeframes;
- Any restriction, probation, suspension, revocation or surrender, or condition, limitation or qualification of the provider’s license or accreditation;
- The provider is convicted of a criminal offense, including any offense related to involvement in any Medicare or Medicaid program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any federally or state-funded healthcare programs;
- Quality of care or quality of service concerns as determined by MCC of AZ;
- Failure to meet or maintain MCC of AZ’s credentialing criteria, including any insurance requirements;
- Failure to comply with any other obligations outlined in the MCC of AZ Provider Participation Agreement, including those within this provider handbook;
- Provider ceases to be in compliance with applicable laws, a violation of which would materially impact the ability of the provider to conduct business and meet obligations;
- Provider-initiated termination; or
- There is no current business need within the provider’s geographic area, subject to applicable state and federal law.

MCC of AZ will make a good faith effort to provide members written notice of termination of a contracted provider at least 15 calendar days of the termination effective date to all members who regularly use the provider’s services. This will include all members who are in a course of active treatment with the provider, assigned to the provider as a PCP, or have prior authorized care with the provider. MCC of AZ will allow the members in active treatment to continue to receive care from the provider until the course of treatment is completed, another provider is selected, or during the next
open enrollment period—not to exceed six months after the termination date. Pregnant members are permitted to continue the course of treatment until completion of postpartum care.

If a provider is terminated for cause, notification will occur as soon as practicable (not to exceed five business days, but immediately if the member is in imminent danger) and the following continuity of care provisions do not apply.

In the event of a contract termination by either party, the provider will continue to render necessary care to MCC of AZ member(s) consistent with contractual or legal obligations. A terminated provider can refuse to provide care to a member who is abusive or noncompliant. All services provided under the continuity of care provisions will be reimbursed at the rates included in the last active contract.

If a provider chooses to terminate a contract with MCC of AZ, the provider should:

1. Review the terms of the Provider Agreement.
2. Submit a notice of termination in writing, in accordance with the terms of the provider agreement, to:
   Magellan Complete Care of Arizona
   Attn: Network Department
   4801 E. Washington St., Suite 225, Phoenix, AZ 85034
3. Group provider practices shall immediately notify MCC of AZ, in writing, in the event that a healthcare professional ceases to be affiliated with the provider group for any reason. The group practice must ensure that members under the care of the terminating provider are transferred to another group provider who is credentialed with MCC of AZ.
4. If a provider is a group provider practicing under a group agreement and the provider terminates affiliation with the group, MCC of AZ expects the provider to facilitate transition of members in their care to another group provider who is credentialed with MCC of AZ.

Section 5: Risk Management/Serious Incident Reporting

Serious Incident Reporting

Our Serious incidents shall include but not be limited to the following incidents when they occur in settings such as nursing facilities, inpatient behavioral health, or home and community-based services settings (adult day care center, a member’s home, or any other community-based setting) in the provision of care by MCC of AZ staff and contract providers.

- Unexpected death of an MCC of AZ member;
- Suspected physical or mental abuse of an MCC of AZ member;
- Theft against an MCC of AZ member;
- Financial exploitation of an MCC of AZ member;
- Severe injury sustained by an MCC of AZ member;
- Fall of an MCC of AZ member;
- Medication error involving an MCC of AZ member;
- Sexual abuse and/or suspected sexual abuse of an MCC of AZ member; and
- Abuse and neglect and/or suspected abuse and neglect of an MCC of AZ member.

Providers must report Serious Incidents and actions to MCC of AZ:
- Within 24-hours* of the Provider’s discovery/awareness of the serious incident.
- If the initial report is submitted verbally, a written MCC of AZ Serious Incident Report form must be submitted to MCC of AZ within 48 hours*.
- Reports may be submitted verbally by calling 1-800-424-5891, by secure e-mail to MCCAZQOC@MagellanHealth.com, or by fax at 1-888-656-7510, 24 hours/day, 365 days/year.

Additional requirements:
1. Immediately, and not to exceed 24-hours*, the Provider must take steps to prevent further harm to any and all members and respond to any emergency needs of members.
2. Providers must conduct an internal serious incident investigation and submit a report on the investigation as soon as possible, and no later than thirty (30) days after the date of the incident. MCC of AZ will review the provider’s report and follow up with the provider as necessary to ensure that an appropriate investigation was conducted, and corrective actions were implemented within applicable timeframes.
3. Providers are required to cooperate with any investigation conducted by MCC of AZ or outside agencies (e.g., AHCCCS, Adult Protective Services, and law enforcement).

Issues related to non-compliance may be escalated to the MCC of AZ Provider Credentialing Committee for evaluation of the provider’s continued credentialing eligibility.

Providers may access the current version of the MCC of AZ Serious Incident Report form on the company website at www.MCCofAZ.com. Providers may also obtain a copy of the form by calling 1-800-424-5891. *Note: 24- and 48-hour timeframes equal actual clock hours - NOT business day(s).

**Identifying and Reporting Abuse, Neglect and Exploitation**

The Arizona Abuse Hotline serves as the central reporting center for allegations of abuse, neglect, and/or exploitation for all children and vulnerable adults in Arizona. As a contracted provider, providers are required to report suspected or known abuse, neglect, or exploitation immediately by calling one of the following hotline numbers:

*Arizona Department of Child Safety*
888-767-2445 (888-SOS-CHILD)

*Arizona Adult Protective Services*
877-767-2385 (877-SOS-ADULT)

The hotlines will accept a report when there is reasonable cause to suspect that:
1. A child who can be located in Arizona or is temporarily out of the state but expected to return in the immediate future, has been harmed or is believed to be
threatened with harm from a person responsible for the care of the child.

2. Any vulnerable adult who is a resident of Arizona or currently located in Arizona:
   a. Is believed to have been abused or neglected by a caregiver in Arizona
   b. Is suffering from the ill effects of neglect by self and is in need of service
   c. Is being exploited by any person who stands in a position of trust or confidence, or any person who knows or should know that a vulnerable adult lacks capacity to consent, and contains or uses, or endeavors to obtain or use, their funds, assets or property.

Duty to Report

All providers regardless of their specialty or area of practice, have a duty to warn under A.R.S. §36-517.02 and to protect others against a member’s potential danger to self and/or danger to others. This statute supplements other immunities of behavioral health providers or mental health treatment agencies that are specified in law. With respect to the legal liability of a behavioral health provider, A.R.S. §36-517.02 provides that no cause of action or legal liability may be imposed against a behavioral health provider for breaching a duty to prevent harm to a person caused by a patient unless both of the following occur:

1. The patient has communicated to the mental health provider an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat, and
2. The mental health provider fails to take reasonable precautions.

This statute also provides immunity from liability when the behavioral health provider discloses confidential communications by or relating to a patient under certain circumstances: The behavioral health provider has no liability resulting from disclosing a confidential communication made by or relating to a patient when a patient has explicitly threatened to cause serious harm to a person or when the behavioral health provider reasonably concludes that a patient is likely to cause harm, and the behavioral health provider discloses a confidential communication made by or relating to the patient to reduce the risk of harm.

When a provider determines, or under applicable professional standards, reasonably should have determined, that a patient poses a serious danger to self or others, the provider has a duty to exercise care to protect others against imminent danger of a patient harming him/herself or others. The foreseeable victim need not be specifically identified by the member but may be someone who would be the most likely victim of the member’s dangerous conduct.

The responsibility of behavioral health provider to take reasonable precautions to prevent harm threatened by a member may include any of the following:

- Communicating, when possible, the threat to all identifiable victims,
- Notifying a law enforcement agency in the vicinity where the member or any potential victim resides,
- Taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate, and in accordance with AMPM Policy 320-U, or
• Taking any other precautions that a reasonable and prudent provider would take under the circumstances.

Section 6: Compliance/Program Integrity

Fraud, Waste and Abuse Responsibilities

MCC of AZ does not tolerate fraud, waste or abuse, by providers, members or staff. Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. MCC of AZ’s programs are wide-ranging and multi-faceted, focusing on prevention, detection and investigation of all types of fraud, waste and abuse in government programs and private insurance.

MCC of AZ’s expectation is that the provider will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting MCC of AZ access to member treatment records and allowing MCC of AZ to conduct on-site audits or reviews, including on-demand reviews in cases of emergent and urgent complaints. MCC of AZ also may interview members as part of an audit or review, without notifying the provider.

Our policies in this area reflect that both MCC of AZ and providers are subject to federal and state laws designed to prevent fraud and abuse in government programs (e.g., Medicare and Medicaid), federally funded contracts and private insurance. MCC of AZ complies with all applicable laws, including the Federal False Claims Act, state false claims laws (see State-Specific Information on our provider website), applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state-funded programs, federally funded programs (e.g., Medicare Advantage, SCHIP and Medicaid) and other payers.

The provider’s responsibility is to:
• Comply with all laws and MCC of AZ requirements
• Comply with all federal and state laws regarding fraud, waste and abuse
• Provide and bill only for medically necessary services that are delivered to members in accordance with MCC of AZ’s policies and procedures and applicable regulations
• Ensure that all claims submissions are accurate
• Notify MCC of AZ immediately of any suspension, revocation, condition, limitation, qualification or other restriction on the provider’s license, or upon initiation of any investigation or action that could reasonably lead to a restriction on the provider’s license, or the loss of any certification or permit by any federal authority, or by any state in which the provider is authorized to provide healthcare services
• Cooperate with MCC of AZ’s audits and reviews. MCC of AZ’s expectation is that each provider will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting Magellan access to member treatment records and allowing MCC of AZ to conduct on-site audits or reviews. MCC of AZ also may interview members as part of an audit or review, without notifying providers.
Definitions—Fraud, Waste and Abuse

1. **Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

2. **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary costs to federally and/ or state-funded healthcare programs, and other payers.

3. **Waste** means over-utilization of services or other practices that result in unnecessary costs.

**Examples of Potential Fraud, Waste and Abuse (including, but not limited to):**

1. Billing for services or procedures that have not been performed or have been performed by others;
2. Submitting false or misleading information about services performed;
3. Misrepresenting the services performed (e.g., up-coding to increase reimbursement);
4. Retaining and failing to refund and report overpayments (e.g., if the provider’s claim was overpaid, the provider is required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion);
5. A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act;
6. Providing or ordering medically unnecessary services and tests based on financial gain;
7. An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day;
8. An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day;
9. Providing services over the telephone or internet and billing using face-to-face codes;
10. Providing services in a method that conflicts with regulatory requirements;
11. Treating all patients weekly regardless of medical necessity;
12. Routinely maxing out of members’ benefits or authorizations regardless of whether or not the services are medically necessary;
13. Inserting a diagnosis code not obtained from a physician or other authorized individual;
14. Violating another law (e.g., a claim is submitted appropriately but the service was
the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals);
15. Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs; and/or
16. Lying about credentials, such as degree and licensure information.

**Reporting Suspected Fraud, Waste or Abuse**

MCC of AZ expects providers and their staff and agents to report any suspected cases of fraud, waste or abuse. MCC of AZ will not retaliate against the provider if he/ she informs MCC of AZ, the federal government, state government or any other regulatory agency with oversight authority of any suspected cases of fraud, waste or abuse.

MCC of AZ has the responsibility to assess the merits of and report any allegation of fraud, waste, or abuse. MCC of AZ will coordinate and fully cooperate and assist Arizona Health Care Cost Containment System and any state or federal agency in identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste. MCC of AZ will provide records and information, as requested.

**Reporting to Magellan Complete Care of Arizona**

Reports of provider fraud, abuse or waste should be made to MCC of AZ via one of the following methods:
- Special Investigations Unit Hotline: 1-800-755-0850
- Special Investigations Unit Email: SIU@MagellanHealth.com
- Corporate Compliance Hotline: 1-800-915-2108
- Compliance Email: Compliance@MagellanHealth.com

Reports to the Corporate Compliance Hotline may be made 24-hours a day / 7-days a week. The hotline is maintained by an outside vendor. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

To report suspected recipient fraud to Arizona Health Care Cost Containment System, contact:

**Provider Fraud**
- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

**Member Fraud**
- In Maricopa County: 602-417-4193
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

If providers have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS Office of Inspector General (OIG).
- Email: AHCCCSFraud@azahcccs.gov
- Website: [https://www.azahcccs.gov/Fraud/ReportFraud/](https://www.azahcccs.gov/Fraud/ReportFraud/)
Confidentiality/HIPAA

Confidentiality is a key consideration of MCC of AZ’s operations and processes. MCC of AZ has developed policies and procedures that describe how we protect the privacy of confidential health information that is used or disclosed by our company, consistent with provisions of the Health Insurance Portability and Accountability Act (HIPAA).

Some of the ways that MCC of AZ protects access to protected health information (PHI) include:

- Utilizing strict guidelines for how member information may be used and disclosed;
- Requiring all employees to understand and adhere to the processes for responding to any unauthorized uses or disclosures of confidential member information;
- Requiring employees and visitors to sign statements concerning confidentiality of information, release of information, and communication requirements;
- Making sure that the Authorization to Use or Disclose Protected Health Information form we use complies with applicable state and federal laws;
- Monitoring provider adherence to privacy policies and procedures through site visits, quality reviews and routine contact;
- Monitoring member feedback through the complaint process, member satisfaction survey results, and internal quality audits;
- Complying with applicable state and federal laws and accrediting organization standards;
- Establishing and maintaining procedures for timely and appropriate responses to member rights issues, including but not limited to requests for confidential communications, access to protected health information, amendments to protected health information, and accounting of disclosures;
- Implementing technical barriers and protections to systems by requiring authorizations and passwords to access systems containing confidential information; and
- Requiring employees to use the minimum necessary information for routine uses and disclosures of health information.

As an MCC of AZ provider, the provider’s responsibility is to:

- Comply with applicable state and federal laws and regulations that pertain to member privacy and confidentiality of PHI;
- Use only HIPAA-compliant authorization forms and consent for treatment forms that comply with applicable state and federal laws*;
- Use only secure email and secure messaging when requesting member PHI;
- Establish office procedures regarding communication with members (e.g., telephone and cellphone use, and written, fax and internet communication);
- Establish a process that allows members to access their records in a confidential manner;
- Establish systems that safeguard member PHI at the provider location and anywhere PHI may be stored;
- Maintain the confidentiality of a minor’s consultation, examination, and treatment for a sexually transmissible disease, in accordance with Arizona laws and regulations;
- Participate in and comply with Magellan’s quality review, site visit process and contract obligations.
MCC of AZ’s responsibility is to:

- Collaborate with providers to protect member privacy and confidentiality;
- Request the minimum necessary PHI to perform needed healthcare operations and payment activities;
- Only respond to electronic (internet) requests for PHI through secure email channels; and
- Only provide PHI upon receipt of a valid authorization of use and disclosure form.

* When the HIPAA Privacy Rule is applicable, it allows Magellan and our providers to use and disclose PHI for treatment, payment and healthcare operations activities.

**HIPAA Transaction Standards**

To address HIPAA and its regulations regarding standard interface between healthcare organizations and providers, we send and receive HIPAA Standard Transactions. HIPAA Standard Transactions define the required formats for encounter data, referrals, authorizations, enrollment and claims data between members, providers, healthcare organizations and others that require this information.

As an MCC of AZ provider, the provider’s responsibility is to:

- Comply with HIPAA Standard Transactions requirements for all covered transactions submitted to MCC of AZ;
- Use the provider’s National Provider Identifier (NPI) on all electronic transactions submitted to MCC of AZ; and
- Use current standard procedure, diagnostic, and revenue codes on all claims transactions submitted to MCC of AZ.

MCC of AZ’s responsibility is to:

- Be able to receive and send the HIPAA Standard Transactions;
- Use clearinghouses or online services to provide the administrative functions required to establish HIPAA-compliant electronic communications; and
- Inform providers about how to contact us to initiate electronic communications.

**HIPAA Standard Code Sets**

HIPAA specifically identifies the following procedure and diagnostic code sets as standard:

1. ICD-10-CM
2. CPT®-4 and modifiers
3. HCPCS Level II and modifiers
4. Revenue codes
5. Place of Service codes
6. Type of Bill codes.

MCC of AZ requires the use of these standard code sets (and successor code sets when published, upon their effective dates) on both paper and electronic claim transactions.
As an MCC of AZ provider, the provider responsibility is to:

- Make sure all electronic information submitted to MCC of AZ contains current standard codes in accordance with HIPAA requirements;
- Apply for and use a National Provider Identifier (NPI) on all claims submitted to MCC of AZ;
- Obtain a current copy of MCC of AZ’s Universal Services List (USL) for standard codes for most facility and program services;
- Use current standard codes, and successor code sets on their effective date, on electronic and paper claims submitted to MCC of AZ.

To comply with HIPAA, MCC of AZ will:

- Recognize standard procedure and diagnostic codes and communicate those standards to providers;
- Be compliant with HIPAA’s standard coding requirements;
- Accept only compliant codes in covered electronic transactions;
- Accept only covered electronic transactions that include an NPI;
- Share the provider’s NPI with health plans with which we coordinate the provider’s HIPAA-standard transactions;
- Advise providers on how to contact us to initiate electronic communications;
- Provide notice on remittance vouchers for services submitted with invalid codes; and
- Maintain information about HIPAA code sets on our website.

**Encounter Validation Studies**

The purpose of encounter validation studies is comparing utilization information from a clinical record or other documented source with submitted encounter data. Analysis of records validates or confirms that a covered service is encountered timely, correctly and is complete.

The following criteria used in encounter validation studies include correctness, timely and omission of encounters, as well as, encountering for services not documented in the medical record.

- **Timeliness** - The time between the date of service and the date that the encounter is received;
- **Correctness**: Correct encounters contain a complete and accurate description of a covered health service provided to a person;
- **Omission**: Provider record submitted indicates a service was provided but an encounter was not submitted.

**Provider Requirements**

MCC of AZ providers must deliver covered services in accordance with [AHCCCS Covered Health Services Guide](#) and [AHCCCS Complete Care Contract Section D](#).

The Centers for Medicare and Medicaid Services (CMS) requires the Arizona Health Care Cost Containment System (AHCCCS) to conduct encounter validation studies as a condition for receiving Federal Medicaid funding. AHCCCS requires the AHCCCS Complete Care Contractor to conduct encounter validation studies of their providers. The effectiveness of AHCCCS’s encounter collection
actions are based on the results of encounter data validation studies. This Handbook section provides Contractors with the methodology and statistical formulae used in Encounter Data Validation.

For guidelines and further information on validation of encounters, see AHCCCS Encounter Data Validation Technical Document, the AHCCCS Encounter Manual and the AHCCCS Demographic and Outcomes Data Set User Guide.

MCC of AZ conducts encounter validation studies for its subcontracted providers. Encounters are reviewed to verify that documentation and claims are consistent with requirements in the AHCCCS Covered Health Services Guide, the Provider Agreement, the Provider Handbook and applicable State guidelines. Technical assistance and stated corrections to encounter submission for subcontracted providers may include, but are not limited to, changes to documentation, increased frequency of validation and monitoring and training on an ad hoc basis.

Claiming patterns are reviewed by the Vendor Management department using a claims stratification process. Stratification of data including number of units, service code type, and/or claim reimbursement can identify claim outliers that are then reviewed for accuracy.

The total number of encounters/claims are determined based on the total number of encounters/claims submitted. Audit results for individuals not found to be in full compliance (95%) are assigned as follows:

1. **Error rate of 6%-25%**: The provider needs correction. The provider will correct and rebill, or otherwise have encounters with errors voided/replaced. Technical assistance will be provided as needed.

2. **Error rate of 26%-49%**: The provider needs improvement. A formal technical assistance report is issued identifying focused technical assistance needs. Formal training may accompany the technical assistance report. The provider will be audited again within six (6) months.

3. **Error rate of 50% or greater**: There is a mandatory technical assistance report along with mandatory focused training, and performance improvement activities. The provider will be audited quarterly until acceptable performance is achieved.

Because random samples are selected by member rather than by claim, a single error (such as a diagnosis code error) may replicate across every sampled claim for that member when it would not have appeared in a random sample, compromising statistical reliability. To control for this, on a quarterly basis, MCC of AZ uses the Data Validation Findings Summary which is produced as a deliverable to AHCCCS. This deliverable measures the overall encounter error rate for MCC of AZ.

1. If the overall Data Validation Findings Summary indicates an overall encounter validation error rate above 5%, MCC of AZ performs a root-cause analysis and will conduct additional technical assistance and/or performance improvement with providers substantially contributing to the error rate. This ensures conformance to a 95% minimum performance standard.

2. Encounters that are able to be corrected must be corrected within the timeframe described below.
a. Encounter validation errors must be corrected by the provider within 15 calendar days after the date of the data validation audit findings letter. Encounter/claim adjustments necessary to correct data validation results must be processed by the provider through MCC of AZ’s claim system with the void and/or void/replace transaction.

b. Electronic replacement claims must use frequency code 7. Electronic void claims must use frequency code 8. Providers billing paper claims must submit a replacement claim with the corrected information, including the initial claim’s ICN number in field #19 for CMS 1500 claims and field #64 for UB04 claims.

c. For paper claims, MCC of AZ will void and recoup claims internally if the claim cannot be rebilled.

d. MCC of AZ will notify the provider in writing when adjustment transactions are complete. The provider will submit final corrected claims and any omissions within 21 days after the date of the audit findings letter. If a provider does not correct data validation errors within this time frame, MCC of AZ may consider a sanction for each incorrect claim, day of delay, or other sanction at its discretion and pursuant to the Provider Agreement and Provider Handbook.

If fraud or abuse is suspected at any time during encounter validation, the suspected fraud or abuse is reported to the MCC of AZ Corporate Compliance Officer. A provider may be considered to be submitting fraudulent or abusive claims if Magellan Complete Care has given the provider written feedback or technical assistance about a pattern of errors and the provider continues the same practice after feedback is received. In order to ensure appropriate technical assistance is given, MCC of AZ Encounter Data Validation studies are aggregated for the statewide error report.

Any data validation findings that indicate suspected fraud and/or program abuse must be reported to the AHCCCS Office of Inspector General as required. A determination of overpayment as the result of a data validation study will result in a recovery of the related funds/voiding of related encounters as required, pursuant to the Affordable Care Act.

**AHCCCS ENCOUNTER DATA VALIDATION**

AHCCCS performs periodic data validation studies. All AHCCCS contractors and subcontractors are contractually required to participate in this process. In addition, the data validation studies enable AHCCCS to monitor and improve the quality of encounter data. Information regarding AHCCCS Encounter Data Validation Study procedures can be found in the [AHCCCS Contractor Operation Manual (ACOM)](https://www.ahcccs.gov/).  

Written preliminary results of all Title XIX/XXI encounter validation studies are sent to AHCCCS for review and comment. AHCCCS will review results and documentation that may affect the final calculation of error rates and sanction.
**Provider Promotional, Marketing and Outreach Activities**

All promotional, marketing and outreach activities must be conducted in a responsible manner so that potential members receive the most accurate and complete information possible to allow the member to make an informed decision.

Provider promotional, marketing and outreach activities must comply with all relevant federal and state laws, and provisions in the MCC of AZ contract (Section 11.12) related to marketing requirements. This includes, when applicable, the anti-kickback statute, and civil monetary penalty prohibiting inducements to members [42 CFR §438.104].

Provider promotional, marketing and outreach activities targeting prospective members may not:

- Engage in any informational or marketing activities which could mislead, confuse, or defraud prospective members or misrepresent the Department (42 CFR§438.104).
- Directly or indirectly, conducting door-to-door, telephonic, or other “cold call” marketing of enrollment at residences and provider sites (42 CFR § 438.104).
- Participate in any mailings on behalf of a health plan without being processed through the AHCCCS.
- Conduct unsolicited personal/individual appointments to influence enrollment in a health plan.
- Offer financial incentive, reward, gift, or opportunity to prospective members as an inducement to enroll in a health plan.
- Conduct continuous, periodic activities to the same prospective member, e.g., monthly or quarterly giveaways, as an inducement to enroll in a health plan.
- Assert that prospective members must enroll with a health plan to keep from losing benefits.

**Presence on Federal and State Exclusion List**

MCC of AZ is required to review the sanctions and exclusions prior to entering into a contract with a provider and on a monthly basis thereafter. As a contracted provider, each provider is also required to perform monthly checks of state and federal exclusion and sanction lists to ensure the provider does not employ staff, or utilize contractors or individuals with ownership interest, as per the provider’s contract with MCC of AZ. MCC of AZ and its contracted providers are prohibited from employing or contracting with any individual who is excluded from participation in any federal or state healthcare or contracting programs.

Providers identified as being excluded will be denied participation or terminated from participation in MCC of AZ and will not be considered for participation or reinstatement until the exclusion is lifted and reinstatement is verified. Reinstatement is not automatic. A new application must be submitted, and the credentialing process begun again.

Excluded providers may not receive any payments from federal or state healthcare programs. MCC of AZ will immediately stop all payments to providers upon confirmation of provider’s sanction or exclusion and will withhold payment until such time that an investigation is complete and MCC of AZ is allowed by state and federal regulators to release payment.
Providers must ensure that no management staff, individuals with ownership interest in the provider’s practice or other persons who have been excluded by Medicaid, Medicare or other federal or state health care programs are employed or subcontracted by the provider. Providers must immediately notify MCC of AZ of any imposed sanction or adverse action taken against the provider, any individual with ownership interest in the practice, any member of their staff or subcontractor.

Providers must disclose to MCC of AZ whether they, a staff practitioner or subcontractor have any prior violation, fine, suspension, termination or other administrative action as a result of violation of any of the following:

- Medicare or Medicaid laws,
- The rules or regulations of any state where the provider practices,
- The federal government, and/or
- Any public insurer

Section 7: Member Rights and Responsibilities

Member Rights

Key provider responsibilities related to Member Rights and Responsibilities are:

- **Treatment of Member**: The provider agrees to treat all members with respect and dignity, to provide them with appropriate privacy and to treat member disclosures and records confidentially, giving the members the opportunity to approve or refuse their release in accordance with HIPAA and applicable state laws.

- **Disclosure of Information to Member**: The provider agrees to provide to members complete information concerning their diagnosis, evaluation, treatment and prognosis, and to give members the opportunity to participate in decisions involving their health care, regardless of whether the member has completed an advance directive, except when contraindicated for medical reasons.

Members have the right to:

1. Be treated with respect and with due consideration for his or her dignity and privacy.
2. Be treated fairly and not be discriminated against regardless of race, color, national origin, sex, religion, pregnancy, transgender status, gender identity, ethnicity, age, disability, or source of payment.
3. Receive information on available treatment options and alternatives presented in a manner appropriate to the member’s condition and ability to understand.
4. Have the opportunity to choose a Primary Care Provider (PCP), within the limits of the provider network, and choose other providers as needed from among those affiliated with the network. This also includes the right to refuse care from specified providers.
5. A second opinion from a qualified health care professional within the network, or arrangements will be made to obtain one outside the network, at no cost to the
participant.

6. Participate in decisions regarding his or her health care, including the right to refuse treatment. Have a representative facilitate care or treatment decisions when the member is unable to do so.

7. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

8. Be provided with information about formulating Advance Directives.

9. Access emergency health care services from in or out-of-network providers without prior authorization, consistent with the member’s determination of the need for such services as a prudent lay-person.

10. Know what services are available and have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds as well as members with visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired, and written materials available in Braille for the blind or in different formats, as appropriate. This includes oral interpretation and the use of auxiliary aids such as Teletypewriter (TTY) & Telecommunications Device for the Deaf (TDD) and American Sign Language. Members have the right to:

11. Information about available treatment options (including the option of no treatment) or alternative courses of care.

12. Procedures for obtaining services, including authorization requirements and any special procedures for obtaining mental health and substance abuse services, or referrals for specialty services not furnished by the member’s Primary Care Provider.

13. Procedures for obtaining services outside the geographic service area.

14. Provisions for obtaining AHCCCS covered services that are not offered or available through the MCCAZ, and the right to obtain family planning services from an appropriate AHCCCS registered provider, from an appropriate AHCCCS registered provider, and

15. A description of how the organization evaluates new technology for inclusion as a covered benefit.

16. Be provided with information regarding grievances, appeals and requests for hearing.

17. Have the right to complain about the managed care organization.

18. Request and receive a copy of their medical records and request that they be amended or corrected.

19. Have free exercise of rights; the exercise of those rights does not adversely affect the way the provider treats the member.

20. Be furnished health care services in accordance with the AHCCCS Complete Care Program Contract.


22. Receive a prompt response to questions and requests.

23. Know who is providing their medical services and care.
24. Know what rules and regulations apply to their conduct.
25. Be given the truth about their health status.
26. Refuse any treatment, except as otherwise provided by law.
27. Participate in decisions about their health care.
28. Be given full information and counseling on the availability of known financial resources for their care.
29. Know whether the healthcare provider or facility accepts the MCC of AZ contract rates.
30. Receive in writing from the provider, before receiving any non-covered services, notice: (a) of the non-covered service(s) to be rendered; (b) that said services are not covered under the member benefits; (c) that the member will be liable for the cost of the service(s), (d) the cost of the service(s), and (e) upon request, provide a copy of such writing to the Plan. If the member does not agree to pay for such non-covered services in writing, neither the member nor the Plan is liable for the cost.
31. Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
32. Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
33. Know if medical treatment is for purpose of experimental research. If it is, the member can refuse or accept the services.
34. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.
35. Be furnished healthcare services in accordance with federal and state regulations.

Members are responsible for:
1. Giving the provider accurate information about their past and present health status.
2. Reporting unexpected changes in their health status.
3. Telling the provider, they understand what is expected of them.
4. Following the treatment plan recommended by the provider.
5. Keeping doctor appointments.
6. If they can’t keep an appointment, notify the provider that they cannot attend.
7. Knowing what will happen to them if they ignore the provider’s treatment plan.
8. Making sure financial responsibilities are met.
9. Following the provider’s conduct rules and regulations.

The State of Arizona must ensure that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or AHCCCS treat the member. As a participating provider, each provider is expected to not only respect these rights but assist members in leveraging these rights.

Healthcare Advance Directives

The Patient’s Right to Decide
Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment. When a person becomes unable to make decisions due to
a physical or mental change, such as being in a coma or developing dementia (like Alzheimer’s disease), they are considered incapacitated.

To make sure that an incapacitated person’s decisions about healthcare will still be respected, the legislature of the State of Arizona enacted legislation pertaining to healthcare advance directives. The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

Questions about Healthcare Advance Directives

**What is an advance directive?**
It is a written or oral statement about how an individual wants medical decisions made should they not be able to make them themselves and/or it can express the wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning. Three types of advance directives are:

1. A Living Will
2. A Healthcare Surrogate Designation
3. An Anatomical Donation

An individual may wish to complete any one or a combination of the three types of advance directives, depending on their needs.

**What is a living will?**
It is a written or oral statement of the kind of medical care an individual wants or does not want if they become unable to make their own decisions. It is called a living will because it takes effect while they are still living. Many individuals discuss this with their healthcare provider or attorney to be certain they have completed the living will in a way that their wishes will be understood.

**What is a healthcare surrogate designation?**
It is a document in which a person names someone else to make medical decisions for them if they are unable to do so. It can include instructions about any treatment an individual does or does not want, similar to a living will. It may also designate an alternate surrogate.

**What is an anatomical donation?**
It is a document that indicates a person’s wish to donate, at death, all or part of their body. This can be an organ and tissue donation to persons in need, or the donation of their body for training of healthcare workers. An individual can indicate their choice to be an organ donor by designating it on their driver’s license or state identification card, signing a uniform donor form, or expressing their wish in a living will.

**Are individuals required to have an advance directive under state law?**
No, there is no legal requirement to complete an advance directive. However, without one, decisions about an individual’s health care or an anatomical donation may be made by a court-appointed guardian, a spouse, an adult child, a parent, an adult sibling, an adult relative, or a close friend. The
person making decisions may or may not be aware of an individual’s wishes. An advance directive better assures that an individual’s wishes will be carried out.

**Must an attorney prepare the advance directive?**
No, the procedures are simple and do not require an attorney, although some individuals choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

**Can a person change their mind after completing an advance directive?**
Yes, an advance directive can be changed at any time. Any changes should be written, signed and dated. However, it can also be changed by oral statement, physical destruction of the advance directive, or by writing a new advance directive. If a person’s driver’s license or state identification card indicates they are an organ donor, but they no longer want this designation, they can contact the nearest driver’s license office to cancel the donor designation and a new license or card will be issued.

**What if an individual filled out an advance directive in another state and needs treatment in Arizona?**
An advance directive completed in another state, as described in that state’s law, can be honored in Arizona.

**What should a person do with their advance directive if they choose to have one?**
If a person wants to designate a healthcare surrogate and an alternate surrogate, they should be sure to ask them if they agree to take on this responsibility, discuss with them how matters should be handled, and provide them with a copy of the document.

Make sure that their healthcare provider, attorney, and the significant persons in their life know that they have an advance directive and tell them where it is located or provide them with a copy. Set up a file where a copy of the advance directive (and other important paperwork) can be kept. Some people keep original papers in a bank safety deposit box.

Keep a card or note in their purse or wallet that states they have an advance directive and where it is located.

If an individual changes their advance directive, they should be sure that their healthcare provider, attorney and other significant persons in their life have the latest copy.

**More Information on Healthcare Advance Directives**

Before making a decision about advance directives, an individual might want to consider additional options and other sources of information, including the following:

1. Designating a durable power of attorney, through a written document naming another person to act on their behalf. It is similar to a healthcare surrogate, but the person can be designated to perform a variety of activities (e.g., financial, legal, medical, etc.). An attorney can provide further information.

2. Following is a list of additional sources of information about Advance Directives:
Nothing in this manual shall be interpreted to require a member to execute an advance directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicaid program. Complaints concerning noncompliance with the advance directive requirements may be filed with AHCCCS.

Section 8: Member Grievances and Appeals

MCC of AZ is required to have a system in place to respond to grievances and appeals received from members, and we are required to furnish information about the grievance and appeals processes to all network providers and subcontractors. MCC of AZ ensures that individuals making decisions regarding grievances or appeals:

- Are not involved in any previous level of review or decision making or a subordinate of the decision maker
- Have the appropriate clinical expertise to make the decision.

For questions regarding Member Grievances and Appeals please contact MCC of AZ AHCCCS Complete Care Program Provider Services Line at 1-800-424-5891.

Grievances

AHCCCS defines a grievance as a member’s expression of dissatisfaction with any matter, other than an adverse benefit determination. A grievance is any complaint or dispute expressing dissatisfaction with any aspect of the contractor’s or provider’s operations, activities, or behavior. A grievance may be filed at any time. With the member’s written consent, a provider or authorized representative may file a grievance on behalf of a member. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the contractor, or failure to respect the member’s rights, as provided for in 42 CFR § 438.400 et seq.

MCC of AZ will maintain a system that meets, at a minimum, the following standards:

- Timely acknowledgement of receipt of each member grievance;
- Timely review of each member grievance- as expeditiously as the member’s condition requires;
- Standard response, electronically, or in writing, to each member grievance within a reasonable time, but no later than 10 days after MCC of AZ receives the grievance, absent extraordinary circumstances. However, no grievances shall exceed 90 days for resolution. Contractor
decisions on member grievances cannot be appealed. [42 CFR 438.408(a), 42 CFR 438.408(b)(1)].

If a member or their authorized designee (provider, family member etc.) needs help with filing a grievance, please call the Grievance and Appeals department toll-free at 1-800-424-5891. Interpreter services are available. Our Grievance and Appeals department is available from 8:00 am to 5:00 pm. Monday - Friday. Members may also submit a grievance via secure e-mail appeal to: MCCofAZAppealsandGrievances@MagellanHealth.com, or via mail to:

Magellan Complete Care of Arizona
Attn: Grievance and Appeals Department
4801 E Washington St, Suite 225
Phoenix, AZ 85034

Appeals

An appeal is the request for review of an Adverse Benefit Determination [42 CFR 438.400(b)]. Adverse Benefit Determinations are any of the following:

- Denial or limited authorization of a requested service, including determinations based on the:
  - Type or level of service, requirements for medical necessity, appropriateness, setting or
  - Effectiveness of a covered benefit
- Reduction, suspension or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner, as defined by the State;
- Failure to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) required for
  standard resolution of appeals and standard disposition of grievances; or
- Denial of a rural member’s request to obtain services outside the Contractor’s network under
  42 CFR 438.52(b)(2)(ii), when the Contractor is the only Contractor in the rural area
- Denial of a member’s request to dispute a financial liability, including cost sharing, copayments,
  premiums, deductibles, coinsurance, or other member financial liabilities.

Appeals Process

MCC of AZ supports the right of our members to request a review of adverse actions or benefit determinations (“adverse determination”). MCC of AZ accepts appeal requests from our members, their authorized representatives, and their providers for any covered service that has been denied, reduced, suspended or terminated. A member’s authorized representative may be anyone who is authorized to file the appeals request on behalf of the member, so long as the member has provided written permission. Examples of designees include a family member, legal guardian, provider or attorney.

Standard Appeal

Members may file an appeal with MCC of AZ within 60 calendar days from the date on the Notice of Adverse Benefit Determination. Appeals may be filed verbally, in writing, via fax or email. If the
member chooses to call us with a verbal request, it must be followed by a written, signed appeal received within 10 days of the phone call (unless the request is for expedited resolution), in order for the appeal to be documented as filed on the day of the verbal request.

To file an appeal, members may call us at 1-800-424-5891 (TTY 711) from 8 a.m. to 5 p.m. local time, Monday through Friday. If needed, our agents will provide assistance in completing the appeal request. Interpreter services are available, as needed. Members may also send us their written appeal via secure e-mail to MCCofAZAppealsGrievances@MagellanHealth.com, by fax at 1-888-656-7505, or by mail to:

Magellan Complete Care
Attn: Grievance and Appeals Department
4801 E Washington St, Suite 225
Phoenix, AZ 85034

MCC of AZ will make a decision on an appeal within 30 calendar days from the initial date of receipt of the appeal. The written notification will include the decision, and the reason for denial, including information on their second level appeal rights through the State Fair Hearing process with AHCCCS.

**Expedit**

MC**ed Appeal**

MCC of AZ has an expedited review process for appeals if we or the member’s provider determines that the time expended in a standard resolution could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function. If a provider is filing an expedited appeal on behalf of an MCC of AZ member, a valid AOR/AUD/Member’s permission is required to file the appeal. We will resolve all expedited appeals as expeditiously as the member’s health condition requires but not later than 72 hours from the date the Contractor receives the expedited appeal.

**Continuation of Benefits**

While the appeal decision is being made, the member can continue to receive care for previously authorized services if the member requests a continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the member’s favor, the member may be liable for the cost of the services if the services are upheld by the Plan. If the final decision is in the member’s favor, services will be reinstated within 72 hours for expedited and standard appeals.

**State Fair Hearing Process**

**State Fair Hearing**

Members, their authorized representatives, or their provider have a right to appeal MCC of AZ’s adverse determination on their appeal request through the State Fair Hearing process. Completion of MCC of AZ’s appeal process is a prerequisite to filing for a State Fair Hearing. A member is also able to file for a State Fair Hearing if MCC of AZ fails to adhere to the required time frames for processing the member’s appeal.
The appeal for a State Fair Hearing must be filed within 120 days after receipt of MCC of AZ’s appeal decision. Members needing assistance filing a State Fair Hearing appeal can contact MCC of AZ at 1-800-424-5891 (TTY 711) from 8 a.m. to 5 p.m. local time, Monday through Friday. MCC of AZ will attend and defend our appeals decisions at all hearings or conferences in person or on the phone, as deemed necessary by AHCCCS.

If AHCCCS reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, MCC of AZ must authorize the disputed services no later than 72 hours from the date MCC of AZ receives the notice reversing the decision. MCC of AZ does not have the right to appeal AHCCCS’ appeal decisions.

**Continuation of Benefits**

While the State Fair Hearing decision is being made, the member can continue to receive care for previously authorized services if the member requests continuation of benefits either within 10 days of the date on the notice of adverse benefit determination, or by the date the change in services is scheduled to occur. If the final decision is not in the member’s favor, they may be liable for the services provided. If the final decision is in the member’s favor, services will be reinstated within 72 hours.

**Section 9: Medical Management**

**Utilization Management**

The purpose of the MCC of AZ Utilization Management program is to support optimal use of healthcare services and supports for the evaluation, treatment, and integration of medical, dental and behavioral health conditions. The MCC of AZ Utilization Management and Care Management teams collaborate to ensure seamless, timely, and accurate care and service authorization processes.

The program meets its objectives in part by conducting prospective, concurrent, retrospective and discharge planning review of services rendered to its members. The utilization department monitors quality, continuity, and coordination of care as well as overutilization and underutilization of services. High risk/high cost cases are followed closely by the utilization staff to ensure that the most cost-effective services are identified, coordinated, implemented, and evaluated on a continual basis. Services provided are not less than the amount, duration, and scope for the same services delivered to fee for service (FFS) Medicaid members. Medically necessary services are no more restrictive than used in the State defined program. MCC of AZ makes the utilization management criteria available in writing, by mail, or fax. MCC of AZ supports continuity and coordination of care for physical, dental, and behavioral health providers.

Providers can call our toll-free number at 1-800-424-5891 with any utilization management questions:
- Our MCC of AZ team members are available for incoming calls from 8 a.m. to 5 p.m. local time, Monday through Friday
• Our MCC of AZ team members can receive incoming calls regarding utilization management concerns after normal business hours
• Our MCC of AZ team members can send communications out regarding questions during normal business hours, unless otherwise agreed upon
• Our MCC of AZ team members are available to accept collect calls
• Our MCC of AZ team members will identify themselves by name, title and our organization name of MCC of AZ when initiating or returning calls
• Our MCC of AZ team members are available to callers who have questions about the utilization management processes
• Providers can leave voice mail messages after business hours, 24-hours a day / 7-days a week
• A utilization management dedicated fax line can be used to submit requests for medical necessity determinations 24-hours a day / 7-days a week
• An afterhours, on-call nurse is available for emergent/urgent concerns

In addition, the Utilization Management program is charged with developing, implementing and continuously monitoring the Utilization Management Work Plans. The Utilization Management team collaborates with the Care Management and Health Services teams to ensure that all Works Plans are coordinated between departments. The Utilization Management program generates policy and procedures and provides general direction and guidance toward policy execution. The Utilization Management, and care management programs, and the Quality Improvement Committee (QIC) work together to ensure the health and well-being of individuals enrolled in MCC of AZ. This is achieved through the development and administration of healthcare benefits and health case coordination processes that facilitate the availability and accessibility of services in accordance with corporate policies, federal, state, and local regulations and accreditation standards.

Medical Necessity Criteria

Information sources used to determine benefit coverage and medical necessity include AHCCCS state (AMPM/ACOM), and CMS Medicare coverage policies MCG, Magellan Proprietary Guidelines, National Practice Guidelines/ evidence-based guidelines, expert board-certified consultant advisors, enrollee-specific information gathered during care management, including behavioral and physical health history, social needs, information from family members, as well as specific treatment information from providers.

MCC of AZ defaults to all applicable state and federal guidelines regarding criteria for authorization of covered services. MCC of AZ utilizes nationally established and recognized criteria, MCG, to determine medical necessity and appropriateness of care. The criterion used is designed to assist clinicians and providers in recognizing the most effective health care practices used today which ensures quality of care to our members. The medical necessity criteria are not intended to serve as a set of rules or as a replacement for a physician’s medical judgment about their patient’s health care needs. MCC of AZ also has polices developed to complement nationally recognized criteria. Criteria are reviewed at least annually with input from network providers and updated as necessary.
Utilization review determinations are based only on appropriateness of care, service, and benefit coverage. MCC of AZ does not reward providers or any staff members for adverse decisions for coverage or services. There are no financial incentives for our staff members that encourage them to make decisions that result in underutilization. An authorization does not replace the provider’s judgment with respect to the member’s condition or treatment requirements.

If a member’s clinical documentation does not meet the criteria, the case is forwarded to the Medical Director for further review and determination. The Medical Director reviews the documentation, discusses the case with the UM staff and may make the decision to call the attending or referring physician for additional information. The requesting physician may be asked to submit additional information. Based on the discussion with the requesting provider or additional clinical information sent, the medical director will decide to approve, make an adverse decision, modify, reduce, suspend, or terminate the service.

The MCC of AZ Medical Directors are available to discuss individual cases with attending physicians upon request. Upon request, MCC of AZ will provide the clinical rationale or criteria used in making medical necessity determinations. Providers may request the information by calling 1-800-424-5891 or faxing the Utilization Management Department at 1-888-656-7501. If providers would like to discuss an adverse decision with MCC of AZ’s Medical Director, we request they call the Utilization Management Department within five (5) business days of the determination.

**Post stabilization services**

Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting. To request authorization for an inpatient admission, an inpatient admission from observation or have any questions related to post-stabilization services, please contact the Utilization Management Department at 1-800-424-5891 (TTY 711). Inpatient admissions will be reviewed for medical necessity.

For the most up-to-date listing of services requiring prior authorization, please see our website [www.MCCofAZ.com](http://www.MCCofAZ.com), and click on the Provider Tab and Provider Tools.

**Clinical Practice Guidelines**

MCC of AZ uses nationally accepted, evidence-based criteria clinical practice guidelines, developed by specialty organizations, national policy committees and/or industry recognized review organizations in addition to State or Federal policies or regulations (as appropriate), medical policy or internally developed criteria, physician and clinical judgment to evaluate necessity of medical and behavioral health services. MCC of AZ has adopted evidence-based clinical practice guidelines or protocols (see our website at [www.MCCofAZ.com](http://www.MCCofAZ.com)) for a wide variety of medical conditions and services delivered in different medical and/or behavioral health settings. MCC of AZ has adopted MCG evidenced –based clinical practice guidelines for management of medical, behavioral, home health, and nursing facility services.
MCC of AZ adopts practice guidelines that meet the following requirements:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals and service providers in a particular field;
- Consider the needs and preferences of the members;
- Are adopted in consultation with providers; and
- Are reviewed and updated periodically, as appropriate.

MCC of AZ disseminates any revised practice guidelines to all affected providers upon request, to members and potential members. The practice guidelines provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply.

**Concurrent Review**

MCC of AZ supports a Concurrent Review process of reviewing an institutional stay at admission and throughout the stay to determine medical necessity for an institutional level of care. MCC of AZ reviewers assess the appropriate use of resources, Length of Stay, Level of Care (LOC), and service, according to professionally recognized standards of care. Concurrent review validates the medical necessity for admission and continued stay and evaluates quality of care.

MCC of AZ’s policies and procedures govern the utilization of services in institutional settings to determine medical necessity prior to a planned institutional admissions (precertification) and ongoing institutional care (concurrent review).

MCC of AZ’s concurrent review processes include:

1. A review of relevant clinical information when making hospital length of stay decisions. Relevant clinical information includes but is not limited to symptoms, diagnostic test results, diagnoses, and required services.
   a. Initial institutional stays are based on MCC of AZ’s adopted criteria, the member’s specific condition, and the projected discharge date.
   b. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay is assigned a review date each time the review occurs. MCC of AZ ensures that each continued stay review date is recorded in the member’s record.
2. Specificity of timeframes and frequency for conducting concurrent review and decisions:
   a. Authorization for institutional stays have a specified date by which the need for continued stay will be reviewed, and
   b. Admission reviews are conducted within one business day after notification is provided to MCC of AZ by the hospital or institution (this does not apply to precertifications) (42 C.F.R. 456.125).
3. A review that includes but is not limited to:
   a. Necessity of admission and appropriateness of the service setting,
   b. Quality of care,
   c. Length of stay,
d. Whether services meet the member needs,
e. Discharge needs, and
f. Utilization pattern analysis

Criteria for decisions on coverage and medical necessity are clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals. When providing concurrent review, MCC of AZ compares the member’s medical information against medical necessity criteria that describes the condition or service, Initial institutional stays are based on the MCC of AZ’s adopted criteria, the member’s specific condition, and the projected discharge date,

Continued stay determinations are based on written medical care criteria that assesses the need for the continued stay. The extension of a medical stay is assigned a review date each time the review occurs. MCC of AZ ensures that each continued stay review date is recorded in the member’s record.

MCC of AZ assesses the appropriate use of resources, Length of Stay, Level of Care and service, according to professionally recognized standards of care. UM decision making is based only on appropriate of care and service and the applicable coverage levels.

Requests for concurrent medical or behavioral health care to extend a current course of treatment must include relevant clinical information when making hospital length of stay decisions.

**Post-Stabilization Care Services**

These covered services, which are related to an emergency medical condition, are provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member’s condition. These services shall be deemed prior authorized if MCC of AZ does not respond within the timeframes established (one (1) hour) for responding to a request for authorization being made by the emergency department.

A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

**Treatment Adherence**

MCC of AZ has medication and treatment adherence programs available to help ensure that members continue in care and obtain maximum benefit from their care. Through interdisciplinary meetings and treatment planning, we are able to work in collaboration and coordination with our providers to establish and monitor treatment plans that are targeted and tailored to each member.

Our health guides, peer support specialists and care coordinator/care managers conduct outreach to members, providing them with the support they need to address barriers influencing their ability to obtain care and aiding them in transitions of care that can be difficult to navigate. At each step we rely on the collaboration with our network providers to develop treatment adherence strategies that work for our members.
Mental Health and Substance Use Assessments

1. MCC of AZ’s plan preference is for providers to use the following assessments:
2. CAGE-AID for substance use
3. AUDIT (Alcohol Use Disorders Identification Test)
4. DAST-10 (Drug Abuse Screen Test)
5. PHQ-9 for depression
6. Mental Health Screening Form III.

We recognize there are additional tools for the assessment of substance use and mental health and MCC of AZ will support the use of and make available other peer-reviewed and independently validated instruments.

Continuity of Care

MCC of AZ will allow members in active treatment to continue to receive care from their current provider. We will work closely with the member and the non-participating provider to determine continuation of care by the non-par provider. Please find additional continuity of care information in Section 4 of this handbook.

Prior Authorization

Prior authorization must be requested for some services through MCC of AZ’s Health Services department, which is available 24-hours a day / 7-days a week. Providers are expected to submit a pre-service authorization request prior to providing the service or care. Any services that require an authorization but was not prior authorized, will be denied for payment. Please call us at 1-800-424-5891 for any questions regarding prior authorization. Providers can utilize the prior authorization forms found on www.MCCofAZ.com and fax to 1-888-656-7501, including all supporting documentation. For the most up-to-date listing of services requiring prior authorization, please see our website at www.MCCofAZ.com for the Prior Authorization List.

Our care coordinator/care managers and health guides work collaboratively in coordinating care with members, as needed, and their PCP to ensure that all care and services are coordinated and integrated into the member’s comprehensive treatment plan. We may allow a standing authorization to be approved for members with chronic or disabling conditions. Providers should specifically request these authorizations when working with MCC of AZ case and disease managers on care plans for their patients.

Decisions on routine prior authorizations will be rendered within fourteen (14) calendar days. Decisions on expedited prior authorization requests will be rendered within 72 hours, if MCC of AZ determines that the request qualifies for expedited consideration. The provider will be notified if the request will not be considered as an expedited request. Decisions for approved services are based only on appropriateness of care and service and existence of coverage. A retrospective review is for medical necessity of services after the care has been rendered and an authorization has not been obtained. A retrospective review involves the review of services after a claim has been denied for an authorization. The rendering provider must submit the clinical information. The review will be conducted with 14
calendar days from receipt of the information for medical necessity. Providers are responsible for verifying eligibility and benefits before providing services. Authorization is not a guarantee of payment for services.

**Referrals**

A referral is conducted between the member’s assigned PCP and a specialist within the MCC of AZ participating network without a prior authorization. The PCP may make a referral by telephone, fax or in writing to the requested specialist. A specialist may also make a referral to another specialist when the condition that was originally referred to them by the member’s PCP is the same. If there is no participating specialist to meet the needs of the member the PCP can make a referral outside the network. The PCP should contact us if they wish to request the exception referral for the member to see an out-of-network provider. If an out-of-network provider provides emergency care, the service will be paid.

**Care Management Program**

Our belief is that care management and case management services are integral tools in providing support for members across the continuum of care and services. MCC of AZ offers care management services to facilitate member assessment, care management, care planning and advocacy to improve health and wellness outcomes for members. We support the treatment plans developed by our providers and ICTs and rely on our providers to help coordinate the placement and cost-effective treatment of members who are eligible for our care management Programs. These range from high risk, complex case management to health, wellness and disease management programs.

Members may be identified for care management in various ways, including:

1. AHCCCS program requirements
2. A referral from a member’s PCP
3. Self-referral
4. Referral from a family member
5. After completing a Health Risk Assessment
6. Data mining for members with high utilization, high risk conditions and gaps in care.

Key elements of the care management process include:

1. Screening, Clinical Assessment and Evaluation – A comprehensive assessment of the member is completed to determine where she or he is in the health continuum. This assessment gauges the member’s support systems and resources and seeks to align them with appropriate clinical needs;
2. Care/Service Planning – Collaboration with the member and/or caregiver as well as the PCP to identify the best ways to fill any identified gaps or barriers to improve access and adherence to the provider’s plan of care;
3. Service Facilitation and Coordination – Working with community resources to facilitate member adherence with the plan of care. Activities may be as simple as
reviewing the plan with the member and/or caregiver or as complex as arranging services, transportation and follow-up; and

4. Member Advocacy – Members are a key participant in the inter-disciplinary care team. The care management process advocates on behalf of the member within the health care system.

Care coordinator/care managers engage members in their health and treatment plan and work collaboratively with PCPs and specialists to coordinate care for the member, expediting access to care and needed services. They also support the PCP and/or behavioral health provider in actively linking the member to other providers, medical services, residential, social and other support services, as needed. Providers may request care management services for any member.

**Individualized Service Plan**

MCC of AZ’s model of care and clinical programs are person-centered, community-focused, population-based, and evidence-driven. Our focus is on activities designed to improve quality of life and health outcomes by targeting and influencing behavioral, social, economic, and clinical determinants of those outcomes at both the individual and group level.

This individualized, person-centered approach engages individuals with disabilities and chronic conditions to effectively interact with the provider delivery system to ensure choice, control, and access to a full array of quality services. This approach ensures optimal outcomes such as independence, health and wellness, and quality of life.

The critical components of MCC of AZ’s person-centered plan:

1. Active participation by the member (or designee) in the Individualized Service Plan (SP) delivery and planning process that starts with the member’s goals and meaningful choices of service alternatives
2. Holistic SPs based on a comprehensive needs assessment
3. Opportunities to self-direct community-based services.

Our approach builds an infrastructure within the health and services system that supports and enhances the relationship between members and providers. Based on the member’s goals, choice, and medical and psychosocial necessity criteria, we offer holistic support and demonstrated cost savings through the delivery of medical and pharmacy services at the most appropriate, least restrictive level of care.

**Population Health and Disease Management Program**

MCC of AZ has several population health and integrated disease management programs and services to assist providers in effectively helping members better self-manage their chronic disease. Our care coordinator/care managers fully integrate disease management approaches into their daily routine and engagement with members. We use traditional and digital, web-based approaches within our menu of services. A sample of these programs include:

1. Congestive Heart Failure
2. Diabetes
3. High Risk Maternity

Please call our care management department at 1-800-424-5891 (TTY 711) to enroll a member in a disease management program.

RN – Nurse Advice Line

MCC of AZ offers a 24/7 Nurse Triage Line (CareLine) as a resource for assisting members with a wide variety of healthcare and service needs. The Nurse Triage Line staff, who are all registered nurses, help members choose appropriate psychosocial, medical and behavioral services, find a physician or hospital in their community, understand treatment and covered services options, achieve a healthy lifestyle, or answer medication questions. The Nurse Triage Line nurses reinforce health education about appropriate ER use and help members understand the resources and services available and how to access them. To reach the Nurse Triage Line call 1-800-424-5891 (TTY 711).

Preventive Health and Wellness

MCC of AZ has developed numerous education, promotion and outreach strategies, and continuously monitors the effectiveness of these strategies, to encourage healthy behaviors and ensure all members receive appropriate screenings, digital and mobile health apps, and treatment, if needed. To promote self-care and personal responsibility, we offer member incentive programs that reward members for activities such as completing a preventive visit or Health Risk Screening and Assessment. By participating in these healthy behaviors, members can earn rewards that are loaded onto a Complete Care Counts “reloadable” debit card that they can use to purchase health-related services and supplies. To learn more, visit our website at www.MCCofAZ.com.

Transitions of Care

MCC of AZ supports a comprehensive Transitions of Care approach which includes the member, the member’s primary MCC of AZ care coordinator/care manager, the MCC of AZ care transitions coordinator, the member’s PCP, other care providers, and the ICT members in all aspects of the member’s transitions of care activities.

MCC of AZ applies its Transitions of Care approach when a transition occurs, as members move from one care or residential setting to another due to a planned choice, change in health status, circle of support, living circumstance, or moving in and out of the judicial system.

We employ dedicated care transitions coordinators who are subject matter experts and are based within each region. The care transition coordinators offer expert assistance and support with any type of transition of care. This support is available to the primary care coordinator/care manager assigned to each member, the member, PCP, other providers, and the ICT. We incorporate nationally recognized best-practice approaches and measures, in addition to application of AHCCCS requirements and recommendations. Collectively, these approaches are based on key components of AHCCCS expertise.
and recommendations, the National Transitions of Care Coalition and Eric Coleman’s Care Transitions Program®, and the Camden Coalition's work with super-utilizers to reduce preventable hospital readmissions. We believe that both planned and unplanned transition periods require diligent planning, communication, and follow-up to avoid readmissions to acute care settings, hasty placements in institutions, or re-institutionalizations.

Out of State Placements

In the event, Out-of-State Placements for young adults and children for Behavioral Health Treatment is necessary based upon the MCC of AZ Member’s specific clinical need and supporting circumstances per AMPM 450; Out-of-State Placements for Children or Young Adults for Behavioral Health Treatment. https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/450.pdf

Definitions

- **Service Plan**: A complete written description of all covered health services and other information supports which includes individualized goals, family support services, care coordination activities and strategies that assist the member in achieving an improved quality of life.

- **Child and Family Team (CFT)**: A defined group of individuals that includes, at a minimum, the child and his or her family, a behavioral health representative, and any individuals important in the child’s life that are identified and invited to participate by the child and family. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches and community resource providers, representatives from churches, synagogues or mosques, agents from other service systems like (DCS) Department of Child Safety or the Division of Developmental Disabilities (DDD). The size, scope and intensity of involvement of the team members are determined by the objectives established for the child, the needs of the family in providing for the child, and by who is needed to develop an effective service plan, and can therefore expand andContract as necessary to be successful on behalf of the child.

- **Adult Recovery Team (ART)**: A group of individuals that follow the nine guiding principles for Recovery-Oriented Adult Behavioral Health Services and Systems, working in collaboration and are actively involved in a member’s assessment, service planning, and service delivery. At a minimum, the team consists of the member’s, guardian/designated representative (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include members of the enrolled member's family, physical health, behavioral health or social service providers, other agencies serving the member, professionals representing various areas of expertise related to the member's needs, or other members identified by the enrolled member.

- **Tribal Behavioral Health Authority (TRBHA)**: Tribal Regional Behavioral Health Authority overseeing behavioral health care for tribal residents.

Decisions with regard to placing members in Out-of-State placements for behavioral health care and treatment will be examined and made once the CFT, ART, or TRBHA have reviewed all other relative in-state provider options, including use of single case agreements with an in-state provider and the
development of a Service Plan that incorporates a combination of support services and clinical interventions.

Services provided Out-of-State shall meet the same requirements as those rendered in state. MCC of AZ shall also ensure that Out-of-State providers follow all AHCCCS reporting requirements, policies and procedures, including appointment standards and timelines specified in ACOM policy 417.

Out-of-State placement providers shall coordinate with MCC of AZ, the member’s outpatient BH team and the members CFT and provide required updates.

The following factors may support determination by a member’s Child and Family Team (CFT) or Adult Recovery Team (ART) to assess the temporary out-of-state placement:

1. member requires specialized programming not currently available in the State of Arizona in order to effectively treat a specific behavioral health condition,
2. an out-of-state placement’s approach to treatment incorporates and supports the unique cultural heritage of a member,
3. A current lack in-state bed capacity,
4. Geographic proximity encourages support and facilitates family involvement in the member’s treatment process,
5. The member’s family/guardian/designated representative is in agreement with out-of-state placement (for minors and members between 18 and 21 years of age under guardianship)
6. The Out-of-State placement is registered as an AHCCCS provider,
7. Prior to placement, MCC of AZ, Contractors, TRHBAs, and fee-for-service providers shall have a plan in place to ensure the member has access to non-emergency medical needs by an AHCCCS registered provider,

**Out-of-State Placement Documentation**

MCC of AZ and the outpatient BH provider shall ensure that documentation in the clinical record indicates the following conditions have been met before a referral for an Out-of-State placement is made.

1. At least three in-state facilities have declined acceptance of the member
2. The CFT or ART has been involved in the service planning process and is in agreement with the Out-of-State placement,
3. The CFT or ART has documented how it will remain active and involved in service planning once the Out-of-State placement has occurred,
4. A Service Plan has been developed,
5. All applicable prior authorization requirements have been met,
6. The Arizona Department of Education has been consulted to ensure that the educational program in the Out-of-State placement meets the Arizona Department of Education Academic Standards and specific educational needs of the member as applicable,
7. Coordination has occurred with all other state agencies and/or Contractors
involved with the member, including notification to the Medical Director of the Division of Developmental Disabilities (DDD) when the member is enrolled with DDD and the Medical Director of the Comprehensive Medical and Dental Plan (CMDP) when the member is enrolled with CMDP.

8. Coordination shall occur between the member’s primary care provider, outpatient BH provider and non-emergency medical care. All providers shall be registered with AHCCCS.

Service Plan for Out of State Placement

For a member placed Out-of-State, the Service Plan developed by the CFT, ART or TRBHA shall require the following:

1. Discharge planning is initiated at the time of admission, including:
   a. Measurable treatment goals and criteria necessary for discharge back to in-state services,
   b. The possible proposed in-state residence where the member will be returning,
   c. The recommended services and supports required once the member returns from the Out-of-State placement,
   d. How effective strategies implemented in the Out-of-State placement will be transferred to the member’s subsequent in-state placement,
   e. The actions necessary to integrate the member into family and community life upon discharge.

2. Contractor or TRBHA - shall ensure coordination between the CFT, ART and Out-of-State placement and document how they will remain active and involved in service planning by reviewing the member’s progress after significant events or at least every thirty (30) days.

3. When appropriate, the member/guardian/designated representative is involved throughout the duration of the placement. This may include family counseling in person of by teleconference or videoconference.

4. Home Passes – are allowed as may be clinically appropriate and in accordance with the AHCCCS Policy. For youth in Department of Child Safety (DCS) custody, approval of home passes is determined in collaboration with DCS.

5. Member’s needs, strengths, and cultural considerations have been addressed.

Notifications to AHCCCS/Division of Health Care Management (DHCM)

The Contractors, TRBHAs, and fee-for-service provider are required to notify AHCCCS prior to or upon notification of a member being placed in an Out-of-State placement and complete the AHCCCS Out-of-State placement form, Attachment A.


1. DHCM – will review the information on the AHCCCS Out-of-State placement Form (Attachment A) to ensure all requirements in this policy have been met. DHCM will acknowledge receipt of the form within one to three (1-3) business days. If the information is incorrect or incomplete, the form will be returned for correction.
The corrected form shall be resubmitted.

2. Contractors, TRBHAs, and fee-for-service providers – are required to submit progress updates, using Attachment A, to AHCCCS DHCM the fifth working day of each month.

3. All Out-of-State providers are required to meet the reporting requirements of all incidences of injury/accidents, abuse, neglect, exploitation, healthcare acquired conditions, injuries from seclusion/restraint implementations as described in AMPM Policy 960.

Section 10: Covered Services

MCC of AZ provides the covered services required in Arizona’s AHCCCS Complete Care Program as medically necessary services with certain requirements and limitations as described in the AHCCCS Medical Policy Manual, Chapters 300:
http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf and Chapter 400:

All services must be provided in-network, except in emergency situations or when Prior Authorization has been obtained. Certain covered services, even when provided in-network may require Prior Authorization. Please refer to the Prior Authorization outline for a list of services that require Prior Authorization.

Important Note:

Services that are not covered by AHCCCS may not be on the Prior Authorization outline. Please refer to the AHCCCS Medical Policy Manual for a full listing of covered services or contact us at 1-800-424-5891 further information.

Services listed as non-covered by Medicaid are covered when medically necessary for children under age 21 in accordance with Federal EPSDT requirements. No covered services are excluded on the basis of religious, moral or ethical objections.

<table>
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<tr>
<th>General Covered Service Categories (see AHCCCS AMPM Chapters above for detailed information, including requirements and limitations)</th>
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<tr>
<td>Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services</td>
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Emergency Services

MCC of AZ covers, and is financially responsible for, all health screenings, evaluations, and examinations that are reasonably calculated to assist the provider in arriving at the determination as to whether the member’s condition is an emergency medical condition. MCC of AZ does not deny payment for emergency services obtained under any of the following circumstances:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part;

2. A representative of MCC of AZ instructs the member to seek emergency services; or

3. Emergency services and care is provided at a hospital without parental consent.

Members are instructed by Customer Services and/or Health Services staff and through the member handbook to contact their PCP after receiving emergency care services. In addition, the UM and care management teams will assist the member with scheduling a PCP appointment. Emergency room utilization is monitored quarterly, and members with a pattern of overuse are followed by the care coordination/care management and care transitions programs.

It is the expectation of MCC of AZ that the PCP will educate members on the difference between appropriate and non-appropriate use of emergency care services. Emergency care services are to be used for very serious or life-threatening situations. Common illnesses and minor injuries should be treated within a doctor’s office or urgent care setting.

Out of Area Emergency Services

If the member is away from home and has an emergency, they are instructed to go to the nearest emergency room or any emergency setting of their choice. MCC of AZ covers any medically necessary duration of stay in a non-contracted facility, which results from a medical emergency, until such time as

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<td>Immunizations</td>
<td>Treat and Refer Services</td>
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<tr>
<td>Maternity Services</td>
<td>Vision Services, Ophthalmology, Optometry</td>
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</table>
we can safely transport the member to a participating facility. In such situations, the member should call their PCP as soon as possible.

**EPSDT/Immunizations**

MCC of AZ is committed to supporting AHCCCS in its obligation to assure the federal government that EPSDT services are being provided as required. MCC of AZ covers EPSDT screenings according to the American Academy of Pediatrics guidelines. In addition, in partnership with our network providers, MCC of AZ offers comprehensive healthcare services through primary prevention, early intervention, diagnosis, and medically necessary treatment to correct or improve defects and physical or mental illness discovered by the screening of members under age 21. MCC of AZ screens, assesses, and monitors all children; covers immunizations; educates providers and schools regarding reimbursement of immunizations; and works with AHCCCS to achieve its goal related to increased immunization rates. MCC of AZ expects providers to follow the CDC, AAP, AAFP, and ACOG recommended immunization schedule for children and adolescents aged 18 years or younger - [https://www.aap.org/en-us/Documents/immunization_schedule2018.pdf](https://www.aap.org/en-us/Documents/immunization_schedule2018.pdf). In addition, and in accordance with AHCCCS Medical Policy Manual 430, PCPs are required to:

1. Provide EPSDT services for all assigned members from birth to 21 years of age. Services must be provided in accordance with the AHCCCS EPSDT and Dental Periodicity Schedules.
2. Agree to utilize the standardized AHCCCS EPSDT Tracking Forms or, if electronic medical records are utilized, they must contain all the elements of the current AHCCCS EPSDT Tracking Forms.
3. Implement procedures to ensure compliance by PCPs with all EPSDT standards and contract requirements.
4. Implement protocols to ensure that health problems are diagnosed and treated early, before they become more complex and the treatment more costly (including follow-up related to blood lead screening and tuberculosis screening).
5. Have a process for to assisting members in navigating the healthcare system, as well as inform members of any other community-based resources that support optimal health outcomes, to ensure that members receive appropriate support services.
6. Implement protocols for coordinating care and services with the appropriate state agencies for EPSDT eligible members, and ensure that members are referred to support services, as well as other community-based resources to support good health outcomes.
7. Refer eligible members to Head Start and the special supplemental nutrition program for Women, Infants and Children (WIC), for WIC approved formula and support services. Ensure that medically necessary nutritional supplements are covered by the Contractor (For more information, refer to Refer to Section C, EPSDT Service Standards, Item 6 - Nutritional Assessment and Nutritional Therapy of this policy).
8. Utilize the criteria specified in this policy when requesting medically necessary nutritional supplements (Refer to Section C, EPSDT Service Standards, Item 6 - Nutritional Assessment and Nutritional Therapy of this policy and AMPM Exhibit 430-2, AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements).
9. Coordinate with Arizona Early Intervention Program (AzEIP) to identify children 0-3 years of age with developmental disabilities needing services, including family education and family support needs focusing on each child’s natural environment, to optimize child
health and development (EPSDT services, as defined in 9 A.A.C. 22, Article 2, must be provided by the Contractors). Contractors must require their providers to communicate results of assessments and services provided to AzEIP enrollees within 45 days of the member’s AzEIP enrollment. Refer to Procedures for the Coordination of Services under EPSDT and Early Intervention (Exhibit 430-3) for more information related to the coordination and referral process for early interventions services.

10. Document immunizations into Arizona State Immunization Information System (ASIIS) and enroll every year in the Vaccine for Children program (program details discussed further in “Vaccines for Children” section).

MCC of AZ has numerous education, promotion, and outreach strategies, and continuously monitors the effectiveness of these strategies to ensure that all members eligible for EPSDT are receiving appropriate screenings, diagnosis, and most importantly, treatment. Multiple modes of communication are used proactively to reach out to members regarding EPSDT screenings and services. Members needing each service are identified by MCC of AZ’s analytics systems. When specific members are known to lack needed services such as immunizations or dental services, MCC of AZ reaches out to influence participation among those members.

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.

**EPSDT Forms and Periodicity Schedules**

MCC of AZ providers are required to use the AHCCCS EPSDT Tracking Forms to document all age-specific required information related to EPSDT screenings and visits. Only the AHCCCS forms may be used; substitutes are not acceptable. Submit the completed form to MCC of AZ at the following address or fax number. A copy of the form must be placed in the members’ medical record. Send EPSDT forms to:

Magellan Complete Care of AZ  
Attn: EPSDT  
4801 E. Washington St., Suite 225, Phoenix, AZ 85034  
Fax: 1-888-656-7539

To order EPSDT forms please call the Quality Improvement Department at 1-800-424-5891 or fax the EPSDT order form to 1-888-656-7539. Requests are processed within 24-48 hours from receipt.

**Sick Visit Performed in Addition to an EPSDT Visit**

Billing of a ‘sick visit’ (CPT codes 99201-99215) at the same time as an EPSDT is a separately billable service if:

- An abnormality is encountered, or a preexisting problem is addressed in the process of performing an EPSDT service and the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service.
- The ‘sick visit’ is documented on a separate note.
• History, Exam, and Medical Decision-Making components of a separate ‘sick visit’ already performed during the course of an EPSDT visit are not to be considered when determining the level of the additional service (CPT code 99201-99215).

• The current status (not history) of the abnormality or preexisting condition is the basis of determining medical necessity.

Modifier 25 must be added to the Office/Outpatient code to indicate that a significant, separate identifiable E/M was provided by the same care provider on the same day as the preventive medicine service. Acute diagnosis codes not applicable to the current visit should not be billed. An insignificant problem encountered in the process of performing the preventive medicine evaluation and management service, and which does not require additional work, is included in the EPSDT visit and should not be reported separately.

**Family Planning Services**

Family planning services are covered for male and female members who voluntarily choose to delay or prevent pregnancy. Physicians or practitioners should discuss and document in the medical record that each member of reproductive age was notified verbally or in writing of the availability of family planning services.

Family planning services include covered medical, surgical, pharmacological, and laboratory benefits specified below. Covered services also include the provision of accurate information and counseling to allow members to make informed decisions about specific family planning methods available. Covered family planning services for members include the following:

• Contraceptive counseling, medication, and/or supplies, including, but not limited to: oral and injectable contraceptives, LARC, diaphragms, condoms, foams and suppositories,

• Associated medical and laboratory examinations and radiological procedures, including ultrasound studies related to family planning,

• Treatment of complications resulting from contraceptive use, including emergency treatment,

• Natural family planning education or referral to qualified health professionals, and

• Post-coital emergency oral contraception within 72 hours after unprotected sexual intercourse (Mifepristone, also known as Mifeprex or RU-486, is not post-coital emergency oral contraception), and

• Sterilization services are covered for both male and female members when the requirements for sterilization services are met (including hysteroscopic tubal sterilizations). See [https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/420.pdf](https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/420.pdf) for details on Sterilization.

Sterilizations are covered for members 21 years of age or over who are mentally competent and have signed the Sterilization Consent Form located in the AMPM Chapter 420, Attachment A located at the AHCCCS website, [https://www.azahcccs.gov/shared/MedicalPolicyManual/](https://www.azahcccs.gov/shared/MedicalPolicyManual/). The consent form must be signed at least 30 days before the procedure.

The following are not covered for the purpose of family planning services:

• Infertility services including diagnostic testing, treatment services and reversal of surgically induced infertility,
- Pregnancy termination counseling,
- Pregnancy terminations except as specified in AMPM Policy 410
- Mifepristone (Mifeprex or RU 486)
- Hysterectomies for the purpose of sterilization. (Refer to AMPM Policy 310-L for hysterectomy coverage requirements.)

Maternal and Newborn Health Program

MCC of AZ’s Maternal and Newborn Health Program offers comprehensive, ongoing education and support to all pregnant members from preconception through the first year of her newborn’s life. Our MCC Maternal and Newborn Health Program is built to optimize care and outcomes for our Arizona pregnant members and their newborns by engaging members, partnering with providers, and integrating community resources and non-traditional services into local health systems. Our model of care builds an infrastructure within the health system which supports and enhances the relationship between members and their providers. We use every means available to identify, engage and support our pregnant members and to connect them to care in order to achieve the best possible outcome for her and her newborn. Our program empowers members with actionable health information and tools that inform, enable, influence, and incentivize member engagement in self-management. We offer culturally sensitive, individualized interventions designed to help the pregnant woman and her baby remain healthy.

Our maternal and newborn health program is designed to:

1. Optimize the health of our pregnant members
2. Promote the delivery of a healthy, full-term infant
3. Lower overall health care costs related to pregnancy and newborn care.

MCC of AZ provisions maternity care services that include, but are not limited to, medically necessary preconception counseling, identification of pregnancy, medically necessary education and prenatal services for the care of pregnancy, the treatment of pregnancy-related conditions, labor and delivery services, and postpartum care. For additional covered related services, see https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/410.pdf.

Providers and practitioners shall adhere to the following:

- Follow the ACOG standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.
- Ensure that high-risk members have been referred to a qualified provider and are receiving appropriate care.
- All pregnant members are screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once a trimester, and for those members receiving opioids, appropriate intervention and counseling must be provided, including referral of members for behavioral health services as indicated for Substance Use Disorder (SUD) assessment and treatment.
- Members are educated about health behaviors during pregnancy, including the importance of proper nutrition, dangers of lead exposure to mother and child, tobacco cessation, avoidance of alcohol and other harmful substances, including illegal drugs, screening for sexually transmitted
infections, the physiology of pregnancy, the process of labor and delivery, breastfeeding, other infant care information, prescription opioids use, and postpartum follow-up.

- Perinatal and Postpartum depression screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained.
- Postpartum depression screening is considered part of the global service and is not a separately reimbursable service.
- Providers should refer to Appendix F [https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixF_PostpartumDepression.pdf](https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixF_PostpartumDepression.pdf) which is intended to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the plan/entity responsible for the provision of behavioral health services if clinically indicated.
- Member medical records are appropriately maintained and document all aspects of the maternity care provided.
- Members must be referred for support services to the Special Supplemental Nutrition Program for WIC, as well as other community-based resources, in order to support healthy pregnancy outcomes.
- Members must be notified that in the event they lose eligibility for services, they may contact the ADHS Hotline for referrals to low-cost or no-cost services.
- The first and last prenatal care dates of service, as well as the number of obstetrical visits that the member had with the provider, are recorded on all claim forms submitted to the Contractor regardless of the payment methodology used.
- Postpartum services must be provided to members within 60 days of delivery utilizing a separate “zero-dollar” claim for the postpartum visit.

**Arizona Early Intervention Program (AzEIP)**

Early identification of infants and children with developmental delays is critical to the future health of the child and the well-being of the family. For eligible infants and toddlers, Early Intervention (EI) services provide critical supports to family members and caregivers to enhance their child’s development. These services are incorporated into the SP for members under age three. Infants and toddlers’ birth through age two years are referred to EI when there are risk factors for developmental delay, premature birth or suspicion of developmental delays.

Referrals to early intervention can be completed by the parent, care manager, medical or services provider, and parents are consulted prior to referral by a care manager. Our care managers encourage parents to fully participate in the referral, assessment, and service planning process to ensure the infant or toddler receives all needed services. When the infant or toddler is in foster care, the care manager facilitates the transfer of clinical information, including diagnoses, medications, provider names, and other clinical assessments and available medical records. The care manager also ensures the member’s PCP signs the Individualized Family Service Plan (IFSP) and physical therapy referral quickly to ensure timely commencement of services.
MCC of AZ covers EI services in accordance with EI coverage criteria and guidelines and the Early Intervention Program Manual.

MCC of AZ contracts with AzEIP providers to provide AzEIP services. Non-Contracted AHCCCS registered AzEIP providers will be reimbursed for authorized services at the Fee-For-Service (FFS) rates. IFSP services must be reviewed for medical necessity prior to reimbursement.

**Telemedicine**

MCC of AZ supports the use of telemedicine. Providers interested in providing telemedicine services should contact their provider contracting representative to add the appropriate addenda to their contract. The contract documents will spell out requirements and rates for telehealth, and training will be scheduled.

At a minimum, the requirements for providers participating in Magellan’s telemedicine program include:

- Interactive and real-time synchronized multimedia (audio and video) transmission. Remote camera control is preferred. The provider must have a dedicated secure line and utilize an acceptable method of encryption.
- The originating site (location of the member) must have telehealth support staff able to assist the member with the technical equipment and connection. A protocol must be in place to access emergent or urgent clinical care if the designated telehealth support staff are not clinicians. The member site should be a room that provides privacy.
- Providers should have completed basic training on telehealth equipment, provide the same rights to confidentiality and security of clinical information as provided in face-to-face services, and must include in the member’s clinical record that the service was provided via telehealth.

**Community Referrals**

MCC of AZ provides assistance when there is a need for a referral for services outside the plan. We have relationships, agreements and affiliations with service bureaus, provider associations, and community-based service agencies that each offer services that complement the traditional benefits covered by the plan. These relationships allow us to collaborate with agencies that offer important ancillary services such as emergency shelter, housing, home-delivered meals, and emergency child care.

MCC of AZ providers should call us at 1-800-424-5891 (TTY 711) to obtain a pre-service authorization if a member is in need of referrals to services either covered through MCC of AZ or related community service providers or to simply better support the delivery of health care to members.
Section 11: Member Management Support

Health Assessment
As part of our onboarding process, we follow up on all Health Risk Assessment (HRA) received to ensure we understand our members’ needs. The health guide reviews the assessments and identifies resources, referrals and care management needs. A review of any social determinants of health is assessed and documented to ensure resource linkage and care coordination. Those individuals who are referred to care management are assigned, and a care plan is established. This may include scheduling appointments, following up with specialist and making referrals to community agencies.

To accommodate members with limited English proficiency, the care manager has access to a real-time language line for interpreter services. We hire care managers with a background in diverse cultures and populations, including those who may have physical disabilities themselves. All staff that interface directly with members are trained to communicate in a culturally and developmentally appropriate manner.

Appointment Scheduling
Each member’s care manager is responsible for making sure that they can easily access key information about the care management program, including contact details for all providers and members of their team. This same information is included in the Member Welcome Kit received upon enrollment.

The care manager supports the member in scheduling appointments and arranging for peer support and education. The care manager also assists in accessing community support agencies who offer education and training on self-management skills such as CILs, ARC, and AAA.

When the care manager is not immediately available, the Member Support Center staff is able to handle the majority of member requests including assisting with changing service providers, scheduling appointments and referrals, and making transportation arrangements. The Support Center staff also sends a message to the care manager that the member called, describes the actions taken, and requests a follow-up. In addition, the Support Center staff has direct access to the Nurse Triage Line available 24/7 to assist with service coordination activities.

Interpreter Services
MCC of AZ provides interpreter access for members from culturally and linguistically diverse backgrounds and for people with hearing, speech and communication impairments. Interpreter services for all languages, including sign language, are provided free for our members. MCC of AZ facilitates language assistance provided to limited English proficient members, including how to work with interpreters and telephone language services or working with translated written materials.
Members, or providers on behalf of a member, can schedule an on-site interpreter by calling Customer Service at 1-800-424-5891 to request interpretation services.

Magellan Complete Care has a telephone language line available 24 hours a day, seven days a week. Participants who are hearing-impaired or have speech impairment have access to the TTY/TDD service line by calling TTY 711. Participants who do not have TTY can communicate with a TTY user through Message Relay Center (MRC). MRC has TTY operators available to send and interpret TTY messages.

Section 12: Dental/Vision/Transportation

The following benefits are services offered by the MCC of AZ to Members in accordance with the AHCCCS Complete Care Program program’s covered services.

Dental Services

Magellan Complete Care of Arizona (MCC) has a comprehensive dental network of providers through our partnership with DentaQuest. Providers can find information about contracted dentists by contacting us online at MCCofAZ.com or by calling our Customer Service number at 800-424-5891.

Dental Emergency Services for Adults over the age of 21

Services are covered under the following conditions:

- Treatment for the relief of pain, infection, injury or swelling
- General anesthesia, conscious sedation when local anesthesia is not warranted or when pain management of a patient requires it
- Extraction of primary and permanent teeth when symptomatic, infected and non-restorable
- Oral examination that focuses on the specific tooth or mouth pain
- Emergency Dental Services up to $1000 per member per contract year (October 1st to September 30th) include the following;
  - X-ray of the painful tooth or teeth
  - Resin used to seal a recent tooth fracture
  - Prefabricated crown used to eliminate tooth pain on a recent tooth fracture
  - Root canal when needed to stop an infection or eliminate pain
  - Removal of the painful tooth
- Limitations include the following:
  - Maxillofacial dental services provided by a dentist are not covered except to the extent prescribed for the reduction of trauma, including reconstruction of regions of the maxilla and mandible.
  - Diagnosis and treatment of temporomandibular joint dysfunction are not covered except for the reduction of trauma.
  - Routine restorative procedures and routine root canal therapy are not emergency dental services.
- Treatment for the prevention of pulpal death and imminent tooth loss is limited to non-cast fillings, crowns constructed from pre-formed stainless steel, pulp caps, and pulpotomies only for the tooth causing pain or in the presence of active infection.
- Fixed bridgework to replace missing teeth is not covered.
- Dentures are not covered

For additional information, the full list of covered services, including exclusions and limitations, can be found at https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/310D1.pdf or by contacting MCC of AZ at 800-424-5891.

**Exceptions for Transplant Cases**
Members who require medically necessary dental services as pre-requisite to AHCCCS covered organ or tissue transplantation, covered dental services are limited to elimination of oral infections and treatment of oral disease, which may include dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations. For purposes of this Policy, a simple restoration means silver amalgam and/or composite resin fillings, stainless steel crowns or preformed crowns. AHCCCS covers these services only after a transplant evaluation determines that the member is an appropriate candidate for organ or tissue transplantation. These services are not subject to the $1000 adult emergency dental limit.

Additional information can be found at https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/310D1.pdf or by contacting MCC of AZ at 800-424-5891.

**Exception for Transplant Cases**
Prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head is covered. These services are not subject to the $1000 adult emergency dental limit.
Additional information can be found at https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/310D1.pdf or by contacting MCC of AZ at 800-424-5891.

**Dental Home Program for Children under the age of 21**
Members under one year of shall be assigned to a dental home prior to their first birthday. Members over one year of age but under 21 years of age shall be assigned to a Primary Dental Provider for their dental care. A Primary Dental Provider is also known as a Dental Home.

Dental homes will coordinate care for members, referring them to specialists when the dental home is unable to provide the necessary services. We will send to the parent or guardian of a child a notice in the mail with the name and location of their dental home. You can call Member Services at 800-424-5891 (TTY 711) to assist the member in choosing or changing their dental home or provider at any time.
Vision Services

MCC of AZ covers eye and optometric services provided by qualified eye/optometry professionals within certain limits based on member age and eligibility.

1. Emergency eye care which meets the definition of an emergency medical condition is covered for all members.
2. For members who are 21 years of age or older, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses, are covered.

Vision examinations and the provision of prescriptive lenses are covered for members under the EPSDT and for adults when medically necessary following cataract removal.

MCC of AZ members eligible to receive vision care services can call Vision Service Plan (VSP) at 1-800-877-7195, or by searching for an in-network Vision provider at www.vsp.com.

Non-emergent Transportation

MCC of AZ members receive non-emergent transportation services through the MCC of AZ non-emergency medical transportation network of providers. Contact MCC Provider Services at 1-800-424-5891 for additional information.

Transportation assistance for trip recovery and after-hour discharges is available 24/7/365. Contact MCC Provider Services at 1-800-424-5891 and an on-call care coordinator/care manager will provide assistance.

Section 13: Covered Pharmacy Services

Pharmacy Policy

Prescription drug benefits are managed though MCC of AZ and are administered by a prescription benefit manager, Magellan Rx. MCC of AZ offers coverage for outpatient prescription drugs listed on their Preferred Drug List (PDL). Medications not listed on the PDL will require prior authorization in order to be considered for approval.

MCC of AZ pharmacy claims are processed by Magellan Rx, the pharmacy benefit manager. MCC of AZ members should obtain covered drugs from a pharmacy within the Magellan Rx pharmacy network unless there is an emergency situation. The Magellan Rx pharmacy network includes retail chain pharmacies, several local independent pharmacies, and home infusion, mail order and specialty pharmacies. Additional information about the pharmacy network can be obtained by contacting MCC of AZ at 1-800-424-5891.
Preferred Drugs

MCC of AZ uses a preferred drug list (PDL). This is a list of prescription drugs approved by MCC of AZ for the use of our members and includes the approved AHCCCS PDL Generic drugs, certain brand name drugs and certain specialty drugs listed in the PDL are covered. Some drugs, even though they are listed on the PDL, may have special limitations such as quantity limits and age restrictions. Others may require the member to try and fail other preferred medications first. Non PDL drugs may be requested through the service authorization process (see below). Some drugs are excluded from the pharmacy benefits such as those for weight loss, infertility and cosmetic purposes. The PDL is available to providers on the MCC of AZ website at https://www.mccofaz.com/member/preferred-drug-list/. The MCC of AZ formulary is one single tier. If a drug is on the list, it is considered Tier 1, which simply means it is a covered drug.

The PDL does not:

1. Require or prohibit the prescribing or dispensing of any medication;
2. Substitute for the independent professional judgment of the physician or pharmacist; or
3. Relieve the physician or pharmacist of any obligation to the patient or others.

Medication additions or deletions to the PDL reflect the decisions made by the Magellan Complete Care Pharmacy Therapeutics (P&T) Committee, and those decisions are inclusive of the Arizona Health Care Cost Containment System (AHCCCS) PDL. The composition of the committee includes licensed pharmacists and medical doctors. Network providers have the right to submit formulary change requests to MCC of AZ by mail to: MCC of AZ Pharmacy Director, 4801 E Washington St. Phoenix, AZ 85034. The request must contain your clearly stated recommendation, reason for your recommendation and your contact information.

AHCCCS usually makes changes to the AHCCCS PDL quarterly. Those changes are also made to the MCC of AZ PDL quarterly. If a covered drug is removed from the PDL, MCC of AZ will send a written notification to the affected members at least 30 days before the change occurs. Providers are made aware of changes through provider bulletins that are emailed, faxed or posted to the provider portal.

Pharmacy Prior Authorizations

The PDL attempts to provide appropriate and cost-effective drug therapy to all participants covered by the MCC of AZ pharmacy program. If a patient requires medication that does not appear on the PDL, the physician can make a request for a non-preferred medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions. In order for a member to receive coverage for a medication requiring prior authorization, the provider must initiate a “Service Authorization Request” and indicate the reason for the exception. Service Authorization Request is the Magellan Rx terminology for Pharmacy Prior Authorization Request. All relevant clinical information and previous drug history should be included, and the form mailed, faxed or the request telephoned to:
You can find Service Authorization Request Forms at [www.mccofaz.com/provider](http://www.mccofaz.com/provider).

**Denial of Pharmacy Services**

If MCC of AZ denies a request for a service authorization, MCC of AZ will notify the provider via phone or fax within 24 hours of receipt of the request and issue a Notice of Action to the prescriber and the member. The Notice of Action will include appeal rights and instructions for submitting an appeal.

**Over-the-counter Items**

Certain over-the-counter items are covered for our members. The MCC of AZ PDL covers several over-the-counter (OTC) medications and can be obtained at a pharmacy with a prescription from a provider.

**Emergency Supply Policy**

All participating pharmacies are authorized to call the Magellan Rx Pharmacy Helpdesk to request an override for a 4-day supply of medication for an emergent situation. An emergent situation is defined as: 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: a) placing the patient’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b) serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part.

The following drug categories are not part of the Magellan Complete Care preferred drug list and are excluded by AHCCCS; therefore, they **are not covered by the emergency supply policy:**

1. Drugs used for anorexia or weight gain;
2. Drugs used to promote fertility;
3. Agents used for cosmetic purposes or hair growth;
4. Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA;
5. DESI (Drug Efficacy Study Implementation) drugs considered by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
6. Drugs that have been recalled;
7. Experimental drugs or non-FDA-approved drugs; and
8. Drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate Program.

**Newly Approved Products**

Newly approved drug products will not normally be placed on the preferred drug list during their first six months on the market. During this period, access to these medications will be considered through the PA review process.

**PCP Management of Behavioral Health Disorders & Medication Prescribing**

Within the scope of his or her practice, PCPs may provide medication management to members with behavioral health disorders including substance use disorders. When a PCP chooses to medically manage an MCC of Arizona member with a behavioral health diagnosis, it is an MCC of Arizona and AHCCCS requirement that details regarding such management will be complete and adequately documented in the member’s medical record. MCC of Arizona, as required by AHCCCS policies, must monitor PCPs for proper diagnosis and management of behavioral health disorders. Monitoring is conducted through review of claims and an audit of PCP records. MCC of Arizona will review selected medical records for current diagnosis, prescribed behavioral health medication, current symptom assessment, appropriate follow-up regarding effectiveness of medications and a treatment plan outlining the plan of care. In the event that the PCP management appears to be inadequate, they will receive an educational packet outlining MCC of Arizona and AHCCCS standards for the management of members with behavioral health conditions and transfer of care requirements. All audit results are presented to the Quality Committee on an annual basis.

A variety of reports including, but not limited to, psychotropic medication reports, buprenorphine reports, claims/encounter data from PCPs, and EPSDT forms documenting behavioral problems will be reviewed for auditing purposes.

**Prescription Monitoring and Pharmacy or Prescriber Lock In Program**

MCC of Arizona monitors controlled and non-controlled medications on an ongoing basis at least quarterly throughout the year. Monitoring includes the evaluation of prescription utilization by members, prescribing patterns by clinicians and dispensing by pharmacies. Drug utilization data is used to identify and screen high-risk members and providers who may facilitate drug diversion or present quality of care concerns.

MCC of Arizona assigns members who meet certain evaluation parameters to an exclusive pharmacy and/or single prescriber for a minimum 12-month period. Criteria for pharmacy and/or prescriber member assignment include any of the following:

1. Overutilization:
   a. Member utilized the following in a 3-month time period:
      \[ \geq 4 \text{ prescribers}; \text{ and} \]
≥ 4 different abuse potential drugs; and
≥ 4 Pharmacies  OR
b. Member has received 12 or more prescriptions of the medications listed in section 1 in the past 3 months.

2. Fraud: Member has presented a forged or altered prescription to the Pharmacy
3. Referral from the MCC of AZ medical management clinical staff.

In addition to exclusive pharmacy and/or prescriber restrictions, other interventions may include:
1. Member specific point of sale safety edits and quantity limits as specified by the treating provider.
2. Referral to a case manager for long term follow up.
3. Referral to a behavioral health service provider or other appropriate specialist.

Magellan Complete Care of Arizona members with one or more of the following conditions will not be subject to pharmacy and/or prescriber assignment or restriction:
1. Members with an active oncology diagnosis
2. Members receiving hospice care
3. Members residing in a skilled nursing facility.

Members who are assigned to an exclusive pharmacy and/or an exclusive prescriber for 12 months are provided a written notice of action at least 30 days prior to the effective date of the assignment. Restrictions are not implemented before providing members notice and opportunity for a hearing. If the member files a request for hearing, no restriction is imposed until such time that a resolution has been made.

5 Day Opioid Limit

MCC of Arizona enforces the opioid days’ supply limitation as required by AHCCCS

Members under 18 years of age
A prescriber shall limit the initial and refill prescriptions for any short-acting opioid medication for a member under 18 years of age to no more than a 5-day supply. An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member’s PBM prescription profile.

The initial and refill prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:
- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Children on opioid wean at time of hospital discharge
- Skilled nursing facility care
• Traumatic injury, excluding post-surgical procedures, and
• Chronic conditions for which the provider has received PA approval through MCC of Arizona

The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for post-surgical procedures. However, initial prescriptions for short-acting opioid medications for postsurgical procedures are limited to a supply of no more than 14 days. Refill prescriptions for short-acting opioid medications for post-surgical procedures are limited to no more than a 5-day supply.

**Members 18 years of age and older**

A prescriber shall limit the initial prescription for any short-acting opioid medication for a member 18 years of age and older to no more than a 5-day supply. An initial prescription for a short-acting opioid medication is one in which the member has not previously filled any prescription for a short-acting opioid medication within 60 days of the date of the pharmacy filling the current prescription as evidenced by the member’s PBM prescription profile.

The initial prescription 5-day supply limitation for short-acting opioid medications does not apply to prescriptions for the following conditions and care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures, and
- Post-surgical procedures.

Initial prescriptions for short-acting opioid medications for post-surgical procedures are limited to a supply of no more than 14 days.

**Controlled Substances and E-Prescribing**

*From AHCCCS:*

This information is to provide notification of the State of Arizona House Bill 2075 as it pertains to Electronic Prescribing of Controlled Substances and the links for additional information on available resources.

Beginning January 1, 2020, a Schedule II controlled substance that is an Opioid shall be dispensed only with an electronic prescription order as required by Federal Law or Regulation. The Arizona State Board of Pharmacy will not issue waivers to providers for this regulation.

This is a statutory mandate to all providers sending and pharmacies receiving Schedule II Opioid Prescriptions. Exceptions to HB2075 include federal facilities, for example, the Indian Health Service, the Department of Veterans Affairs and the Department of Defense; these facilities are not subject to this regulation.
For additional information regarding HB2075, please click the link below to the Arizona State Board of Pharmacy website to view the Frequently Asked Questions tab “E-Prescribing of Schedule II Opioids Mandate.”

https://pharmacy.az.gov/faq

Please contact the AHCCCS Pharmacy Department at AHCCCSPharmacyDept@azahcccs.gov with any questions.

General and Informed Consent

Informed consent is required to be obtained from a member or legal guardian prior to the provision of the following services and procedures as outlined in AMPM 320-Q:

1. Complementary and Alternative Medicine (CAM),
2. Psychotropic medications,
3. Electro-Convulsive Therapy (ECT),
4. Use of telemedicine,
5. Application for a voluntary evaluation,
6. Research,
7. Admission for medical detoxification, an inpatient facility or a residential program (for members determined to have a Serious Mental Illness), and
8. Procedures or services with known substantial risks or side effects

Any member, who is 18 years or older, will need to give voluntary general consent to treatment for any of the above-mentioned procedures. The provider will need to demonstrate consent within the medical record via a signed general consent form. For members under the age of 18, the parent, legal guardian or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05 (C) and (D)) will give general consent for treatment. The provider will need to demonstrate this consent within the medical record via a signed general consent form by the legal representative.

Prior to signing the general consent form the member and/or legal representative must be fully informed of the consequences, benefits and risks of treatment and understands their rights not to consent to receive specific behavioral health services. Member’s over 18 years of age and/or the legal representative may refuse medications unless the member is required by a court order to take prescribed medications or in an emergency situation. Providers who are treating members in an emergency situation are not required to obtain general consent prior to treatment.

The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent. Essential elements for obtaining informed consent for psychotropic medication are contained in a sample form that can be accessed online (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310V1.pdf). The use of the sample form is recommended as a tool to document informed consent for psychotropic medications.
Section 14: Quality

A Commitment to Quality

MCC of AZ is committed to continuous quality improvement and outcomes management through its Quality Improvement Program which includes assessment, planning, measurement, and re-assessment of key aspects of care and service. In support of our Quality Improvement Program, providers must be familiar with our guidelines and standards and apply them with our members in order to provide safe, effective, patient-centered, timely, efficient, and equitable care in a culturally sensitive manner.

We depend on our providers to:

1. Follow the policies and procedures outlined in this handbook;
2. Use evidence-based practices, and adhere to principles of patient safety;
3. Attend provider training and orientation sessions, as needed and requested;
4. Participate in the completion of a remediation plan if quality of care concerns arises;
5. Complete and return provider satisfaction surveys;
6. Using secure technology to make accessing services more convenient for members (e.g., email communication, electronic appointment scheduling, appointment or prescription refill reminders, and online access to personal health record information);
7. Assist with transition of care if a member’s benefits have been exhausted, when a provider leaves the network, or the provider receives a referral of a member whose provider has left the network, a member wants to change providers, or stop services prior to service authorization expiration;
8. Assist in the investigation of member complaints and serious incidents, as necessary;
9. Attend meetings of our quality committees and provider advisory groups, as requested;
10. Take action on member gap-in-care information as applicable; and
11. Be knowledgeable in quality improvement methods and tools including NCQA’s Health Plan Accreditation Standards, and HEDIS® measures.

MCC of AZ’s responsibility is to:

1. Consider the provider’s feedback on clinical practice guidelines, medical necessity criteria, prevention programs, patient safety policies, and new technology assessments;
2. Consider providing feedback to our quality committees;
3. Develop methods to compare treatments, outcomes and costs across the provider network in an effort to diminish the need for case-by-case review of care;
4. Provide member-specific clinical and quality reports to help support a provider’s patients;
5. Monitor provider satisfaction with our policies and procedures as they affect the provider’s practice;
6. Pay claims within applicable timeframes;
7. Join with providers to develop a clear remediation plan to improve quality of care when necessary;
8. Provide timely information and decisions on credentialing and recredentialing processes; and
9. Resolve claims disputes and appeals within applicable timeframes.

**Cultural Competency**

MCC of AZ is committed to embracing the rich diversity of the people of Arizona. We believe in providing high-quality care to culturally, linguistically and ethnically diverse populations, as well as to those who are visually and hearing impaired. All people entering the healthcare system must receive equitable and effective treatment in a respectful manner, recognizing the role that individual spoken language(s), gender, and culture plays in a person’s health and well-being.

MCC of AZ staff are trained in cultural diversity and sensitivity to support our interactions with members, and also, in order to refer members to providers appropriate to their needs and preferences. MCC of AZ provides cultural competency training, technical assistance and online resources to help providers enhance their provision of high-quality, culturally appropriate services.

MCC of AZ provides interpreter access for members from culturally and linguistically diverse backgrounds and for people with hearing, speech and communication impairments. Interpreter services for all languages, including sign language, are provided at no charge for our members. MCC of AZ facilitates language assistance provided to limited English proficient members, including how to work with interpreters and telephone language services or working with translated written materials. Members, or providers on behalf of a member, can schedule an on-site interpreter by calling Customer Service at 1-800-424-5891 to request interpretation services.

Magellan Complete Care’s telephone language line available 24 hours a day, seven days a week. Participants who are hearing-impaired or have speech impairment have access to the TTY/TDD service line by calling TTY 711. Participants who do not have TTY can communicate with a TTY user through Message Relay Center (MRC). MRC has TTY operators available to send and interpret TTY messages. MCC of AZ continually assesses network composition by actively recruiting, developing, retraining and monitoring a diverse provider network compatible with the member population.

We depend on our providers to:
1. Provide MCC of AZ with information on languages spoken by the provider or the provider’s staff.
2. Provide MCC of AZ with any practice specialty information the provider holds on the provider credentialing application.
3. Provide oral and American Sign Language (ASL) interpretation services. In accordance with Title VI of the Civil Rights Act, Prohibition against National Origin Discrimination, providers must make oral interpretation services available to persons with limited English proficiency (LEP) at all points of contact. Oral interpretation services are provided at no charge to members. Members must be
provided with information instructing them how to access these services. Interpretation services are the facilitation of oral or sign-language communication, either simultaneously or consecutively, between users of different languages.

4. Translate any document that requires the signature of the member, and that contains vital information regarding treatment, medications, or service plans, into their preferred/primary language if requested by the member or his/her guardian.

5. Inform us if the provider objects to the provision of any counseling, treatments or referral services on religious grounds.

MCC of AZ’s responsibility is to:

1. Provide ongoing education to help providers deliver culturally informed services to people of all cultures, races, ethnic backgrounds, religions, and those members with disabilities.

2. Provide language assistance, including bilingual staff and interpreter services, to those with limited English proficiency during all hours of operation at no cost to the member.

3. Assist providers in locating interpreters for our members when requested by the member or when requested by the provider. (See Interpreter Services- within Section 11- for more detail)

4. Provide easily understood member materials, available in the languages of the commonly encountered groups and/or groups represented in the service area.

5. Monitor gaps in services and other culturally specific provider service needs. When gaps are identified, MCC of AZ will develop a provider recruitment plan and monitor its effectiveness.

Accreditation

Excellence in clinical care and service can be affirmed through recognition by national accrediting bodies, such as the National Committee for Quality Assurance (NCQA). MCC of AZ policies, procedures and quality initiatives are guided by national accreditation standards, including, but not limited to:

1. Provider accessibility standards;

2. Site visits and medical/treatment record reviews;

3. Credentialing and recredentialing requirements;

4. Clinical practice guidelines;

5. Collaboration and coordination of care;

6. Care management and case management review processes;

7. Prevention/screening programs;

8. Member experience (satisfaction) surveys;

9. Member safety policies and initiatives;

10. Complaint, appeal and grievance policies and procedures;

11. Confidentiality policies and procedures;

12. Medical integration and coordination policies and procedures;

13. Provider quality remediation and review

14. Member communication, including distribution of the Member’s Rights and Responsibilities statement;
15. Provider participation on our quality improvement committees;
16. Quality improvement and care management program descriptions; and
17. Member requests to change providers and transition of care tracking.

**HEDIS® and Performance Measurement**

MCC of AZ supports and promotes the use of evidence-based performance measures that help drive the adoption of recommended care and improvements in population health. “HEDIS®,” which stands for Healthcare Effectiveness Data and Information Set, is owned by the National Committee for Quality Assurance (NCQA) and is the most widely used measure set for driving quality rating systems, as well as for its individual measures which are increasingly used by employers, health plans, and government agencies to drive pay-for-performance quality programs. HEDIS measures cover a wide span of indicators related to the management of physical and behavioral health. Final performance is calculated over the first six months of every calendar year, for the prior calendar year. Some measures allow medical record data, and some reviews occur across a multi-year period.

We depend on our providers to:
1. Submit accurate and complete claims and encounter data with a timely manner of the rendered service;
2. Assure the provider and the provider’s office staff comply with our requests for medical records in the timeframes requested;
3. Notify our staff or delegated vendor immediately if the patient listed on a request for medical records is not a part of the provider’s practice;
4. Provide medical records for a member who was seen by a physician who has retired, died or moved, as data collection can go back as far as 10 years; and
5. Assist us with quality improvement activities that improve the health and wellness of our population.

MCC of AZ’s responsibility is to:
1. Provide education and information as needed regarding HEDIS and other performance measures for which we request a provider’s cooperation and assistance; and
2. Communicate with providers by phone, fax, in writing, or through secure electronic communications to request medical record documentation to verify service delivery.

**Member Experience of Care and Satisfaction Surveys**

Obtaining member input on their experience of care, and satisfaction with their providers and us, is an essential component of our quality program. In addition to the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey, which is mailed on an annual basis, MCC of AZ may survey specific cohorts of members who have received medical services and behavioral health treatment, and
home- and community-based services to determine their level of satisfaction with the care and support they are receiving from us, and from providers in our network.

Each provider’s responsibility is to:
1. Implement actions identified from satisfaction survey results when informed by MCC of AZ;
2. Involve members in their care and treatment plan;
3. Encourage members to provide feedback on the care and services received; and
4. Update provider practice and profile information, which members see in online provider searches, and monitor the provider’s reviews submitted by members.

Peer Review

MCC of AZ has established a Peer Review Committee to analyze and address clinical issues in order to improve the quality and appropriateness of care provided to members by practitioners and providers.

The Peer Review Committee’s scope includes the review of cases where:
1. There is evidence of a quality deficiency in the care or service provided, or
2. There is an omission of care or service, by a participating or nonparticipating health care professional or provider.

Such cases include, but are not limited to:
1. Cases where there is evidence of deficient quality,
2. An omission of the care or service provided by a participating or non-participating physical health care or behavioral health care provider,
3. Questionable clinical decisions, lack of care and/or substandard care,
4. Inappropriate interpersonal interactions or unethical behavior, physical, psychological, or verbal abuse of a member, family, staff, or other disruptive behavior,
5. Allegations of criminal or felonious actions related to practice,
6. Issues that immediately impact the member and that are life threatening or dangerous,
7. Attempted suicide,
8. Opioid-involved/related cases,
9. Unanticipated death of a member,
10. Issues that have the potential for adverse outcome, or
11. Allegations from any source that bring into question the standard of practice.

The Peer Review Committee is chaired by the Chief Medical and includes contracted medical providers, both medical and behavioral, that serve AHCCCS members. The peer review process will ensure that providers of the same or similar specialty participate in review and recommendation of individual peer review cases. Magellan may use peers of the same or similar specialty through external consultation should that specialty not be represented on the committee. Committee members do not participate in peer review activities if they have a direct or indirect interest in the peer review outcome.
The committee evaluates each case referred to peer review case based on all information made available through the quality management process. The committee makes recommendations for action to the Chief Medical Officer that may include, but are not limited to, peer contact education, change in credentials, limitation or caps on provider enrollment, sanctions, or other corrective actions. The Peer Review Committee is also responsible for making recommendations regarding initiation of referrals to the following entities for additional investigation: Department of Child Safety, Adult Protective Services, The Department of Health Service Licensure, the appropriate regulatory agency or board, and AHCCCS. Recommendations to alter the conditions of participation or to reduce, suspend or terminate provider’s credentials are referred to the Peer Review and Credentialing Committee for final determination. Adverse actions taken as a result of the Peer Review Committee are reported to AHCCCS.

All information used in the peer review process, including MCC AZ’s peer review reports, meetings, minutes, documents, recommendations, and participants, are kept confidential and are not discussed outside of the peer review process except for purposes of implementing recommendations made by the committee.

**Peer Review Grievance Procedure**

Providers are notified in writing of any action recommended by the Peer Review Committee. The notice states that an adverse Peer Review Committee action has been proposed, the reason for the proposed action, that the provider may request a hearing before an Appeal panel and a summary of the provider’s rights in the hearing. The appeal request must be submitted within 33 calendar days of the date of the written notification. Should the provider request an appeal panel hearing, the provider will be notified of the date, time and location of the appeal hearing. Providers may participate in the appeal hearing either telephonically or in-person and may be represented by an attorney or another person of the provider’s choice. In addition, they may submit additional materials for consideration, and to present other materials determined to be relevant by the panel. Upon completion of the hearing, the provider is notified in writing of the outcome within 30 calendar days of the hearing. The notification the panel’s recommendations and decision, and the basis for the decision.

Providers whose network participation is terminated due to current license sanctions or disciplinary action, or exclusion from participation in Medicare, Medicaid or other federal healthcare programs, no longer meet MCC of AZ’s network participation criteria and are offered an internal administrative review unless otherwise required by AHCCCS, state or federal requirements. Providers are notified in writing of their network participation status, reason for denial of ongoing participation, and informed of their right to an internal administrative review. Providers are permitted no more than 33 calendar days from the date of MCC of AZ’s written notification to request an administrative review if they disagree with the reasons for the termination. The provider is notified in writing of the outcome within 30 calendar days of the administrative review.

**Provider Input**

Obtaining provider input is an essential component of our quality program. We obtain provider input on our programs and services through provider satisfaction surveys, participation in MCC of AZ quality committees, and our provider website as detailed below.
1. **Provider Satisfaction Survey**: Annually, we survey participating providers in our provider network who have rendered services to members during the survey period to determine their level of satisfaction with MCC of AZ as well as with key aspects of the service they received from us while assisting our members. If selected, the provider’s responsibility is to complete the survey and return it in the timeframe requested. We share aggregate results of our provider satisfaction surveys with our providers, accreditation entities and members. These survey findings identify opportunities for improvement for our policies, procedures and services.

2. **Quality Committees**: MCC of AZ drives leadership and oversight of all aspects of health plan quality through the quality committee structure. We may request a provider participate in our quality committee(s) and to give input on clinical practice guidelines, medical necessity criteria, prevention programs, new technology assessments, and other guidelines and policies.

3. **Provider Website**: Feedback can be submitted through MCC of AZ provider email box: MCCAZProvider@MagellanHealth.com.

**Medical Record Standards**

In support of our commitment to quality care, we request that our providers maintain organized, well-documented member medical records that reflect continuity of care for members. We expect that all aspects of treatment will be documented in a timely manner, including face-to-face encounters, telephone contacts, clinical findings and interventions. The complete list of requirements is documented below.

1. Member identifying information, including name, member identification number, date of birth, gender, and legal guardianship (if any) should be included.

2. Providers must ensure a method for obtaining complete and current patient clinical information and maintaining an updated summary. Examples include a physical form, summary sheet, or checklist that captures significant surgical procedures, past and current diagnoses or problems, allergies, untoward reactions to drugs and current medications.

3. Treatment plans must reflect evidence-based standards of care and be consistent with the diagnosis for each visit.

4. Each record must be legible and maintained in detail.

5. All entries must include the name and credentials of the provider rendering services (e.g., MD, DO, OD), including the date and signature of the provider. All notes written by physician extenders (ARNPs or PAs) must be co-signed by the assigned PCP, indicating their review and approval of the care rendered. All entries must be dated and signed by the appropriate party.

6. All entries must indicate the chief complaint or purpose of the visit, the objective, diagnoses, medical findings or impression of the provider.

7. All entries must indicate studies ordered (e.g., laboratory, x-ray, EKG) and referral reports.

8. All entries must indicate therapies administered and prescribed.

9. All entries must include the disposition, recommendations, instructions to the
member, evidence of whether there was follow-up and outcome of services.
10. All records must contain an immunization history.
11. All records must contain information relating to the member’s use of tobacco products and alcohol/substance use.
12. All records must contain summaries of all Emergency Services and care and hospital discharges with appropriate medically indicated follow-up.
13. Documentation of referral services must be in member’s medical records. This is to include, but not necessarily be limited to, family planning services, preventive services and services for the treatment of sexually transmitted diseases.
14. All records must reflect the primary language spoken by the member and any interpretive needs of the member.
15. All records must identify members needing communication assistance in the delivery of healthcare services.
16. All records must contain documentation that the member was provided with written information concerning the member’s rights regarding Advance Directives (written instructions for living will or power of attorney) and whether or not the member has executed an Advance Directive. If the member indicates they have an Advance Directive, a copy should be included. Providers cannot, as a condition of treatment, require the member to execute or waive an Advance Directive.
17. Include copies of any consent or attestation form used or the court order for prescribed psychotherapeutic medication for a child under the age of 13.

**Medical Record Retrieval**

**Patient Request**

Providers must provide a copy of the member’s medical records to members and their authorized representatives as required by the contractor and within no more than 10 business days of the member’s request.

**Health Plan Request**

For quality review and improvement purposes, and to support accurate HEDIS reporting, and accurate member risk profiling, MCC of AZ may request medical records from providers at different times during the year. We will provide an explanation for the request of the records, and detailed instructions for submission. Each provider’s responsibility is to make the records available for our review in the timeline requested at no extra charge.

Additionally, when a member changes his or her PCP, MCC of AZ will request the member’s medical records or copies thereof be available to the new PCP within 10 business days from receipt of request.

**Medical Record Confidentiality**

Providers will ensure the confidentiality of all medical records in accordance with 42 CFR, Part 431, Subpart F and relevant HIPAA requirements. The confidentiality of a minor’s consultation, examination, and treatment for a sexually transmissible disease must be maintained in accordance with s. 384.30(2), F.S.
Providers are obligated to alert us immediately if there is any violation of the above confidentiality requirements, or any suspected inappropriate use of PHI.

**Medical Record Review**

MCC of AZ will review medical records to determine adherence with MCC of AZ standards for documentation and AHCCCS regulations. Reviews will be done based on a random sample of all providers who are treating our members. The plan will also supplement other data sources such as HEDIS results and claims data to ensure compliance with clinical practice guidelines.

**Section 15: Claims Submission**

**General**

As Participating Provider with MCC of AZ, providers have established a contractual agreement to provide physical, behavioral and/or other long-term support services to our members. The arrangement is fee-for-service for the provision of covered health care services unless otherwise specified under the provider’s Participating Agreement. The rates established in the provider’s Participating Agreement is considered full payment for covered service provided. Accordingly, MCC of AZ members may not be balanced billed for any remaining amounts and/or difference between what is billed, and the provider’s negotiated reimbursement rate defined in the rate exhibit of the provider’s Participating Agreement.

**Contractor Payment Responsibilities**

MCC of AZ will process payment requests from both Physical Health and Behavioral Health Providers. In such cases where the principal diagnosis would designate a payment request as Behavioral Health, MCC of AZ would maintain responsibility for Physical Health services included in that claim in accordance with all processing guidelines. Similarly, in such cases where Behavioral Health services are rendered during a Physical Health visit MCC of AZ would maintain responsibility to adjudicate any Behavioral Health services included in the payment request. This includes payment requests submitted by HIS or tribally owned facilities for Title XIX members.

Professional services billed separately from a Hospital visit will be evaluated and paid separately from the inpatient or ER visit. The professional services will be evaluated based on the primary diagnosis submitted and when billed by a separate entity are payable to the billing entity.

MCC of AZ will, as appropriate, reimburse PCPs for some Behavioral Health services when appropriate. Those services may include depression, anxiety and ADHD. In specific instances, such as medication management, the billing PCP is not required to be the member’s assigned PCP.
In the event a member is residing in the Arizona State Hospital (AzSH) MCC of AZ will cover any required services not rendered by the hospital through a contractual agreement or other coordination of care and payment efforts with MIHS or MMC as required.

**Procedure for Reimbursement of Covered Services**

As a Participating Provider, each provider agrees to bill all covered services provided to MCC of AZ members on the required forms and/or electronic claim file format. All claims should be billed on a fully completed CMS 1500, UB04 and/or CMS 1450 to be considered for adjudication and/or payment. Providers may visit the Centers for Medicare and Medicaid Services (CMS) website at [www.cms.hhs.gov](http://www.cms.hhs.gov) to obtain more information about these forms and/or for more instruction and/or information on the proper use of claims forms for services.

Any claims requiring authorization should include medical the authorization number in the appropriate field of the CMS 1500, UB04 or CMS 1450 to assist with appropriate claims processing and timely claims payment. For a list of services requiring prior authorization, please visit our provider tools and resources on [www.MCCofAZ.com](http://www.MCCofAZ.com) or as indicated reference to the listing can also be found in Section 10: Medical Management of this Provider Handbook.

**Paper Claims**

MCC of AZ Participating Provider are strongly encouraged to submit their claims electronically. However, paper claims can be accepted. When paper claims are submitted, they must be on properly completed original red UB04, CMS-1450 or CMS-1500 (02-12) claim forms and laser-printed or typed. Mail paper claims to:

Magellan Complete Care of Arizona
Claims Service Center
P.O. Box 1105
Elk Grove Village, IL 60009-0956

**Electronic Claims and Electronic Data Interchange (EDI)**

MCC of AZ has the ability to accept provider’s claims electronically. Providers submit their claims electronically to experience the cost-saving benefits, administrative simplification as well as ease in submission and claims payment. MCC of AZ works with many claim clearinghouses. To check if MCC of AZ has a relationship with a provider’s clearinghouse, the provider may call customer service at 1-800-424-5891.

**Timely Filing**

Claims for services provided to MCC of AZ members should be submitting within six months (180 days) of the date of service unless otherwise agreed upon in the Participating Provider Agreement. If not otherwise defined in the Participating Agreement, and /or in the case of a non-Participating provider who provides covered service to an MCC of AZ member, claims must be received within twelve months (365 calendar days) to be considered for processing and payment.
Timely Filing Exception Considerations

1. Coordination of Benefits - When a member has a primary insurance, the primary insurance Explanation of Payment (EOP) or Medicare Summary Notice (MSN) is used to determine the timely filing deadline. For these claims, the time frame begins with the print date on the primary insurance EOP or MSN.

2. Member with Retroactive Eligibility – When a member becomes eligible for AHCCCS Complete Care Program after the date of service, but their coverage is backdated to include the date of service, the time frame for timely filing begins on the date MCC of AZ receives notification from the enrollment broker of the member’s enrollment.

3. Other (Good Cause) – MCC of AZ will consider exceptions on a case by case basis for other causes of filing delays such as incorrect information provided by official sources.

Payment Timeframes

Processing and payment of claims for covered services are generally made within 30 calendar days of receipt of a clean claim as defined in the Provider Handbook.

Clean Claim

A claim is considered clean when the service is billed on the appropriate CMS form (CMS-1500, 1450, or UB04), with current coding standards in the required form field and any required attachment or supporting documentation necessary to properly process and adjudicate the claim(s).

By definition, a “clean” is a claim that will not require MCC of AZ to investigate or update to apply proper adjudication and payment. Clean claims must contain all of the basic information necessary:

1. Current industry standard data coding;
2. Attachments appropriate for submission and procedural circumstance;
3. Completed data elements field required for the CMS-1500, CMS- 1450, or UB04

A claim is considered “unclean” if one or more of the following conditions exist due to a good faith determination and/or dispute regarding:

1. The standards or format used in the completion or submission of the form
2. The eligibility of the person listed for coverage
3. The responsibility of another payer for all or part of the claim
4. The amount of the claim or the amount currently due under the claim
5. The benefits covered
6. The manner in which services were accessed or provided
7. The claim was submitted fraudulently
Correct Form

MCC of AZ requires claims for professional services to be submitted using with CMS 1500 form and claims for hospital /facility services (or other ancillary services) should be submitted using the CMS-1450 or UB-04.

Standard Coding

All fields should be completed using industry standard coding as outlined below:

<table>
<thead>
<tr>
<th>Code Set</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4 (Current Procedure Terminology)</td>
<td>Maintained and distributed by the American Medical Association, including its codes and modifiers, and codes for anesthesia services</td>
</tr>
<tr>
<td>CDT-1 (The Code on Dental Procedures and Nomenclature)</td>
<td>Maintained and distributed by the American Dental Association</td>
</tr>
<tr>
<td>ICD-10 CM (International Classification of Diseases)</td>
<td>Maintained and distributed by the National Center for Health Statistics – Centers Disease Control and Prevention</td>
</tr>
<tr>
<td>HCPCS and Modifiers (CMS Common Procedure Coding System)</td>
<td>Maintained and distributed by the US Department of Health and Human Services</td>
</tr>
<tr>
<td>NDC (National Drug Codes)</td>
<td>Prescribed drugs maintained and distributed of the U.S Department of Health and Human Services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code Set</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASA (American Society of Anesthesiologists)</td>
<td>Anesthesia services, the codes maintained by the American Society of Anesthesiologists</td>
</tr>
<tr>
<td>DSM-IV (American Psychiatric Services)</td>
<td>For psychiatric services, codes distributed by the American Psychiatric Association</td>
</tr>
<tr>
<td>Revenue Codes</td>
<td>For facilities, use the national or state uniform billing data elements specifications</td>
</tr>
</tbody>
</table>

Provider- Specific Billing Instructions and Manuals


Additional training and provider specific resources may also be made available on the MCC of AZ provider portal at www.MCCofAZ.com.

Adherence to provider and service specific billing instructions as defined ensures that the required MCC of AZ encounter data will be accepted by AHCCCS and/or the State’s encounter data warehouse.
Code Review and Claims Editing

MCC applies coding and clinical edits to evaluate claims for accuracy and adherence to national industry and state standards for correct coding methodologies. These edits increase consistency of payment for providers by ensuring correct coding and billing practices are followed.

Claims Edit System (CES)

MCC uses a software application, CES, to automatically review and edit claims submitted by physicians and facilities. The system includes NCCI edits and automatically detects coding errors related to unbundling, modifier appropriateness, diagnoses, and duplicate claims. The CES system improves the accuracy of claims payment for all provider types (i.e. physicians, facilities, and suppliers), in accordance with the required editing protocols for the AHCCCS Complete Care Program.

Medicaid National Correct Coding Initiative (NCCI) Program Edits

NCCI edits reduce improper coding and inappropriate payment of Medicaid claims.

Types of NCCI Edits

The National Correct Coding Initiative (NCCI) contains two types of edits:

1. NCCI procedure-to-procedure (PTP) edits that define pairs of Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. The purpose of the PTP edits is to prevent improper payments when incorrect code combinations are reported.

2. Medically Unlikely Edits (MUEs) define for each HCPCS / CPT code the maximum units of service (UOS) that a provider would report under most circumstances for a single beneficiary on a single date of service.

The NCCI Methodologies in Medicaid

The Medicaid NCCI program consists of six methodologies. These are:

1. A methodology with PTP edits for provider and ambulatory surgical center (ASC) services.
2. A methodology with PTP edits for outpatient services in hospitals (including emergency department, observation, and hospital laboratory services).
3. A methodology with PTP edits for durable medical equipment.
4. A methodology with MUEs for provider and ASC services.
5. A methodology with MUEs for outpatient services in hospitals.
6. A methodology with MUEs for durable medical equipment.

The Medicaid NCCI methodologies apply only to Medicaid fee-for-service claims that are reimbursed on the basis of HCPCS / CPT codes.
Components of the NCCI Methodologies in Medicaid

Each of the Medicaid NCCI methodologies has four components. These are:

1. Set of edits;
2. Definitions of types of claims subject to the edits;
3. Set of claim adjudication rules for applying the edits; and
4. Set of rules for addressing provider appeals of denied payments for services based on the edits.

The presence of a HCPCS / CPT code in a PTP editor of an MUE value for a HCPCS / CPT code does not necessarily indicate that the code is covered by any state Medicaid program or by all state Medicaid programs. States cannot use the files here for processing and paying Medicaid claims. It is important to understand, Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. Additional information and important notices concerning the National Correct Coding Initiative can be found at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

Editing will apply to Professional (1500) and Facility (UB04) claims. Updates to edits range from bi-monthly to quarterly, based on the edit source.

Multiple Procedure Reimbursement Policy

MCC of AZ utilizes and closely follows payment guidance and policy employed by the Centers for Medicare and Medicaid Services (CMS). Multiple procedures performed in the same operative session will be reimbursed at 100% of the contracted and/or negotiated rate for the first procedures from the highest payment group. All other procedures will be paid at 50% of respective rates. This is a professional payment policy applied to covered professional services billed for MCC of AZ members.

Reimbursement Policy for Comprehensive and Component Codes

MCC of AZ models industry policies modeled after the Correct Coding Initiative (CCI) administered through CMS, AMA current procedural terminology (CPT) and other general industry –accepted guidelines.

When two or more related procedures are performed during a single patient visit, there are instances when a claim is submitted with multiple codes instead of one comprehensive code that fully describes the entire services. MCC of AZ will reimburse for the comprehensive code.

Evaluation and Management on Same Day as Surgery

When an evaluation and management (E&M) or inpatient consult procedure is established on the same day a surgical procedure is performed, the E&M procedure is considered included in the fee for the surgical procedure. The fee for certain supplies associated with the procedures is also included in the reimbursement for the surgical procedure. In some cases, an appropriate modifier will override the adjustment.
Global Surgical Package

A global period for surgical procedures is an industry-standard accepted concept where a single fee is billed and paid for all covered services rendered by the surgeon before, during, and after the procedure. The global period range for procedure within 10-days to 90-days are considered subject to the global period and considered inclusive to the surgical reimbursement fee applied.

Durable Medical Equipment Billing

MCC of AZ coordinates, arranges, and authorizes appropriate durable medical equipment to support the care needs of its members. DME equipment types and the duration of needs is determined on a case by case basis based on the member’s specific need determine in the care management planning and ongoing treatment coordination. MCC of AZ will make determinations and authorization as it related to payment for DME based on the member’s short term and long-term needs.

Participating DME providers should review their MCC of AZ authorization which will indicate if the service is rental, purchase, and/or transition to purchase:

- **Rental Only items**: a period of time when the reimbursement is based on a monthly fee for a particular DME item. DME services that are identified as continuous rentals, will be reimbursed at the rental allowance.

- **Rental Items with a Purchase**: a period of time that allows a rental item to pay up to the maximum allowable. Once the allowable rental period is met and the item is going to be purchased, the purchase will be paid over a maximum period of up to 10 months. Example: if an item is rented for 3 months, the purchase price will be divided into 10 monthly payments. The 3-month rental period payments will be subtracted from the 10-month payment. The remaining 7 months will be paid as monthly payments until the purchase price has been paid. The DME payment will not exceed the allowance for the DME purchase price item.

- **Capped rental**: An amount reimbursed on a monthly rental basis, which will not exceed the applicable number of continuous months, if present.

Billing with the appropriate rental or purchase modifier along will be key in ensuring the appropriate payment. Participating DME or other approved DME providers should consult the AHCCCS Billing instruction and guidelines for provider- specific billing instructions on AHCCCS’ website at https://www.azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html.

Additional training and provider specific resources may also be made available on the MCC of AZ provider portal at www.MCCofAZ.com.

Members receiving incontinence products

If a member leaves our plan and is covered under the Arizona Health Care Cost Containment System’s (AHCCCS) fee-for-service program, the member will need to access incontinence supplies through the AHCCCS sole source contractor for incontinence supplies (Home Care Delivered). A member’s
enrollment with our plan is subject to change each month. Providers must hold the member harmless from liability for the cost of any services provided incorrectly as a result of the provider’s failure to verify member eligibility and enrollment.

**Obstetrical, Maternity Care Service and Delivery Billing**

MCC of AZ Participating Providers should adhere to specific billing and coding guidelines to ensure proper claims processing and reimbursement for global care and delivery.

<table>
<thead>
<tr>
<th>Obstetrical Billing Guidelines</th>
<th>CPT® Codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Global Billing for OB Care:</strong> Prenatal care, delivery, and postpartum care should be billed as an all-inclusive, single unit (&quot;global bill&quot;), <strong>except the first prenatal visit</strong></td>
<td>59400 (Vaginal delivery)</td>
</tr>
<tr>
<td></td>
<td>59510 (Cesarean delivery)</td>
</tr>
</tbody>
</table>

**Services included in Global OB Care**

**Antepartum Care:**
- Initial OB visit and subsequent visits
- Monthly visits to 28 weeks gestation
- Biweekly visits to 36 weeks gestation
- Weekly visits until delivery

**Delivery:**
- Admission to hospital
- Admission history and physical examination
- Management of uncomplicated labor
- Vaginal delivery (with or without episiotomy, with or without forceps), or
- Cesarean delivery

**Postpartum Care:**
- Hospital visits
- Office visits following Vaginal or Cesarean delivery

**Other:**

All prenatal visits, including initial history and physical examinations.
- Pregnancy test (CPT codes 81025, 84702, 84703).
- Urinalysis, initial and subsequent (CPT codes 81000, 81001, 81002, 81003, 81005).
- Glucose tolerance test (82947).
- Specimen collection (CPT code 99000).
- Venipuncture and handling charges (CPT codes 36415 and 36416).
- Initial evaluation and resuscitation of the newborn by the obstetrician.
- Observation or inpatient hospital care (99217, 99218, 99219, 99220, 99234, 99235, 99236, G0378) not resulting in delivery.
- Physician standby service (CPT code 99360).
- Episiotomy (CPT code 59300).
### Obstetrical Billing Guidelines

- Labor and delivery (vaginal or cesarean section) services including, but not limited to induction and any internal or external fetal monitoring performed and any obstetrical administered anesthesia except those services otherwise listed (CPT codes 59400, 59510, 59610, 59618).

- All postpartum care through 6 weeks, including suture removal, pap smears, and discussions on birth control (CPT codes: Q0091 pap and 99401 birth control counseling).

- Multiple vaginal or multiple cesarean deliveries are all reimbursed under the single global payment.

- Supervision of labor.

- Delivery of placenta (CPT 59414).

<table>
<thead>
<tr>
<th><strong>Initial Prenatal Visit</strong></th>
<th>Providers will be reimbursed for the initial prenatal visit separately from the “global fee” if the claim is submitted within 30 days of the date of service.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Claims should include:</td>
</tr>
<tr>
<td></td>
<td>- CPT Category II code 0500F</td>
</tr>
<tr>
<td></td>
<td>- EDC (expected delivery date)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Subsequent Visits</strong></th>
<th>Subsequent office visits for global OB care and delivery are considered as part of the “global OB care” reimbursement.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In addition to the global billing code, each subsequent visit should be listed along with:</td>
</tr>
<tr>
<td></td>
<td>- CPT Category II code 0500F for prenatal visits</td>
</tr>
<tr>
<td></td>
<td>- CPT Category II code 0503F to indicate the postpartum care visit</td>
</tr>
<tr>
<td></td>
<td>These codes may be filed when the services are rendered or included on the claim with the global OB charge.</td>
</tr>
</tbody>
</table>

| **Submission of Claims**  | Except for the first prenatal visit, charges for global OB care are to be submitted only after the postpartum visit. When billing for global OB care, the date of delivery is to be used as the billing date. |

| **Surgical Complications** | These services should be coded separately using the appropriate CPT codes.  
(Examples: appendectomy, hernia, ovarian cyst, Bartholin cyst) |
|----------------------------|--------------------------------------------------------------------------------------------------------------------------------|

| **Medical Complications of Pregnancy** | These conditions should be coded separately using the appropriate Evaluation and Management Services CPT codes.  
(Examples: cardiac problems, neurological problems, diabetes, hypertension, pre-eclampsia, hyperemesis, pre-term labor, premature rupture of membranes) |
### Obstetrical Billing Guidelines

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High-Risk Pregnancy Care/Complications of Pregnancy</strong></td>
<td><strong>Additional visits:</strong> MCC will reimburse for additional visits if the member experiences complications during pregnancy and requires more than 13 visits. The provider should code the additional services with a code representing the appropriate level of Evaluation and Management service. The documentation must reflect the necessity of these visits as well as any additional laboratory or radiologic tests performed.</td>
</tr>
</tbody>
</table>
| **Obstetrical Care Provided By Two Different Providers**               | If a practitioner provides all or part of the antepartum and/or postpartum patient care but does not perform delivery due to termination of pregnancy, referral to another provider for delivery, member no longer with MCC, the provider should use the appropriate CPT codes:  
  - **Antepartum Care Only** – 1 to 3 visits – use the appropriate Evaluation and Management (E/M) codes  
  - **Antepartum Care Only** – 4 to 6 visits – use CPT code 59425 & 1 unit  
  - **Antepartum Care Only** – 7 or more visits – use CPT code 59426 & 1 unit  
  - **Postpartum Care Only** – use CPT code 59430  
  **Note:** For other scenarios, refer to the CPT manual for the correct coding. |
| **Out of Network Provider**                                           | Except during the initial continuity of care period, all services provided by out of network providers require prior authorization. Requests by out of network providers are sometimes approved based on ongoing continuity of care for the member. |
| **Assistant at Cesarean Delivery**                                     | Assistant at a Cesarean delivery should be coded using CPT code 59514 *(Cesarean delivery only). Do not use CPT code 59510. 59510 is a global code that includes antepartum and postpartum care. Only use code 59510 if the provider was the physician who provided the antepartum and postpartum care.* |
| **Amniocentesis**                                                     | Code amniocentesis separately from the global delivery code. Amniocentesis is not included in the Global CPT codes of 59400 *(Vaginal delivery)* or 59510 *(Cesarean delivery).* |
| **Ultrasounds**                                                       | Code ultrasounds separately from the global delivery code. Ultrasounds are not included in the Global CPT codes of 59400 *(Vaginal delivery)* or 59510 *(Cesarean delivery).* |
| **Newborns**                                                          | Newborns are eligible for the AHCCCS Complete Care Program, and may be assigned to MCC of AZ. The MCC of AZ Health Services department will remit the appropriate Newborn notification information to AHCCCS. |
Nursing Facility Billing

MCC follows AHCCCS methodology and the RUG-IV 48 grouper for dates of service beginning on July 1, 2017.

Claims should be billed on the UB-04 claim form or the 837-I electronic format by the provider as currently billed. The RUG code should be submitted on the claim with the 0022 revenue code for room and board. The total charges for revenue code 022 should be zero and Revenue code 0658 should continue to be reported.

Example of values to be reported:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HIPPS Rate Code</th>
<th>Units</th>
<th>Billed Charges</th>
<th>Non-Covered Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0022</td>
<td>BB201</td>
<td>30</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>0658</td>
<td></td>
<td>30</td>
<td>6000.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>

The RUG code determined by the RUG-IV 48 grouper must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment or modifier should be reported in the last two digits of the HIPPS rate code. Under the price-based reimbursement methodology, in addition to billing the revenue codes for room and board and ancillary services each nursing facility claim must contain one revenue code “0022” for each distinct billing period of the nursing facility stay.

MCC requires nursing facilities to report the assessment reference date with the occurrence code 50 for each RUG code reported in the HIPPS Rate Code field on the UB-04. The date of service reported with occurrence code 50 must contain the ARD associated with the applicable OBRA assessment. An occurrence code 50 is not required with the HIPPS code reported for default RUG AAA.


Coordination of Benefits

MCC of AZ is the payer of last resort. When the member has commercial insurance coverage, providers must bill the commercial insurance first. This includes for children’s early intervention services except for:

- Those services federally required to be provided at public expense as is the case for
  - Assessment / Evaluation
  - Development or review of the Individual Family Service Plan (IFSP), and
  - Targeted case management / service coordination
- Developmental services; and,
- Any covered early intervention services where the family has declined access to their private health / medical insurance.
Coordination of benefits is not applicable to Arizona Vaccines for Children (AVFC) claims submitted by AVFC providers. MCC of AZ will pay these claims.

**Medicare**

MCC of AZ participates in the automated claims crossover process for claims processing for our members who are dually eligible for Medicaid and Medicare.

**Post Payment Recoveries**

MCC of AZ will adjudicate a claim and then utilize post-payment recovery process when MCC of AZ has not established the probable existence of a liable third party. This includes pay and chase, retroactive recoveries involving commercial insurance payor source and other third-party liability recoveries.

Pay and chase is applied to preventative pediatric services, including EPSDT, and administration of vaccines to children under the VFC program, or services covered by a third-party liability that is derived from an absent parent whose obligations to pay support is being enforced by the Division of Child Support Enforcement.

Other liabilities include, but not limited to, cases involved in motor vehicle accidents, restitution recoveries, worker’s compensation. AHCCCS’ TPL contractor determines the type of case involved whether it is a mass tort, total plan case, or joint case. MCC of AZ only pursues recovery for cases determined to be a total plan case, defined as a case where all payments for services rendered are exclusively the responsibility of MCC of AZ.

**Balance Billing**

Members must be held harmless for any charges for Medicaid covered services. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.

Providers may not balance bill MCC of AZ members for coinsurance, copayments, deductibles, financial penalties, or any other amount. Refer to Section 4: Provider Roles and Responsibilities in this Provider Handbook.

For non-covered services, Participating Providers must inform an MCC of AZ member that a service is not covered by MCC of AZ prior to rendering the service.

**Cost Sharing Responsibility**

Providers must adhere to all contract and regulatory cost sharing guidelines. When a member has other health insurance such as Medicare, a Medicare HMO or a commercial carrier, MCC of AZ will coordinate payment of benefits in accordance with the terms of the plan contract and federal and state requirements. AHCCCS registered providers must coordinate benefits for all MCC of AZ members
in accordance with the terms of their Provider Agreement, the Provider Handbook and AHCCCS guidelines and State law.

Copayments
Copayments are governed by A.A.C. R9-22-711, ACOM Policy 431 and other directives by AHCCCS. Those populations exempt from copayments or subject to non-mandatory (also known as nominal or optional) copayments may not be denied services due to the inability to pay the copayment [42 CFR 438.108]. However, for those populations subject to mandatory copayments services may be denied for the inability to pay the copayment. Members with a CRS qualifying condition are currently exempt from mandatory and optional copayments.

Copayments not charged to the following members:
1. Children under age 19;
2. People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services;
3. Individuals up through age 20 eligible to receive services from the Children's Rehabilitative Services program;
4. People who are acute care AHCCCS members and who are residing in nursing homes or residential facilities such as an Assisted Living Home and only when the acute care member’s medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year;
5. People who are enrolled in the Arizona Long Term Care System (ALTCS);
6. People who are eligible for Medicare;
7. People who receive hospice care;
8. American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs;
9. Individuals in the Breast & Cervical Cancer Treatment Program; and
10. Individuals receiving child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E.
11. People who are pregnant and throughout the postpartum period following the pregnancy
12. People in the Adult Group (for a limited time*)

*For a limited time, persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106% FPL are planned and can be found on the Proposed Copay Changes tab. Members will be told about any changes in copays before they happen.
Copayments are never charged for the following services for anyone:
1. Inpatient hospital services and services in the Emergency Department;
2. Emergency services;
3. Family Planning services and supplies;
4. Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women;
5. Preventative services such as well visits, immunizations, pap smears, colonoscopies, and mammograms;
6. Services paid on a fee-for-service basis;
7. Provider Preventable Conditions as described in the AHCCCS Medical Policy Manual (AMPM), Chapter 1000.

Nominal (Low) Copays for Some AHCCCS Programs

Individuals eligible for AHCCCS through any of the following programs are subject to nominal copayments. Nominal copayments are also referred to as optional copayments. Individuals with nominal (optional) copayments are not charged copayments if they are in a population or category or for a service listed above. Providers are prohibited from refusing services to members who have nominal (optional) copayments if the member states he or she is unable to pay the copayment.

Members with nominal (optional) copayments are:
1. AHCCCS for Families with Children under section 1931 of the Social Security Act);
2. Individuals eligible under the Young Adult Transitional Insurance (YATI) for young adults who were in foster care;
3. Individuals eligible for the State Adoption Assistance for Special Needs Children who are being adopted;
4. Individuals receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled;
5. Individuals receiving SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled; and
6. Individual in the Freedom to Work (FTW) program.

Providers are encouraged to look up the member’s eligibility to determine what copays a member may have. Most people who get AHCCCS benefits are asked to pay the following nominal copayments for medical services. Additional information can be reviewed on AHCCCS’ Copayments page online.

<table>
<thead>
<tr>
<th>Nominal Copay Amounts for Some Medical Services Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Out-patient services for physical, occupational and speech therapy</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of your care</td>
<td>$3.40</td>
</tr>
</tbody>
</table>
**Mandatory Copayments for Certain AHCCCS Members**

Members with higher income who are determined eligible for AHCCCS through the Transitional Medical Assistance (TMA) program will have mandatory copayments for some medical services.

When a member has a mandatory copayment, a provider can refuse to provide a service to a member who does not pay the mandatory copayment. A provider may choose to waive or reduce any copayment under this chapter. TMA members are not charged copayments if they are in a population or category listed in the above sections. Additional information can be reviewed on AHCCCS' Copayments page online.

<table>
<thead>
<tr>
<th>Mandatory Copayments Service</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2.30</td>
</tr>
<tr>
<td>Doctor or other provider outpatient office visits for evaluation and management of care. This excludes emergency room/emergency department visits</td>
<td>$4.00</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
<td>$3.00</td>
</tr>
<tr>
<td>Outpatient non-emergent or voluntary surgical procedures. This excludes emergency room/emergency department visits</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

### 5% Aggregate limit for nominal (optional) and mandatory copays

The total aggregate amount of total copays for persons who have nominal (optional) and/or a mandatory copayment cannot be more than 5% of the family's total income during a calendar quarter (January-March, April-June, July-September, and October-December). If this 5% limit is reached, no more copays will be charged for the rest of that quarter. AHCCCS has a process to track cost sharing. If a member thinks that the total copays they have paid are more than 5% of the family's total quarterly income and AHCCCS has not already told them, the member should send copies of receipts or other proof of how much they have paid to AHCCCS at 701 East Jefferson Street, Phoenix AZ 85034

**ADHS/DBHS Copayments for Non-Title XIX/XXI eligible persons determined to have a Serious Mental Illness (SMI)**

ADHS/DBHS Copayments for Non-Title XIX/XXI eligible persons who are determined to have a Serious Mental Illness (SMI). Additional information can be reviewed on AHCCCS' Copayments page online.

**Provider Overpayment Refunds**

If a provider identifies that a payment by MCC of AZ results in an overpayment, it is the responsibility of the provider to reimburse MCC of AZ for the overpaid amount within the designated timeframe dictated in the Participating Provider Agreement and/or overpayment notice. The provider should return the overpayment with a copy of the Remittance Advice (RA) and a cover letter explaining why the payment is being refunded.
Overpayments should be mailed to:

Magellan Complete Care of Arizona
ATTN: Claims Operations: Refund Request
58 Charles Street
Cambridge, MA 02141

Explanation of Remittance Advice

A Provider Remittance Advice (RA) is the MCC of AZ notification to providers upon each claim payment processed during the payment cycle. A separate remit is provided for each line of business in which a provider participates. The RA informs providers of our handling of claim payment and providers may elect to receive a claim payment (check) through the mail or electronically.

MCC of AZ generates checks each week and claims processed during a payment cycle will appear on the remittance advice (RA) form as paid, denied or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check to not be issued.

Information contained on the RA may include, but not be limited to, the following:

1. Claims adjudicated by MCC of AZ, including claims paid, denied, reversed, adjusted or voided
2. Summary of amount processed for this payment cycle
3. An action code that describes in more detail the results of the claim determination
4. Remit date
5. Processed amount is the total amount processed for each claim represented on the remit
6. Claims disputes rights
7. Billing provider ID number
8. AHCCCS ID number
9. Check date
10. Member/Patient Name
11. Patient account number
12. Check date
13. Provider Name
14. Claim Status
15. Claim Number
16. Service Code
17. Quantity billed
18. Amount billed
19. Excluded and non-allowed amounts
20. Allowed amount
21. Amount of other payer’s payment
22. Member Co-pay/deductible/coinsurance
23. Adjustment/Denial code
Pursuant to the Provider Agreement and the Provider Handbook, providers are urged to carefully review the RA and compare to prior remits to ensure proper tracking and posting of adjustments because providers remain responsible for reconciling their accounts.

Providers have the ability to direct funds to a designated bank account directly through Electronic Funds Transfer (EFT), MCC of AZ encourages providers to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for a mailed check. You may enroll in EFT by submitting an EFT Application Form, available on our Provider Portal.

Providers who have questions about claims payment or information contained on the Remittance Advice or about resubmitting a claim should contact MCC of AZ Claims Resolution Services Unit at 1-800-424-5891.

**Reimbursement under the Vaccines for Children (VFC) Program**

The national Vaccines for Children (VFC) program was established to help raise childhood immunization rates in the United States and to keep children up to age 19 in their medical home. The entitlement program is associated with each State’s Medicaid plan. Children who are eligible for VFC vaccines are entitled to receive pediatric vaccines that are recommended by the Advisory Committee on Immunization Practices.

PCPs who administer childhood immunizations should be enrolled in the Arizona Vaccines for Children program (AVFC), administered by the Arizona Department of Health Services, and participate in the Statewide immunization registry database. For more information, and to register, contact the Arizona Department of Health Services at (602) 364-3676.

**Long Acting Reversible Contraception (LARC) Utilization and Reimbursement**

MCC of AZ supports and covers appropriate family planning and member choice. Accordingly, MCC of AZ covers the member choice to use long acting contraception as a part of their personal decisions with family planning and health optimization. LARC services are covered and reimbursed to both MCC of AZ Participating and non-Participating Providers.

MCC of AZ will reimburse for all long acting reversible contraceptive (LARC) devices provided in a hospital setting at rates no less than the Medicaid fee schedule in place at the time of service. The coverage of this service will be considered an add-on benefit and will not be included in the Diagnostic Related Group (DRG) reimbursement system for the inpatient hospital stay for the delivery. Participating Providers or non-Participating providers will also be reimbursed for the insertion of LARC device immediately post-delivery insertion of a LARC device separate from the hospital DRG at a rate no less than the Medicaid fee schedule.
Prior authorization is not required for covered LARC J codes:

**IUD:**
- J7297 – Liletta
- J7298 – Mirena
- J7301 – Skyla
- J7300 – Paragard

**Implant**
- J7307 – Implanon/Nexplanon

**Physician Billing Instructions**
- Providers billing for the insertion of the device must bill on the CMS 1500 claim form using either 11981 (implant insertion) or 58300 (IUD insertion) depending on the device used and must use place of service Inpatient Hospital (21).
- Providers will also be allowed to bill for and receive separate reimbursement for the applicable CPT code for the delivery.
- Providers can bill the following ICD-10 diagnosis codes:
  - Z30.430 – Encounter for insertion of intrauterine contraceptive device
  - Z30.433 - Encounter for removal and insertion of intrauterine contraceptive device
  - Z30.49 – Encounter for surveillance of other contraceptives

**Facility Billing Instructions**
- Facilities bill all charges including those for the LARC on one inpatient UB-04 claim form
- The bill must contain the revenue code 0250, LARC device J code and NDC.
- The LARC payment is paid on the inpatient claim in addition to the APR-DRG payment.

**Section 16: Provider Claims Disputes**

Provider claims disputes are requests made by the contractor’s AHCCCS Complete Care Program providers (in-network and out-of-network) to review the contractor’s denial, in whole or in part, of payment for a service or recoupment in accordance with the statutes and regulations governing the Arizona Medicaid Claims Disputes process. After a provider exhausts the contractor’s internal appeal process, Arizona Medicaid affords the provider the right to a second level review – Fair Hearing - in accordance with the AHCCCS regulations outlined in ACOM Chapter 445.

A provider may file a claims dispute with MCC of AZ no later than 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial or recoupment of a timely claim submission, whichever is later. Failure to file an appeal with MCC of AZ within this time frame may result in denial of the claim.

A provider must file the dispute with MCC of AZ in writing. The dispute must identify the issues, adjustments, or items the provider is disputing and include supporting documentation, which explains
or satisfies the reason for the original denial and why it should be paid accordingly. Claim disputes will be acknowledged in writing within five business days of receipt.

To file a claims dispute, providers can call us at 1-800-424-5891 (TTY 711) from 8 a.m. to 5 p.m. local time, Monday through Friday. Providers can leave a message after hours that will be returned on the next business day. A dispute request can also be mailed to us at: Magellan Complete Care, Attn: Dispute and Appeal Manager; 4801 E. Washington St., Suite 225, Phoenix, AZ 85034 or by secure e-mail to MCCAZProvider@magellanhealth.com, or by fax at 1-888-656-0369.

**Claims Dispute Resolution**

All provider claims disputes will be thoroughly investigated using applicable statutory, regulatory and contractual provisions, collecting all pertinent facts from all parties and applying MCC of AZ written policies and procedures. At the conclusion of the review, which shall not exceed 30 days, the provider will receive a written decision with an explanation of the decision.

For disputes not resolved wholly in favor of the provider, MCC of AZ’s written Notice of Claims Dispute Decision will include the description of the Provider’s right to request a hearing by filing a written request to the Contractor no later than 30 days after the date the provider receives the Decision. If the provider files a written request for hearing, the Contractor must ensure that the hearing request and supporting documentation is submitted to the AHCCCS Office of Administrative Legal Services (OALS), as specified by ACOM Policy 445.

If the Contractor or the State fair hearing decision reverses a decision to deny, limit or delay services not furnished during the claim dispute or the pendency of the hearing process, the Contractor shall authorize or provide the services promptly and as expeditiously as the member’s health condition requires irrespective of whether the Contractor contests the decision. If the claim dispute is overturned, in full or in part, the requirement that the Contractor shall reprocess and pay the claim(s) in a manner consistent with the decision within 15 business days of the date of the Decision.

### Section 17: Behavioral Health

**Philosophy**

MCC of AZ believes that the most effective and appropriate behavioral health services are best delivered as part of a fully integrated recovery-oriented system that welcomes and engages members and participants at all points in their personal recovery journey—one that recognizes and builds upon individual strengths, needs and preferences of the member. Helping people reach their goals for a better life is our primary focus. We believe that all people can recover from trauma, tragedy, or other stresses. We help people manage their long-term behavioral and chronic conditions and believe that people can and do get better and are able to build a life filled with meaning and purpose.

**Approach**
Our approach for delivering behavioral health services is structured to assure that improved behavioral health is achieved by making an impact, one member at a time, through highly individualized, community-focused approaches through the Integrated Health Neighborhood™ (IHN) – Figure 1, to facilitate healthcare delivery, care management, and self-direction. MCC of AZ’s goal to improve members’ care, quality of life and health outcomes is achieved within the context of where the members live – within neighborhoods and local communities. This helps minimize member disruption through use of familiar local provider networks and support from trusted community organizations.

We use a person-centered treatment planning approach that places the member and family in the center of the planning process and involves all stakeholders in the member’s care. This approach promotes communication, integration, and coordination of care and services, reducing inefficiency and duplication of services.

We deliver behavioral health services through a large established credentialed and contracted network – that has the capability to provide services across the State and across the continuum of care. Our provider and community partnerships are built with a shared commitment to person-centeredness, evidence-based treatment, robust communication, recovery focused, trauma informed approach and teamwork. We work closely with our tribal, provider, and community partners to strengthen connectivity of Health Information Technology (HIT) to exchange the information needed to coordinate care and improve health outcomes.

MCC of AZ’s system of care includes:

- Engaging members through the collaborative engagement
- Serving the whole member – physical health (PH), behavioral health (BH), and their social determinants of health (SDOH)
- Investing in technology to fully integrate care management and simplify program administration
- Strengthening coordination between Indian and non-Indian health providers for American Indian members
- Establishing relationships with advocacy and community-based organizations

IHN model naturally bridges language and cultural barriers.
Children’s System of Care Guiding Principles

**Children’s System of Care**

The Arizona Vision as established by the Jason K. Settlement Agreement in 2001, states, “In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child’s and family’s cultural heritage”.

The Twelve Principles for Children’s Service Delivery (12 Principles) are:

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family’s unique cultural heritage
11. Independence
12. Connection to natural supports
The 12 Principles serve as the foundation, and are universally applied, when working with all enrolled children and their families through the use of the CFT model

**Adult System of Care Guiding Principles**

**Adult System of Care**

For adult members, the Contractor shall adhere to the Adult Service Delivery System Nine Guiding Principles that were developed to promote recovery in the adult behavioral health system; system development efforts, programs, service provision, and stakeholder collaboration must be guided by these nine principles:

1. **Respect**: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.

2. **Persons In Recovery Choose Services And Are Included In Program Decisions And Program Development Efforts**: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the “informed consumer” and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.

3. **Focus On Individual As A Whole Person, While Including And/Or Developing Natural Supports**: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual’s social community.

4. **Empower Individuals Taking Steps Towards Independence And Allowing Risk Taking Without Fear Of Failure**: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.

5. **Integration, Collaboration, And Participation With The Community Of One’s Choice**: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one’s role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.

6. **Partnership Between Individuals, Staff, And Family Members/Natural Supports For Shared Decision Making With A Foundation Of Trust**: A person in recovery, as with any member of a society, finds strength and support
through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.

7. **Persons In Recovery Define Their Own Success:**
   A person in recovery -- by their own declaration -- discovers success, in part, by quality of life community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.

8. **Strengths-Based, Flexible, Responsive Services Reflective Of An Individual’s Cultural Preferences:**
   A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. **Hope Is The Foundation For The Journey Towards Recovery:**
   A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

**Behavioral Health Covered Services**

MCC of AZ is responsible for the management of the following types of medically necessary behavioral health services within the amount, duration, and scope as outlined in AMPM Chapter 300, Policy 310-B Title XIX XXI Behavioral Health Service Benefit.

**AHCCCS Complete Care Program Coverage Chart**

<table>
<thead>
<tr>
<th>Facility-Based Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
</tr>
<tr>
<td>Behavioral Health Residential Facility Services</td>
</tr>
<tr>
<td>Behavioral Health Day Program Services</td>
</tr>
<tr>
<td>Court Ordered Treatment</td>
</tr>
<tr>
<td>Prevention Services</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
</tr>
<tr>
<td>Support Services</td>
</tr>
<tr>
<td>Medication Management</td>
</tr>
<tr>
<td>Individual and Group Counseling</td>
</tr>
<tr>
<td>Intensive Outpatient Program</td>
</tr>
<tr>
<td>Inpatient, Outpatient and Residential Substance Use</td>
</tr>
</tbody>
</table>

MCC of AZ uses a combination of Milliman Care Guidelines (MCG), proprietary Magellan Health guidelines and ASAM criteria in conjunction with the Department’s policies to make medical necessity
determinations. MCC of AZ’s guidelines are consistent with Federal, State, and the Department’s requirements.

MCC of AZ’s medical necessity criteria are not more restrictive than the Department’s criteria and its’ coverage rules and authorization practices comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). MCC of AZ coverage rules for behavioral health treatment services are also compliant with Federal EPSDT coverage requirements for Members under the age of 21.

Following approval by its QIC, MCC of AZ submits its medical necessity guidelines, program specifications and service components for behavioral health services to AHCCCS annually for approval no later than thirty (30) days prior to the start of a new Contract Year, and no later than thirty (30) days prior to any changes.

**Facility-Based Services**

Behavioral inpatient treatment as well as treatment at other higher levels of care can be devastating to one’s self-esteem. Individuals admitted to inpatient care cannot manage their behavioral and emotional issues in a lower level of care; therefore, they are at greater risk of harm to themselves, others and are in need of a secure setting for stabilization. MCC of AZ care coordinator/care managers assess each individual to understand their unique situation including their treatment providers and social support systems. Care coordinator/care managers assist individuals through the following:

**Education**
- The nature of the disease(s)
- The evolution of returning to whole health
- Appropriate course of treatment
- The importance of coordination of care

**Coordination of Care**
- Navigation through the health care system
- Connecting all treatment providers
- Building a community of support
- Identifying and removing barriers to care

**Treatment Shaping**
- Reviewing and reconciling medication regimens, especially at care transitions
- Treatment planning
- Identifying available resources
- Incorporating relapse prevention strategies

**Inpatient Services**

Inpatient services provided by a Level I licensed behavioral health agencies including the following:
- Hospitals (including room and board)
- Subacute Facilities
- Residential Treatment Centers (RTC)

These facilities provide a structured treatment setting with 24-hour supervision and an intensive treatment program, including medical support services.

In accordance with 42 CFR 438.3(e)(2)(i) through (iii), MCC of AZ may provide services in alternative inpatient settings that are licensed by ADHS/DLS, in lieu of services in an inpatient hospital. These alternative settings must be cost effective compared to non-IMD inpatient settings.

In the event that a covered behavioral health service is temporarily unavailable for persons in an inpatient or residential facility who are discharge-ready and require covered, post discharge behavioral health services, policies and procedures shall be in place which stipulate the process for allowing that the member remain in that setting until the service is available or ensure MCC of AZ care management, intensive outpatient services, provider case management, and/or peer service are available to the member while waiting for the desired service.

**General and Informed Consent to Treatment**

**General Requirements**

Any member aged 18 years and older, in need of behavioral health services must give voluntary general consent to treatment, demonstrated by the member’s or legal guardian’s signature on a general consent form, before receiving behavioral health services.

Any member aged 18 years and older or the member’s legal guardian, or in the case of members under the age of 18, the parent, legal guardian or a lawfully authorized decision maker has the right to refuse medications unless specifically required by a court order or in an emergency situation.

For members under the age of 18, the parent, legal guardian, legal decision maker or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C)) must give general consent to treatment, demonstrated by the parent, legal guardian, legal decision maker or a lawfully authorized custodial agency representative’s signature on a general consent form prior to the delivery of behavioral health services.

Providers treating members in an emergency are not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. Title 36, Chapter 5.

Evidence of informed consent and general consent to treatment must be documented in the appropriate patient clinical record pursuant to AMPM Policy 940.

**General Consent**

General consent is a one-time agreement to receive certain services, including but not limited to behavioral health services that is usually obtained from a member during the intake process at the initial appointment, and is always obtained prior to the provision of any behavioral health services.
General consent must be obtained from the member, their legal decision maker or legal guardian’s via a signature.

Informed Consent
Informed consent is a voluntary agreement, oral or written, except when explicitly required to be written, following presentation of all facts necessary to form the basis of an intelligent consent by the person or guardian prior to the provision of specified behavioral health services.

In all cases where informed consent is required by this policy, informed consent must include at a minimum:

- Behavioral health recipient’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;
- Information about the person’s diagnosis and the proposed treatment, including the intended outcome, nature and all available procedures involved in the proposed treatment;
- The risks, including any side effects, of the proposed treatment, as well as the risks of not proceeding;
- The alternatives to the proposed treatment, particularly alternatives offering less risk or other adverse effects;
- That any consent given may be withheld or withdrawn in writing or orally at any time. When this occurs, the provider must document the person’s choice in the medical record;
- The potential consequences of revoking the informed consent to treatment; and
- A description of any clinical indications that might require suspension or termination of the proposed treatment.

Who can give informed consent, and how is it documented? Persons, or if applicable the client’s parent, guardian, health care decision maker or a lawfully authorized custodial agency (including foster care givers A.R.S. 8.514.05(C) shall give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent to the proposed treatment. When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the person, must be established. If the informed consent is for psychotropic medication or telemedicine and the person, or if applicable, the person’s guardian refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner shall document in the person’s record that the information was given, the client refused to sign an acknowledgment and that the client gives informed consent to use psychotropic medication or telemedicine.

Who can provide informed consent and how is it communicated? When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:

- Presented in a manner that is understandable and culturally appropriate to the person, parent, legal guardian or an appropriate court; and
- Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience. It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in
which that is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

Additional Provisions
Written informed consent must be obtained from the person, legal guardian, health care decision maker, an appropriate court or lawful custodial agency (including foster care givers A.R.S.8.514.05 (C)) prior to the person’s admission to any medical detoxification, inpatient facility or residential program operated by a behavioral health provider.

Revocation of Informed Consent
If informed consent is revoked, treatment must be promptly discontinued, except in cases in which abrupt discontinuation of treatment may pose an imminent risk to the person. In such cases, treatment may be phased out to avoid any harmful effects.

Special requirements for children
In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization or state-supported institution, or any individual employed by any of these entities, may procure, solicit to perform, arrange for the performance of or perform mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent’s identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.

If someone other than the child’s parent intends to provide general and, when applicable, informed consent to treatment, the following documentation must be obtained and filed in the child’s comprehensive clinical record:

<table>
<thead>
<tr>
<th>Individual/Entity</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal guardian</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>Relatives</td>
<td>Copy of power of attorney document</td>
</tr>
<tr>
<td>Other member/agency</td>
<td>Copy of court order assigning custody</td>
</tr>
<tr>
<td>DCS out-of-home placements (for children removed from the home by DCS), such as: Foster home, group home, kinship, other member/agency in whose care DCS has placed the child</td>
<td>Legal Notice from DCS</td>
</tr>
</tbody>
</table>

Non-emergency Situations
In cases where the parent is unavailable to provide general or informed consent and the child is being supervised by a caregiver who is not the child’s legal guardian (e.g., grandparent) and does not have power of attorney, general and informed consent must be obtained from one of the following:

- Lawfully authorized legal guardian;
• Foster parent, group home staff or other person with whom the Department of Child Safety has placed the child; or
• Government agency authorized by the court.

Medical Necessity

Medical necessity criteria are developed from MCC of AZ’s clinical practice guidelines. Medical necessity criteria is approved and reviewed annually by the MCC of AZ Medical Management Committee and Quality Improvement Committee. In accordance with 42 CFR §438.236. MCC of AZ utilizes ASAM criteria for medical necessity determinations for Addiction and Recovery Services. MCC of AZ ensures that clinical and administrative staff and delegated entities involved in processing initial/organization decisions and appeals comply with all CMS, AHCCCS and plan coverage rules.

MCC of AZ utilizes proprietary diagnostic services criteria for imaging, nuclear cardiology studies, and certain pain management procedures. These criteria sets are based on sound scientific evidence for recognized settings of care and used to determine the medical necessity and clinical appropriateness of services. If state law or regulation requires additional criteria, it is adopted into policy and implemented.

MCC of AZ uses Milliman Care Guidelines (MCG) in conjunction with the Department’s policies to make medical necessity determinations. MCC of AZ’s guidelines are consistent with Federal and State requirements. MCC of AZ reviews requests for services on an individual basis and determines the length of treatment and any service limits based on the individual’s most current clinical presentation.

MCC of AZ’s medical necessity criteria are not more restrictive than CMS and AHCCCS criteria and its’ coverage rules and authorization practices comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). MCC of AZ coverage rules for behavioral health treatment services are also compliant with Federal EPSDT coverage requirements for Members under the age of 21.

Following approval by its QIC, MCC of AZ submits its medical necessity guidelines, program specifications and service components for behavioral health services to AHCCCS annually for approval no later than thirty (30) days prior to the start of a new Contract Year, and no later than thirty (30) days prior to any changes.

ASAM Criteria and Provider Qualifications

MCC of AZ uses the most current version of the ASAM Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions to guide the identification of medically necessary substance use services for members. MCC of AZ’s Medical Director performs all independent assessment of requests for all substance use intensive outpatient programs, residential treatment services and inpatient services. Qualified staff review treatment requests and utilize ASAM criteria along with the member’s most current multidimensional risk profile to determine the most appropriate level of care, length of treatment and service limits.
MCC of AZ contracts with a wide array of SUD service providers to ensure there are sufficient SUD services available to MCC of AZ members. Service providers include Acute Psychiatric Hospitals, Acute freestanding Psychiatric Hospitals, Substance Abuse Residential Treatment Centers, Crisis Stabilization Units, Intensive Outpatient Services, traditional outpatient providers and peer support specialists. Outpatient providers meet AHCCCS provider qualification requirements for substance use covered services.

**Substance Use Service Authorizations**
MCC of AZ does not require service authorizations Intensive Outpatient Programs or traditional outpatient services.

The following substance use treatment services do require a service authorization to qualify for reimbursement:

- Residential services and,
- Inpatient hospital services.

MCC of AZ may retroactively approve authorizations based on established provider enrollment contractual requirements after a provider has engaged a Member in treatment to promote immediate entry into withdrawal management processes and addiction treatment.

**PCP Management of Behavioral Health Diagnoses**

PCPs are allowed to treat behavioral health conditions within their scope of practice. PCPs, who treat members for behavioral health conditions, may provide the following services: medication management including prescription medications, laboratory and other diagnostic tests necessary for diagnosis and treatment. Providers are encouraged to utilize nationally recognized clinical guidelines, which may be found on the MCC of AZ website, [www.mccofaz.com](http://www.mccofaz.com).

MCC of AZ’s drug formulary consists of all AHCCCS preferred medications to treat members with behavioral health conditions. Medications not on the preferred drug formulary will be subject to MCC of AZ’s pharmacy prior authorization process. All requests for non-preferred medications need to include clinical documentation supporting the need for a non-preferred behavioral health medication (see Section 13 of the Provider Manual Covered Pharmacy Benefit).

PCPs must document all interactions with the member and must ensure at a minimum the following are documented in the member’s medical record: comprehensive assessment, diagnosis, treatment plan, symptomology, assessment of goal attainment, currently prescribed medications with dosage, previously tried medications and response to current medications.

**Behavioral Health Referral Process**

PCPs, who are treating members for a behavioral health condition but feel the member needs to see a behavioral health provider for specialized treatment and assessment may initiate a referral to an MCC of AZ contracted behavioral health provider. The member’s referring PCP must ensure there is care coordination with the receiving behavioral health provider. The transfer of care to the behavioral
health provider should be seamless to maintain continuity of care for the member. PCPs who are prescribing psychiatric medications have to ensure the member has enough prescribed medications through the transition process. During the transition the PCP is required to do the following: obtain a signed authorization for use and disclosure form, send all pertinent clinical records to the receiving behavioral health provider prior to the member’s first appointment, ensure the member has enough medication until their first appointment, and in more urgent cases have a telephonic consultation with the receiving behavioral health provider to discuss the members care. MCC of AZ members may be referred to a behavioral health provider through their PCP or specialist or may self-refer to any contracted behavioral health provider in the MCC of AZ network. MCC of AZ’s goal is to make the process less burdensome for both providers and members to ensure the member receives timely clinically appropriate services.

**Behavioral Health Intake Process**

Behavioral health providers must accept referrals 24 hours a day, seven days a week. Intake triage must be timely and may not be delayed due to incomplete or missing information. If a Serious Mental Illness (SMI) evaluation is requested the receiving behavioral health provider must follow all requirements as they relate to this process; as outlined in sub-section SMI Evaluation Process. When conducting an intake, behavioral health providers must address and document the following at a minimum:

- Member name and, if available, AHCCCS identification number and name of ACC plan,
- Date of birth,
- Name and affiliation of referring source,
- Type of referral per ACOM Policy 417,
- Date and time the referral was received,
- If applicable, date and location of first available appointment and, if different, date and location of actual scheduled appointment, and
- Final disposition of the referral.
- Verification and collection of the member’s insurance information
- Why the member is seeking services and any special accommodations needed
- Collect the member’s demographic information, including the member’s primary/preferred language
- The completion of any applicable authorizations for the release of information to other parties
- The review and completion of a general consent to treatment
- The collection of financial information, including the identification of third party payers and information necessary to screen and apply for Title XIX/XXI eligibility
- Engage the member and/or guardian/family member
- Communicate back the referral source the disposition of the intake within thirty (30) days of the intake evaluation
- All documents related to the intake must be kept confidential and protected in accordance with applicable federal and state stature, regulations and policies
- Obtain all needed release of information forms
- Ensure all information collected during the intake is accurate
• During the intake process assess the urgency of the members situation based on collected information and schedule the assessment within required timeframe
• Review the member’s rights and responsibilities, including the grievance and appeal process
• Review and disseminate MCC of AZs Notice of Privacy Practices and the AHCCCS Notice of Privacy Practices
• All intake activities must be conducted in a strength-based approach

Behavioral health providers are responsible for ensuring members who are referred to them receive intake appointments which meets the following timeframes:

• Urgent care appointments are available as expeditiously as the member’s health condition requires, but no later than twenty-four (24) hours of request.

• Routine care (non-urgent) appointments:
  o Initial assessment within seven (7) calendar days of referral or request for service.
  o The first behavioral health service following the initial assessment: as expeditiously as the member’s health condition requires, but:
    ▪ For members age 18 years or older, no later than 23 calendar days after the initial assessment,
    ▪ For members under the age of 18 years old, no later than 21 days after the initial assessment.
  o All subsequent behavioral health services: As expeditiously as the member’s health condition requires, but no later than forty-five (45) calendar days from identification of need.

For Psychotropic Medications:

• Assess the urgency of the need immediately.
• Provide an appointment, if clinically indicated, with a behavioral health medical professional within a time frame that ensures the member
  o (a) Does not run out of needed medications
  o (b) Does not decline in his/her behavioral health condition prior to starting medication, but no later than thirty (30) calendar days from the identification of need.

• Behavioral health providers must provide the referring source a final disposition within 30 days even if the member declined behavioral health services. The provider must obtain a release of information prior to any communication with the referring entity. The final disposition much include:
  • The date the member was seen for the intake evaluation and the name of the provider and phone number of who will be taking primary responsibility of the member’s care
  • If no services will be provided the reason why no services will be provided
  • Providers must track all referrals received. MCC of AZ will conduct audits to ensure providers are following all requirements as outlined in this section. The following information must be tracked at a minimum:
    o Member name and AHCCCS ID
    o Date of Birth
    o Name and affiliation of referral source
    o Type of referral
    o Date and time referral was received
Outreach, Engagement and Re-Engagement

Outreach Activities

MCC of AZ must inform the public and members of the benefits and availability of behavioral health services and how to access them. They must disseminate information to the general public, other human service providers, school administrators and teachers and other interested parties regarding the behavioral health services that are available to eligible persons.

Outreach activities conducted by MCC of AZ may include, but are not limited to:

- Participation in local health fairs or health promotion activities;
- Involvement with local schools;
- Routine contact with MCC of AZ staff and primary care providers/specialists involved in the members care;
- Development of homeless outreach programs;
- Development of outreach activities to persons who are at risk, are identified as a group with high incidence or prevalence of behavioral health issues or are underserved;
- Distribution of informational materials;
- Liaison activities with local and county jails, county detention facilities, probation departments and the Department of Child Safety (DCS);
- Provision of information to mental health advocacy organizations; and
- Development and coordination of outreach programs to Native American tribes in Arizona to provide services for tribal members.

Engagement Activities

Behavioral health providers must provide services in a culturally competent manner in accordance with MCC of AZ Cultural Competency Plan.

Behavioral health providers must actively engage the following in the treatment planning process:

- The member and/or member’s legal guardian;
- The member’s family/significant others, if applicable and amenable to the member;
- The member’s PCP and other involved physical health providers;
- Other agencies/providers as applicable; and

Re-Engagement Activities

Behavioral health providers must attempt to re-engage member’s in an episode of care who have withdrawn from participation in the treatment process prior to the successful completion of treatment, refused services or failed to appear for a scheduled service. All attempts to reengage
members who have withdrawn from treatment, refused services or failed to appear for a scheduled service must be documented in the member’s comprehensive clinical record.

The behavioral health provider must attempt to re-engage the member by:

- Communicating in the member’s preferred language;
- Contacting the member or member’s legal guardian by telephone, at times when the member may reasonably be expected to be available (e.g., after work or school);
- Whenever possible, attempting to contact the member or member’s legal guardian face-to-face, if telephone contact is insufficient to locate the member or determine acuity and risk;
- Contact any other providers involved in the member’s care to inquire as to if they have had contact with the member;
- Sending a letter to the current or most recent address requesting contact, if all attempts at personal contact are unsuccessful, except when a letter is contraindicated due to safety concerns (e.g., domestic violence) or confidentiality issues. The provider will note safety or confidentiality concerns in the progress notes section of the clinical record and include a copy of the letter sent in the comprehensive clinical record.

If the above activities are unsuccessful, the behavioral health provider must make further attempts to re-engage children, pregnant substance abusing women/teenagers, or any person determined to be at risk of relapse, decompensation, deterioration or a potential harm to self or others. Further attempts may include contacting the member or member’s legal guardian face to face or contacting natural supports who the member has given permission to the provider to contact. If the member appears to meet clinical standards as a danger to self, danger to others, persistently and acutely disabled or gravely disabled the provider must determine whether it is appropriate, and make attempts as appropriate, to engage the member to seek inpatient care voluntarily. If this is not a viable option for the member and the clinical standard is met, initiate the pre-petition screening or petition for treatment process; as outlined in Sub-Section Pre-Petition Screening and Court Ordered Treatment Process.

Follow-up after significant and/or critical events behavioral health providers must also document activities in the clinical record and conduct follow-up activities to maintain engagement within the following timeframes:

- Discharged from inpatient services in accordance with the discharge plan and within 7 days;
- Involved in a behavioral health crisis within timeframes based upon the person’s clinical needs, but no later than 7 days;
- Refusing prescribed psychotropic medications within timeframes based upon the person’s clinical needs and individual history; and
- Released from local and county jails, detention facilities and Department of Corrections within 72 hours.

Additionally, for persons to be released from Level I care, behavioral health providers must help establish priority prescribing clinician appointments within 7 days of the person’s release to ensure client stabilization, medication adherence, and to avoid re-hospitalization.
MCC of AZ behavioral health providers are expected to:

- Involve members, their families, or significant others in transition or aftercare planning;
- For extenuating circumstances involving crisis calls, follow up within 24 hours and if the member is unreachable, initiate a welfare check that could include utilizing law enforcement services, family members and significant others as designated by the member;
- Within 1 business day of notification of an admission, the clinical team contacts the inpatient social worker to schedule discharge planning staffing;
- Involve the member and/or family members in the selection of aftercare providers and appointment times, and make sure that aftercare appointments meet established access standards;
- Formalize discharge planning in writing with a discharge summary and follow up actions clearly indicated with scheduled aftercare appointments;
- Ensure members have sufficient medications or a prescription to last until the follow-up with their behavioral health provider;
- Within seven business days of discharge, a behavioral health provider completes a face-to-face comprehensive evaluation of the member and addresses any medication and/or treatment issues;
- Implement a multi-disciplinary team approach which includes the following:
  - A home visit when clinically appropriate to identify environmental issues that may need interventions to prevent hospital readmission.
  - Weekly contact after discharge for at least 30 days based on the member’s clinical need and need for additional support.
  - Weekly contacts are intended to identify causes which led to the hospitalization and assess the member’s ability to engage in their own wellness and transition successfully to community care.
  - Coordinate care with the member’s physical health providers to reduce duplication of services and minimize drug-drug interactions through medication reconciliation.

The clinical team will formally review the discharge transition after 30 days to determine if the member is at risk for readmission; assess the level of care needed; and develop a written action plan to maintain independence in the community.

**Behavioral Health Assessment and Service Planning Process**

MCC of AZ supports a model for assessment, service planning, and service delivery that is strength-based, person-centered, family friendly, culturally and linguistically appropriate, and clinically sound and supervised. The model is based on four equally important components:

- Input from the member regarding his/her individual needs, strengths, and preferences;
- Input from other persons involved in the member’s care who have integral relationships with the member;
- Development of a therapeutic alliance between the member, behavioral health provider and physical health providers that fosters an ongoing partnership built on mutual respect and equality.
• Clinical expertise/qualifications of individuals conducting the assessment and treatment planning.

Behavioral health providers have to develop a Child and Family Team (CFT) for children/adolescents and an Adult Recovery Team (ART) for adults.

At a minimum, the functions of the CFT and ART must include:

• Ongoing engagement of the member, family health care decision maker and others who are significant in meeting the behavioral health and physical needs of the member, including their active participation in the decision-making process and involvement in treatment;
• An assessment process that is conducted to: (a) elicit information on the strengths, needs and goals of the member and his/her family, (b) identify the need for further or specialty evaluations, and (c) support the development and updating of a service plan which effectively meets the member’s/family’s needs and results in improved health outcomes;
• Continuous evaluation of the effectiveness of treatment through the CFT or ART process, the ongoing assessment of the member, and input from the member and his/her team resulting in modification to the service plan, if necessary;
• Provision of all covered services as identified on the service plan, including assistance in accessing community resources, as appropriate and, for children, services which are provided consistent with the Arizona Vision and Principles, and for adults, services which are provided consistent with the Adult Service Delivery System Nine Guiding Principles.
• Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of services is important to achieving positive outcomes (e.g., primary care providers, school, child welfare, juvenile or adult probation, other involved service providers);
• Oversight to ensure continuity of care by taking the necessary steps (e.g., clinical oversight, development of facility discharge plans, or after-care plans, transfer of relevant documents) to assist members who are transitioning to a different treatment program, (e.g., inpatient to outpatient setting), changing behavioral health providers and/or transferring to another service delivery system (e.g., out-of-area, out-of-state or to an Arizona Long Term Care System (ALTCS) Contractor); and
• Development and implementation of transition plans prior to discontinuation or modification of behavioral health services.

All members must have a behavioral health assessment upon an initial request for services. Members who continue to receive behavioral health services, updates to the assessment must occur at a minimum annually. Behavioral health assessments must be utilized to collect necessary information that will inform providers of how to plan for effective care and treatment of the member.

The initial and annual assessment must be completed by a behavioral health professional (BHP) or behavioral health technician (BHT) under the clinical oversight of a BHP, who is trained on the minimum elements of a behavioral health assessment.

The minimum elements which must be present on the assessment are:

• Presenting issues/concerns;
• History of present illness, including review of major psychiatric symptoms (i.e., mood, depression, anxiety, psychosis, suicidal ideation, homicidal ideation, and other behavioral health symptoms) and frequency/duration of symptoms;
• Psychiatric history, including history of previous psychiatric hospitalization(s) and psychotropic medication trial(s);
• Medical history;
• Current medications, including over the counter (OTC) medications;
• Allergies and other adverse reactions;
• Developmental history for children/youth under the age of 18 and with other populations if clinically relevant;
• Family history;
• Educational history/status;
• Employment history/status;
• Housing status/living environment;
• Social history;
• Legal history, including custody/guardianship status, pending litigation, Court Ordered Evaluation/Court Ordered Treatment (COE/COT) history, criminal justice history, and any history of sex offender adjudication;
• Substance abuse history including type of substance, duration, frequency, route of administration, longest period of sobriety, and previous treatment history;
• Standardized substance use screen for children age 11 to 18 and referral for comprehensive assessment when screened positive;
• Substance use screen for adults age 18 and older using the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions;
• Labs/diagnostics, if applicable;
• Mental status examination;
• Risk assessment: the potential risk of harm to self or others based on self-reports, clinical symptoms, personality factors, history, substance abuse, criminogenic factors, etc.;
• Assessment of Social Determinants of Health;
• Axial diagnoses I-V;
• Cultural needs (i.e. age, ethnicity, race, national origin, sex (gender), gender identity, sexual orientation, tribal affiliation, disability);
• Date, begin, and end time of the assessment and printed name, signature, and professional credential of the provider completing the behavioral health assessment. If a BHT completes the assessment, the assessment must also include a printed name, signature, professional credential, date and time of the BHP who reviewed the assessment information;
• Primary Care Provider (PCP) name and contact information;
• Involvement with other agencies (e.g., Department Child Safety (DCS), Probation, Division of Developmental Disabilities (DDD);
• Children Age 0 to 5: Developmental screenings must be conducted;
• Children Age 6 to 18: Child and Adolescent Service Intensity Instrument (CASII) score and date, must be completed annually;
Children Age 6 to 18: Children with a CASII score 4 or higher: Strength, Needs and Culture Discovery Document form must be completed;

- Linguistic needs (i.e. primary language, preferred language, language spoken at home, and alternative language).

Behavioral health providers must develop a written plan for services after the initial assessment and periodic updates to the plan to meet the changing behavioral health needs for members who continue to receive behavioral health services. MCC of AZ does not mandate a specific service planning tool or format. Service plans must be utilized to document services and supports which will be provided to the member, based on behavioral health service needs identified through the member’s behavioral health assessment.

If a member is in immediate or urgent need of behavioral health services, an interim service plan may need to be developed to document services until a complete service plan can be developed. A complete service plan, however, must be completed no later than 90 days after the initial assessment.

At a minimum, the member, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative must be included in the development of the service plan. In addition, family members, designated representatives, agency representatives, physical health providers and other involved parties, as applicable, may be invited to participate in the development of the service plan with the member’s approval. Behavioral health providers must coordinate with MCC of AZ, PCP and/or any others involved in the care or treatment of the member, as applicable, regarding service planning recommendations.

The service plan must be documented in the comprehensive clinical record and contain the following elements:

- The member/family vision that reflects the needs and goals of the member/family;
- Identification of the member’s/family’s strengths;
- Measurable objectives and timeframes to address the identified needs of the member/family, including the date when the service plan will be reviewed;
- Identification of the specific services to be provided and the frequency with which the services will be provided;
- The signature of the member/guardian and the date it was signed;
- Documentation of whether or not the member/guardian is in agreement with the plan;
- The signature of a clinical behavioral health team member and the date it was signed;
- The Service Plan Rights Acknowledgement, dated and signed by the person or guardian, the person who filled out the service plan, a designated representative or advocate (if any), and a behavioral health professional if a behavioral health technician fills out the service plan.
- The member/guardian must be provided with a copy of his/her plan within 7 calendar days from date of completion and/or requested.

The behavioral health provider will make every effort to ensure that the service planning process is collaborative, solicits and considers input from each team member and results in consensus regarding the type, mix and intensity of services to be offered. In the event that a member and/or legal or health care decision maker disagrees with any aspect of the service plan, including the inclusion or omission
of services, the team should take reasonable attempts to resolve the differences and actively address the member’s and/or legal or designated representative’s concerns.

The behavioral health providers must complete an annual assessment update with input from the member and family, if applicable, CFT and ART that records a historical description of the significant events in the member’s life and how the member/family responded to the services/treatment provided during the past year. Following this updated assessment, the service plan should then be updated as necessary. While the assessment and service plan must be updated at least annually, the assessment and service plan may require more frequent updates to meet the needs and goals of the member and his/her family.

Behavioral Health Provider Coordination of Care Responsibilities

MCC of AZ requires behavioral health providers conduct coordination of care activities with all involved physical health providers involved in the member’s care and any other behavioral health entities who are providing additional supportive services. Behavioral health providers are required to share relevant clinical information, in accordance with all HIPAA regulations with other providers involved in the member’s care. At a minimum, behavioral health provider must share pertinent clinical information when there is a significant change in the member’s health status; such as diagnoses, medications, recent hospitalization, crisis services and laboratory results. MCC of AZ encourages behavioral health providers to take an active role and incorporate all providers in the assessment, care planning and re-assessment process. Care Coordination is key to reduce duplication of services and medication interactions. Behavioral health providers are required to incorporate any clinical records received from other providers involved in the member’s care into the member’s clinical record when there is no integrated electronic medical record (EMR) between all the providers.

Behavioral Health Provider Screening and Verification Process

Behavioral health providers must verify and assist members with applying for Arizona Public Programs (Medicare Savings Programs, Nutrition Assistance, and Cash Assistance) and Medicare Part D low income subsidy program, as outlined in AHCCCS Medical Policy Manual (AMPM) Chapter 600, Policy 650 (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/650.pdf). Verifying eligibility is essential to ensure members receive the services they are entitled to under their behavioral health benefit. Providers may verify eligibility through the AHCCCS web-based verification system (24/7), customer service 602-417-4451, interactive voice response (IVR) system and Medifax. Please reference the AHCCCS Reference Subsystem Codes and Values description on the AHCCCS website for eligibility key codes and rate code values.

Behavioral health providers shall offer assistance to members who qualify for Medicare and/or Medicare part D. To verify a member’s Medicare eligibility providers can call 1-800-MEDICARE. Medicare offers a number of web-based tools to assist members and providers with choosing a Part D plan that meets their needs at www.medicare.gov. Providers should assess to determine if member’s meet criteria for Medicare Part D Extra Help. This is a federal program in which the federal government pays for all or a portion of the cost sharing requirements of Medicare Part D on behalf of
the member. Please visit [www.ssa.gov](http://www.ssa.gov) for qualifying income and resource limits for the Part D Extra Help Program.

Dual eligible members who meet the following criteria automatically qualify for Part D Extra Help:

- Have full Medicaid coverage,
- AHCCCS pays Part B premiums, and
- Receive Supplemental Security Income (SSI) benefits.

The provider will assist the member with the application process for Part D Extra Help. The Part D Extra Help application may be obtained and submitted through the following avenues:

- Online at: [https://secure.ssa.gov/apps6z/i1020/main.html](https://secure.ssa.gov/apps6z/i1020/main.html),
- Call Social Security Administrator (SSA) at 1-800-772-1213,
- In person at a local SSA office, or
- Mailing a paper application (Form SSA-1020) to the SSA.

If a member refuses to participate or enroll in a program they are eligible for, the provider will actively encourage the member to participate in the screening/application process for all eligible programs. If a member refuses to participate in programs they are eligible for the provider must have the member sign Attachment A, in the AMPM Chapter 600, Policy 650 and document the refusal and reason in the member’s medical record. Members must be provided written notification of the intended termination of their behavioral health covered services. Members must also be given a name and number of a behavioral health provider if the member later decides to participate in the screening/application process.

**Behavioral Health Family Involvement**

Family involvement is crucial to the member recovery process and includes having families involved at all levels of the treatment process. Through the CFT/ART process, parents/caregivers, health care decision makers and members are treated as full partners in the planning, delivery and evaluation of services and supports.

Parents/caregivers and health care decision makers are an equal partner representing the family perspective as participants in systems transformation, behavioral health providers must:

- Ensure families have access to information on the CFT/ART process and have the opportunity to fully participate in all aspects of service planning and delivery;
- Approach services and view the enrolled member in the context of the family rather than isolated in the context of treatment;
- Recognize families play an important role in service planning and delivery;
- Provide culturally and linguistically relevant services that appropriately respond to a family’s unique needs;
- Offer family and support and make peer representation available to the CFT/ART process when requested;
- Provide information to families on how they can contact staff at all levels of the service delivery system.
Peer Support/Recovery Services

People who have achieved and sustained recovery can be a powerful influence for individuals seeking their own path to recovery. By sharing personal experiences, peers help build a sense of self-worth, community connectedness, and an improved quality of life.

MCC of AZ supports the use of peer support services to assist members on their road to recovery. This may involve assistance with more effectively utilizing the service delivery system (e.g., assistance in developing plans of care, identifying needs, accessing supports, partnering with professionals, overcoming service barriers) or understanding and coping with the stressors of the person’s disability (e.g., support groups), coaching, role modeling and mentoring.

Behavioral health providers should utilize peer supports for enrolled members and/or their families who require greater structure and intensity of services who are not yet ready for independent access to community-based recovery groups (e.g., Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Dual Recovery). Peer services may be provided to a person, group or family and are designed to assist in the creation of skills to promote long-term, sustainable recovery.

Peer Supports are employed by or contracted with behavioral health providers, or a licensed facility allowed to provide these billable services. Peer Supports are credentialed as Peer/Recovery Support Specialists through an approved Peer Support Employment Training Program, self-identify as a “peer” and are qualified as behavioral health professionals, behavioral health technicians, or behavioral health paraprofessionals. A “peer” is defined as an individual who is or has been a recipient of behavioral health services or substance abuse and/or has an experience of recovery to share.

Crisis Services

Crisis services are available to members through the crisis system, which services the entire MCC of AZ service area. A crisis is defined as when a person presents with a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis interventions are provided for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided via telephonic and face-to-face in the community where the member resides. These intensive and time limited services may include screening, (e.g., triage and arranging for additional crisis services) counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation.

If you have a member experiencing a behavioral health crisis, please utilize the following crisis numbers for assistance.

Maricopa County - 1-800-631-1314 or 602-222-9444
Pinal County - 1-866-495-6735
Gila County - 1-877-756-4090
Pre-Petition Screening and Court Ordered Treatment (COT)

MCC of AZ recognizes at times, it may be necessary to initiate civil commitment proceedings to ensure the safety of an MCC of AZ member or the safety of other persons, due to a member’s mental disorder when that member is unable or unwilling to participate in treatment.

In accordance with the A.A.C. R9-21-101 and A.R.S. § 36-533 in Arizona, an individual can be ordered by the court to undergo mental health treatment if found to fit one of the following categories due to a mental disorder:

- Danger to Self;
- Danger to Others;
- Gravely Disabled, which means the individual is unable to take care of his/her basic physical needs; or
- Persistently or Acutely Disabled, which means the individual is more likely to suffer severe mental or physical harm that impairs his/her judgment such that the person is not able to make treatment decisions for him/herself.

In accordance with A.A.C. R9-21-101 and A.R.S. § 36-520 any responsible person may submit an application to the County or designated screening agency to provide a pre-petition screening when a member is alleged to be, danger to self, danger to others, gravely disabled or persistently or acutely disabled. Please contact MCC of AZ member services at 800-424-5891 for assistance with this process. MCC of AZ Court Coordinator will work closely with all behavioral health agencies who provide services to members on COT. MCC of AZ will ensure providers are adhering to all reporting requirements related to the COT. Members on COT are to be seen at a minimum monthly by a behavioral health licensed physician or psychiatric Nurse Practitioner to ensure they are following the terms of the court order. If a member misses a scheduled appointment the behavioral health clinical team will conduct outreach to remind the member of their appointment and attempt to get them in as soon as possible. When members refuse to engage or follow their COT, the behavioral health agency should file an amendment to have the member located by police and brought into the hospital for evaluation. Every 60 days the provider must inform the member of his/her right to Judicial Review and must document in the member’s clinical record. The responsibility of the behavioral health agency is to ensure the safety of the member and community.

Serious Mental Illness (SMI) Determination Process

Behavioral health providers who identify an MCC of AZ member as potentially needing a SMI evaluation should make a SMI evaluation referral to a qualifying SMI evaluation provider. Providers may also contact Crisis Response Network (CRN) at (602) 427-4600 for details around how to make a SMI evaluation. Without receipt of appropriate care, members are at high risk for further deterioration of their physical and mental condition, increased hospitalizations and potential homelessness and incarceration. Members must meet diagnostic and functional criteria to qualify for SMI services (see AHCCCS Medical Policy Manual Chapter 300, Policy 320-P, Attachment B for a list of qualifying SMI diagnoses). MCC of AZ can assist with ensuring members receive appropriate care as it relates to their behavioral health condition, please contact member services at 800-424-5891 for assistance.
Section 18: Helpful Links and Provider Resources

Provider Portal

MCC of AZ’s website specifically for AHCCCS Complete Care Program providers at www.MCCofAZ.com, is our primary portal for provider communication, information and business transactions. This website is continually updated to provide easy access to information and greater convenience and speed in exchanging information with MCC of AZ. We encourage providers to use our website often as a self-service tool for supporting the provider’s practice or organization.

To realize the benefits of the MCC of AZ provider website, providers should:

- Have access to a personal computer, internet service provider and current web browser software;
- Sign in to MCC of AZ’s secure website to access applications (e.g., eligibility, authorizations and claims) by using the provider’s username and password;
- Visit our websites frequently to take advantage of new capabilities and access resources; and
- Provide us with feedback on any difficulties the provider may experience in using our online resources or on enhancement ideas.

MCC of AZ’s responsibility is to:

- Maintain operation of online services on a 24-hours a day, 7-days a week basis;
- Inform users of service problems if they occur;
- Use provider feedback to continually improve our website capabilities; and
- Provide online access to tools to assist the provider.

Connect with our Provider Inquiry Line

Monday through Friday 8 a.m. to 6 p.m. local time except for company holidays. Our provider service associates can provide claim status information, answer reimbursement questions, and provide other assistance. Outside of regular hours, providers receive a recorded message about accessing the online services, and an IVR selection menu with prompts for leaving a voicemail message, which is returned on the next business day; and/or to utilize our automated eligibility line. In addition, providers have direct access to our nurse advice line, 24-hours / 7-days a week.

Arizona Health Care Cost Containment System (AHCCCS) Website References

AHCCCS Program Manuals:

AHCCCS Complete Care Program:
https://www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/
Section 19: Glossary of Terms

**Abuse** – Either: (1) Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medicaid program; or, (2) the suspected or known physical or mental mistreatment of a Member which must be reported immediately upon discovery.

**Appeal (member)** – An Member’s request or a provider on behalf of a member’s request for review of the Contractor’s coverage or payment determination, in accordance with 42 CFR § 438.400 et seq. ([http://www.gpo.gov/fdsys/pkg/C.F.R.-2012-title42-vol4/pdf/C.F.R.-2012-title42-vol4-part438.pdf](http://www.gpo.gov/fdsys/pkg/C.F.R.-2012-title42-vol4/pdf/C.F.R.-2012-title42-vol4-part438.pdf)). In accordance with 12VAC30-110-100, Appeals for denial determinations must initially be filed with the Contractor. The filing of an internal Appeal and exhaustion of the Contractor’s internal Appeal process is a prerequisite to filing an external Appeal to Medicaid.

**Appeal (provider)** – Requests made by a provider (in-network and out-of-network) to review an adverse benefit determination in accordance with the statutes and regulations governing the Arizona Medicaid appeal process. After a provider exhausts the appeal process, Arizona Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with AHCCCS policy.

**Authorized Representative** – A person who is authorized to conduct the personal or financial affairs for an individual who is 18 years of age or older.

**Concurrent Review** – Utilization management reviews conducted during a member’s continued hospital stay. Concurrent review determines medical necessity for treatment at the appropriate level of care. Concurrent reviews are also conducted for outpatient procedures and services to extend a current course of treatment.

**Covered Service** – A Medically Necessary service or supply shown in the Contract for which benefits may be available.

**Downstream Entity** – any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a first tier entity. These written...
arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §, 423.501).

**Durable Medical Equipment (DME)** – Medical equipment, supplies, and appliances consistent with 42 CFR 440.70(b)(3).

**Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)** – The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid’s comprehensive and preventive child health program benefit for individuals under the age of 21 and provides coverage for children with a comprehensive set of screenings, interventions, and other support services. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT Member even if the service is not available under the state’s Medicaid plan to the rest of the Medicaid population. See also, 42 CFR § 441 Subpart B (Sections 50-62).

**Emergency Medical Condition** – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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 health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

**Emergency Medical Transportation** – Urgent care transportation to and from a member’s covered medical and dental appointments.

**Emergency Services** – Those health care services that are rendered by participating or non-participating providers, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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: (1) placing the Member's health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily or mental functions; or (3) serious dysfunction of any bodily organ or part or behavior.

**Excluded Services** – Health care services that the health insurance or plan doesn’t pay for or cover.

**First Tier Entity** – Any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provider administrative services or health care services to a Medicare eligible individual under the MA program or Part D program (See, 42 C.F.R. § 423.501).
Grievance – In accordance with 42 CFR § 438.400, a grievance means an expression of dissatisfaction about any matter other than an “action.” A “grievance” is any complaint or dispute expressing dissatisfaction with any aspect of the Contractor’s or provider’s operations, activities, or behavior. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the Contractor, or failure to respect the Member’s rights, as provided for in 42 CFR § 438.400 et seq.

Home Health Care – Includes intermittent or part-time nursing services (R.N. or L.P.N.), personal care services by a home health aide, and medical items (limited to approved types of supplies and equipment, suitable for use in the home).

Hospital Outpatient Care – Outpatient services provided in an outpatient hospital setting. The PCP can obtain prior notification for health care services that may require notification.

Hospitalization – Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Medically Necessary – Per Arizona Medicaid, an item or service provided for the diagnosis or treatment of a member’s condition consistent with standards of medical practice and in accordance with Arizona Medicaid policy and EPSDT criteria (for those under age 21) and Federal regulations as defined in 42 CFR § 438.210 and 42 CFR § 440.230.

Member – A person eligible for and enrolled in the Plan to receive Covered Services.

Non-covered Services – Services, supplies, products and accommodations that Plan is not required to provide to Member(s).

Participating Provider – Any duly licensed physician, hospital, ancillary, or other health care provider that has contracted directly or indirectly with Magellan to provide Covered Services to Plan Member(s) and is credentialed in accordance with the Plan’s credentialing criteria.

Physician Services – Includes all services and procedures rendered by a participating provider when needed for preventive, diagnostic, therapeutic, or to treat a particular injury, illness or disease. Excludes experimental procedures and cosmetic surgery. These physicians include: advanced registered nurse practitioner, physician assistant, podiatry, ambulatory surgical centers, community health departments, rural health clinic services, federally qualified health centers, birthing centers, certified nurse midwives, chiropractic, psychiatrist and nursing care.

Prescription Drugs – Includes prescribed drugs currently covered by the Medicaid Program, when ordered by a participating provider and supplied by a licensed participating pharmacy.

Primary Care Physician (PCP) – A practitioner who provides preventive and primary medical care for eligible Members and who certifies service authorizations and referrals for all medically necessary specialty services. PCPs may include pediatricians; family and general practitioners; internists; and
specialists who perform primary care functions such as surgeons; and, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Integrated Health Centers, etc.

Prior Authorization (Preauthorization) – Prior Authorization verifies the Medical Necessity of certain treatments, as well as the setting where medical services are provided. For pharmacy benefits, Prior Authorization helps determine cost-effective alternatives for certain prescription drugs.

Reconsideration – A request to MCC of AZ from a member or their authorized representative to re-review a service that was previously denied, terminated, or reduced.

Related Entity – any entity that is related to an MAO or Part D sponsor by common ownership or control and:

- Performs some of the MAO or Part D plan sponsor’s management functions under contract or delegation;
- Furnishes services to Medicare enrollees under an oral or written agreement; or
- Leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than $2,500 during a contract period. (See, 42 C.F.R. §423.501).

Specialist – A doctor who specializes in treating certain diseases, health problems, or conditions; for the purposes of this contract, not primary care or pediatric doctor.

Urgent Care – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an emergency medical condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent care is appropriately provided in a clinic, physician’s office, or in a hospital emergency department if a clinic or physician’s office is inaccessible. Urgent care does not include primary care services or services provided to treat an emergency medical condition.