

Chapter 3

PROVIDER SERVICES

CMDP Preferred Provider Network

CMDP has the responsibility of creating and maintaining a physician network that meets the needs of its members. Primary Care Providers (PCPs) are the primary participants in the CMDP Preferred Provider Network (PPN). The PPN also includes dentists, obstetricians, other specialists, behavioral health professionals, and pharmacies.

CMDP follows a clearly prescribed application process to ensure all participating providers in the PPN are subject to the same standards and requirements and have access to the same information, and all regulatory requirements are met.

Role of Provider Service Representatives

Provider Service Representatives have 3 major functions in CMDP. Representatives participate in network development and monitoring activities. They also have roles as both provider educators and advocates, and they often serve as intermediaries between the provider and other units within CMDP.

The Provider Service Representatives routinely review information about CMDP's provider network. Representatives work with many other health plan personnel to identify potential areas for network expansion or modification. Provider Service Representatives monitor the services our network is providing and assist providers in the CMDP registration process.

Provider Service Representatives are available to provide initial and follow-up training for office staff. They will visit your office regularly to review changes and updates to CMDP policies and procedures, and review specific provider profile information. Representatives also participate in routine site audits and surveys of the provider network to assess compliance with CMDP policies and standards. Please consult with your Provider Service Representative as questions arise. Provider Service Representatives can answer many of your questions directly, research your concerns, and direct you to the proper resources. All provider inquiries will be addressed within 3 days and completed no later than 30 days from initial request.

Supplies, such as EPSDT forms, are obtained by contacting your provider service representative at (602) 351-2245 or (800) 201-1795.

Provider Responsibilities

- It is mandatory to report suspected child abuse or neglect (A.R.S. § 13-3620).
- Providers shall submit claims to CMDP as soon as possible, but no later than 6 months, after service has been provided. *See Chapter 9.*
- Providers shall advocate on behalf of the member to include the member's health status and medical treatment options, including alternative treatment that may be self-administered.
- Providers shall provide any information the member needs to decide among all relevant treatment options and discuss the risk factors, benefits, and consequences of treatment or non-treatment.

- Providers shall inform the member of his or her right to participate in decisions regarding personal health care and treatment options, including the right to refuse treatment or express preferences regarding future treatment decisions.

Primary Care Providers

PCP Responsibilities

Primary Care Providers include, but are not limited to, family practitioners, general practitioners, pediatricians, internists, nurse practitioners, and physician assistants. All providers must have an AHCCCS Registration Number and a National Provider Identifier, and must conduct their office operations in accordance with the following AHCCCS standards:

- The PCP shall provide or arrange for covered services to members as defined herein, including emergency medical services, on a 24 hours per day, 7 days per week basis.
- PCP shall verify the enrollment and assignment prior to providing services, via:
 - AHCCCS website, www.azahcccs.gov
 - Medifax
 - CMDP Member Services at (602) 351-2245 or (800) 201-1795, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Failure to verify member enrollment and assignment may result in claim denial.

- The term “participating PCP” refers to a health care provider (as defined above), including locum tenens, licensed to practice in one of the following fields: general medicine, internal medicine, family practice, pediatrics, or obstetrics/gynecology, who assumes primary responsibility for supervising, coordinating, and providing initial and primary care to members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.
- The PCP is responsible for maintaining the member’s primary medical records, which contain documentation of all health risk assessments and health care services.
- Primary care covered services refer to basic or general health care services traditionally provided by family practice, pediatrics, and internal medicine.
- Office wait time shall not be longer than 45 minutes from the appointment time, except when the provider is unavailable due to an emergency.
- Phone availability shall be within 5 rings to answer and less than 5 minutes on hold after answer.
- After hour care directions may be accessed by:
 - Physician-contracted answering service
 - Answering recording with a pager number for the physician
 - Answering machine that pages the physician
- **Immediate direction of members to the hospital emergency department should be avoided.**
- Office visits are scheduled during regular office hours.
- Office visits, home visits, or other appropriate visits during non-office hours as determined medically necessary.
- PCP shall assure primary care is available to members 24 hours a day, 7 days a week. It is the PCP’s responsibility to notify CMDP of all providers sharing 24 hour coverage. Each provider must be an active, AHCCCS-registered provider. Availability of primary care may be through

coverage arrangements with other physicians. The PCP must maintain a method to inform members of how to access care 24 hours a day.

- PCP s and other participating providers shall maintain continuity of care and reduce duplication of diagnostic procedures, immunizations, medication trials, and specialist consultations by maintaining a complete medical record and forwarding medical records to specialists upon referral.
- PCPs and all participating providers are expected to coordinate care of the member with biologic parents, foster parents, AZEIP providers, specialists including Behavioral Health providers, the courts, probation department, AZ Dept. of Corrections and the custodial agency representative- the DCS specialist (DCSS) as appropriate.
- PCP s and other participating providers shall maintain an office that is clean, safe, accessible, and that ensures member privacy and confidentiality.
- PCP s and other participating providers shall maintain staff membership and admission privileges in good standing at a given hospital.
- PCP s and other participating providers shall maintain a current DEA number—CMDP encourages the PCP to record the DEA number on all prescriptions.
- PCP s and other participating providers shall prescribe pharmaceuticals that are on the CMDP formulary and agree to abide with CMDP's policies.
- PCP s and other participating providers shall be Board Certified/Board Eligible and have training and experience in his/her respective field(s) of practice, completed an approved training program, or be generally recognized by the medical community as being skilled in his/her respective practice.
- PCP s and other participating providers shall provide immunizations, tuberculosis and other disease screening, and other measures for the prevention and detection of disease, including instruction in personal health care measures, and information on proper and timely use of appropriate medical resources. All immunizations must be documented in the medical chart, and providers are mandated under A.R.S. § 36-135 to report all immunizations administered to children from birth through 18 years of age to the Arizona State Immunizations Information System (ASIS). ASIS also allows providers to query the registry for current and historical patient immunization records. If you have any questions, please contact the ASIS technical support line at (602) 364-3899 or toll free at (877) 491-5741.
- PCP shall provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to members according to the federally mandated EPSDT Periodicity Schedule. CMDP supports providers following the American Academy of Pediatrics (AAP) Recommendations for Clinical Care that were outlined in the AAP policy statement: Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, from October 2015.
- PCPs may use AHCCCS approved developmental screening tools as indicated by the American Academy of Pediatrics. The developmental screening should be completed during the 9month, 18 month and 24 month EPSDT visit, A copy of the screening tool, with interpretation and report, must be kept in the medical record. CMDP's unique population means that CMDP members are at greater risk of development delay and we encourage screening at every EPSDT visit with the age appropriate, AHCCCS approved, screening tool. Developmental testing (includes assessment of motor, language, social, adaptive) are not considered screening tools. To receive the developmental screening tool payment, the EP modifier must be added to the 96110. For claims to be eligible for payment of code 96110, the provider must have satisfies the training requirements and have completed an AHCCCS approved developmental screening tool.

- Providers must only use the AHCCCS EPSDT Tracking Forms to document delivery of EPSDT services (including dental referrals and behavioral health screenings) and send a copy of the EPSDT form attached to the CMS 1500 form to CMDP. However, the provider may utilize an electronic EPSDT Tracking Form generated by the provider's electronic health record, as long as the electronic form includes all the components of the AHCCCS EPSDT Tracking Form. Electronic EPSDT tracking forms must also be sent with the CMS 1500 form to CMDP. When providers utilize electronic billing, the EPSDT form must also be submitted to CMDP when the EPSDT is billed electronically.
- EPSDT providers must be enrolled in the Vaccines for Children (VFC) Program and enter immunizations into the ASIIS system.
- PCP s and other participating providers shall refer members to specialty providers or hospitals that are AHCCCS registered, as appropriate—or, if necessary, refer members to specialty providers when one is not available in the network.
- PCP shall assist in prior authorization (PA) procedures for members.
- PCP shall conduct follow up (and obtain records of services provided) for referral services that are rendered to their assigned members by other providers, specialty providers, and/or hospitals.
- PCP shall supervise coordination and provision of care to each assigned member.
- PCP shall maintain continuity of care for each assigned member.
- PCP shall maintain the member's medical records, including documentation of all services provided to the member by the PCP, as well as any specialty or referral service, including behavioral health services.
- PCPs may treat members for uncomplicated depression (including post-natal depression), anxiety, and attention deficit and hyperactivity disorder (ADHD). All other Behavioral Health conditions must be referred to Behavioral Health Services. PCPs that elect to prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan. As members in CMDP may have significant trauma and other behavioral health conditions, if the PCP prescribes psychotropic medications, these members will be monitored to ensure appropriate psychotropic prescribing, documentation of evaluations, side effects, risks, benefits, informed consent and appropriate follow up and coordination. Clinical guides that include assessment tools and algorithms have been developed to assist PCPs in the service, planning, or treatment for members seeking behavioral health treatment through their PCP. Behavioral Health Tool Kits can be found on the CMDP Provider Services webpage at <https://dcs.az.gov/cmdp/providers>.
- PCPs are encouraged to implement prenatal and postpartum depression screenings to identify and refer members who would benefit from additional treatment due to concerns related to prenatal and postpartum depression.
- Dental history must be included in the member's medical record, if available, as well as current dental needs and/or services.
- PCP shall NOT collect co-payments or payments of any kind from CMDP members, the child's custodial agency representative, any fiscal intermediary, his/her estate, the child's caregivers, his/her biological parent/relative, or any party as a result of services rendered. **Caregivers are not to be referred to collection agencies at any time. (A.A.C. R6-5-6006 and A.R.S. § 36-2903.01)**
- PCP is encouraged to participate in quality management and utilization review meetings and activities, as scheduled by CMDP, when requested.

- A provider acting on behalf of the member, with the custodial agency representative's written consent, may file an appeal or request a State Fair Hearing for a denied service.

Appointment Standards

PCP Visits

CMDP members are to be seen within 21 days of request for a routine appointment. Members shall not be required to wait longer than 45 minutes after appointment time to be seen in the provider's office, except in emergency cases or unforeseen circumstances. For purposes of this section, *urgent* is defined as an acute but not necessarily severe disorder which, if not attended to, could endanger the patient's health.

CMDP members are required to be seen in the following timeframes:

- Routine care PCP appointments – within 21 days of request.
- Urgent Care PCP appointments – within 2 days of request.
- Emergency PCP appointments – same day of request.

DCS requires that each member receive a comprehensive medical examination (EPSDT) and a comprehensive dental examination within 30 days after the initial out-of-home placement.

In addition to the required visits above CMDP recommends that the initial medical examination occur within 72 hour of out-of-home placement, or as soon as possible, in order to identify any clinical signs of abuse or neglect, or acute health issues, and provide for any needed medication or equipment (a significant majority of children in DCS custody are removed for neglect and so may not have had a forensic examination upon removal).

Specialty Appointment Standards

- Emergency appointments will be available within 24 hours of referral.
- Urgent care appointments will be available within 3 days of referral.
- Routine appointments will be available within 45 days of referral.

When needed, CMDP will provide assistance to members in selecting a specialist. Call a CMDP Provider Service Representative at (602) 351-2245 or (800) 201-1795.

Referral Procedures

The member's PCP can refer to a specialist when necessary. CMDP encourages PCPs to refer to specialists within its PPN. Specialty physicians shall not begin a course of treatment for a medical condition other than for what a member was referred, *unless approved by the member's PCP*. The first visit to the specialist for the consultation does not require prior authorization. However, before treatment begins prior authorization may be required. Providers can obtain a PPN list from their CMDP Provider Service Representative or on the CMDP website, <https://dcs.az.gov/cmdp>. See Chapter 5 for information on prior authorization requirements.

Dental Appointment Standards

- Emergency appointments will be available within 24 hours of request.
- Urgent care appointments will be available within 3 days of request.
- Routine appointments will be available within 45 days of request.
See section on dental coverage in Chapter 5.
- **DCS requires that each member receive an initial dental examination within 30 days after the initial out-of-home placement.**

Prenatal Care Appointment Standards

- First trimester appointments will be available within 14 days of request.
- Second trimester appointments will be available within 7 days of request.
- Third trimester appointments will be available within 3 days of request.
- Appointments for high-risk pregnancies will be available within 3 days of identification of high risk to the maternity care provider, or immediately if an emergency exists.

Network physicians and practitioners will adhere to the American Congress of Obstetricians and Gynecologists (ACOG) standards of care, including the use of a standardized medical risk assessment tool and ongoing risk assessment.

In the case of pregnancy, the member's PCP should confirm the pregnancy and make a referral to an obstetrics (OB) doctor. The OB doctor requests a prior authorization from CMDP for a total OB package to begin regularly scheduled appointments to ensure the pregnancy is going well, deliver the child, and perform a post-partum visit.

Pregnancy terminations must be *medically necessary*. CMDP follows the AHCCCS Medical Policy, which allows a termination only if one of the following conditions exists:

- The pregnant member suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated.
- If the pregnancy is the result of rape or incest. Documentation that the incident was reported to the proper authorities is required. This consists of the name of the agency to which it was reported, the report number if available, and the date the report was filed.
- The pregnancy termination is medically necessary according to the medical judgment of a licensed physician who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or mental health problem for the pregnant member by:
 - Creating a serious physical or mental health problem for the pregnant member,
 - Seriously impairing a bodily function of the pregnant member,
 - Causing dysfunction of a bodily organ or part of the pregnant member,
 - Exacerbating a health problem of the pregnant member, or
 - Preventing the pregnant member from obtaining treatment for a health problem.

The child's custodial agency representative and CMDP will assist in obtaining the necessary documentation. The attending physician must acknowledge that a pregnancy termination has been determined medically necessary by submitting the Certificate of Necessity for Pregnancy Termination.

The Certificate must certify that, in the physician's professional judgment, one or more of the above criteria has been met.

Unless a life-threatening emergency exists, the provider must obtain CMDP approval, and the child's legal representative must obtain a court order, before the procedure may be performed.

See Court Ordered Treatment section in Chapter 2.

Missed or Canceled Appointments

One of CMDP's priorities is to assist members in keeping appointments with their primary care, specialty, and ancillary providers. You are encouraged to notify Member Services at (602) 351-2245 or (800) 201-1795 if a member continually misses or cancels appointments without rescheduling them.

If a pregnant member misses 2 consecutive prenatal care appointments, the primary care obstetrician (PCO) should notify the Maternal Child Health Coordinator at (602) 351-2245 or (800) 201-1795.

Transportation Standards

Licensed caregivers are required to provide transportation for CMDP members to medical appointments. If a member needs non-emergent medically necessary transportation that cannot be provided by the parent or legal guardian, CMDP shall require its transportation provider to schedule the transportation so the member arrives on time for the appointment, but no sooner than 1 hour before the appointment; does not have to wait more than 1 hour after making the call to be picked up; nor has to wait for more than 1 hour after conclusion of the appointment for transportation home.

Monitoring of Appointment Standards

CMDP actively monitors the adequacy of its providers' appointment process to reduce the unnecessary use of alternative methods such as emergency room visits. CMDP also actively monitors and ensures that a member's waiting time for a scheduled appointment at the PCP's or specialist's office is not more than 45 minutes, except when the provider is unavailable due to an emergency.

Children's Rehabilitative Services

The PCP shall initiate and follow-up on appropriate referrals to Children's Rehabilitation Services (CRS) for evaluation, follow-up, and treatment services for all members under 21 years of age who have been diagnosed with medically-eligible CRS diagnoses. Questions may be directed to the CRS Program, administered by United Healthcare Community Plan at (888) 586-4017. *See Chapter 5 for more information.*

Behavioral Health Services

Behavioral Health services for Title XIX members in the State of Arizona are administered by AHCCCS. AHCCCS contracts with community-based organizations known as Regional Behavioral Health Authorities (RBHAs) to administer behavioral health services throughout the state. RBHAs function in a fashion similar to a Health Maintenance Organization (HMO).

Children in out-of-home care are automatically enrolled in the RBHA at the time they are made eligible for AHCCCS. RBHAs are assigned to members in foster care according to the ZIP code of the court of jurisdiction involved in removing the child from the home.

When a child enters out-of-home care, DCS refers the child to the RBHA for an evaluation—this referral is called the **Rapid Response Referral**. The referral begins a series of Behavioral Health services that can assist in evaluation of the child and their needs as well as helping the child and family with the traumatic event of the recent removal from their home. All children receive this referral, including infants. The focus of the evaluation for young children is not just their behavioral needs but their developmental needs as well. Please encourage families to follow through with the Behavioral Health appointments.

Rapid Response Referral – This is completed and sent within 24 hours of the child being taken into out-of-home care.

Within 72 hours of this referral, the child should have an **Rapid Response Assessment** by a RBHA provider.

Within 7 days of the assessment, the child should have an **Intake Assessment** by a RBHA provider.

Within 21 days of the assessment, if a service need is identified, the child should have their first service appointment (behavior coaching, therapy, group therapy, etc.).

If a provider identifies a child that requires Behavioral Health services, and has not yet been evaluated by the RBHA, the provider should refer the child to the RBHA.

The following is the procedure for PCP referral to Behavioral Health services through the RBHA system.

If the member is not already RBHA enrolled, the PCP may refer directly to the RBHA by:

- Submitting the AHCCCS referral form.
 - [Policy Form 103.1, Referral for Behavioral Health Services](#)
- Directing the member to the RBHA to do a self-referral by calling the RBHA member services number.
 - In order to do this, you will need to know what RBHA the child is assigned to. RBHAs are assigned to members in foster care according to the ZIP code of the court of jurisdiction involved in removing the child from the home. This can be located at <https://azahcccs.gov/Members/Downloads/Resources/BHServicesForChildrenInFosterCareBilingual.pdf> on the AHCCCS website.
- Contacting the custodial guardian (DCS) to initiate the Rapid Response Referral if it has not already been done.

Providers may contact CMDP member services for additional information and guidance about enrolling the member in BH services.

If the member is already enrolled in Behavioral Health services, the procedures outlined above can still be followed.

PCPs, within the scope of their practice, who wish to provide psychotropic medications and medication adjustment and monitoring services, may do so for members diagnosed with:

- Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
- Depression (including postnatal depression)
- Anxiety disorders

All other Behavioral Health conditions must be referred to Behavioral Health Services.

PCPs that elect to prescribe medications to treat ADHD, depression, or anxiety disorders must complete an annual assessment of the member's behavioral health condition and treatment plan.

As members in CMDP may have significant trauma and other behavioral health conditions, if the PCP prescribes psychotropic medications, these members will be monitored to ensure appropriate psychotropic prescribing, documentation of evaluations, side effects, risks, benefits, informed consent and appropriate follow up and coordination.

For each of the 3 named diagnoses, there are clinical guidelines that include assessment tools and algorithms that have been developed to assist PCPs in the service, planning, or treatment for members seeking behavioral health treatment through their PCP. These can be found at the AHCCCS website at <https://www.azahcccs.gov/shared/MedicalPolicyManual/> under Plans/Provider, Contractor Guides & Manuals, AMPM, Appendix E. These clinical guides can also be found on the CMDP Provider Services webpage at <https://dcs.az.gov/cmdp/providers>, and are also included at the end of this chapter.

CMDP strongly encourages PCPs to utilize the Behavioral Health services for children in out-of-home care who have endured psychological trauma and so may require more intense services than initially apparent.

CMDP also encourages providers to utilize a trauma based approach in the treatment of children in out-of-home care.

PCPs may also choose to transition a child to the RBHA. This occurs when a PCP has initiated medication management services to treat a member's behavioral health disorders, and it is subsequently determined by the PCP that the member should be transferred to the RBHA for evaluation and/or continued management services for complex behavioral disorders

See Chapter 6 for more information.

Human Immunodeficiency Virus (HIV)

For children who are HIV positive or who have been diagnosed with acquired immune deficiency syndrome (AIDS):

- The PCP shall not deny services to any child on the basis of HIV status.
- CMDP's members will be treated by a qualified HIV/AIDS professional who is recognized in the community as having a special interest, knowledge, and experience in the treatment of HIV/AIDS, and agrees to the Centers for Disease Control and Prevention (CDC) treatment guidelines for HIV/AIDS. These providers agree to provide primary care services and/or specialty care to CMDP members with HIV/AIDS, and have current board certification or recertification in infectious diseases, or have completed annually at least 10 hours of HIV/AIDS-related Continuing Medical Education (CME), which meets the CME requirements under A.A.C. R4-16-102. The CDC guidelines for the treatment of HIV/AIDS can be found at www.cdc.gov/hiv/living/treatment/guidelines.html.
- A physician or practitioner not meeting the criteria for a qualified HIV/AIDS treatment professional, who wishes to provide primary care services to a member with HIV/AIDS, must

send documentation to CMDP Health Services demonstrating that she/he has an established consultative relationship with a physician who meets the criteria for a qualified HIV/AIDS treatment professional. This documentation is maintained in CMDP's credentialing file. These practitioners may treat members with HIV/AIDS in the following circumstances:

- In geographic areas where the incidence of members with HIV/AIDS is low, and/or where there are no available AHCCCS/CMDP registered HIV/AIDS treatment professionals meeting this criteria; or
- When a member with HIV/AIDS chooses a provider who does not meet the criteria.

HIV/AIDS Testing of a Child in Out-of-Home Care

HIV testing is available to all children who are eligible for CMDP services. HIV testing must be deemed medically necessary and ordered by a qualified physician or practitioner to determine the diagnosis and identify the child's medical needs. An out-of-home care provider can consent for testing.

The DCSS will:

- Personally communicate to the child's health care provider any factors that would place the child at risk for HIV/AIDS exposure, including intravenous drug use, sexual abuse, and voluntary risk behavior of either the mother or the child.
- To the extent possible, consult with each biological parent of the child whose parental rights have not been terminated, when making decisions about HIV testing for a child in the Department's custody..
- Request court approval for a child age 12 or older, when the child meets the testing criteria and testing is determined to be medically necessary, but the child refuses to give consent for testing

Members 12 years or older are allowed to consent to his or her own HIV/AIDS testing if the youth meets the criteria for testing. No additional consent is required, nor does the parent need to be informed, if the minor requests testing

EPSDT

The AHCCCS EPSDT Periodicity Schedule (*located at <https://azahcccs.gov/>*) describes at what age children should be seen for preventive care and which medical screens are required at each age. PCPs are requested to perform the services within the timeframes outlined on the Periodicity Schedule. This includes performing the newborn visit within 14 days of the baby's birth.

CMDP supports providers in following the American Academy of Pediatrics (AAP) Recommendations for Clinical Care that were outlined in the AAP policy statement: Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, from October 2015. These recommendations outline an enhanced visit schedule and close follow up, as well as providing guidelines in the care of children in out-of-home care. This policy can be found at: <http://pediatrics.aappublications.org/content/136/4/e1131>
<http://pediatrics.aappublications.org/content/136/4/e1142>

Although CMDP can only pay for EPSDT at the recommended EPSDT periodicity, the enhanced visit schedule for follow-up comprehensive assessment is encouraged.

CMDP encourages all providers to schedule the next periodic screen at the current office visit, particularly for children 24 months of age and younger. **Providers must use the standardized AHCCCS EPSDT tracking forms or an electronic version that includes all the components of the AHCCCS EPSDT Tracking Forms.** See *Chapter 5* for a complete description of EPSDT requirements.

EPSDT Providers must document immunizations into ASIIS and enroll every year in the Vaccines for Children (VFC) Program.

Developmental Screening Tools

PCPs may use AHCCCS approved developmental screening tools as indicated by the American Academy of Pediatrics.

The developmental screening should be completed during the 9 month, 18 month and 24 month EPSDT visit. A copy of the screening tool, with interpretation and report, must be kept in the medical record.

CMDP's unique population means that CMDP members are at greater risk of development delay and we encourage screening at every EPSDT visit with the age appropriate, AHCCCS approved, screening tool.

Current AHCCCS approved developmental screening tools include:

- The Parent's Evaluation of Developmental Status (PEDS) tool which may be obtained from www.pedstest.com or www.forepath.org.
- Ages and Stages Questionnaire (ASQ) tool which may be obtained from www.agesandstages.com.
- The Modified Checklist for Autism in Toddlers (MCHAT) may be used only as a screening tool by a primary care provider, for members 16-30 months of age, to screen for autism when medically indicated. Copies of the completed tools must be retained in the medical record.

Developmental testing (includes assessment of motor, language, social, adaptive) are not considered screening tools.

To receive the developmental screening tool payment, the EP modifier must be added to the 96110.

For claims to be eligible for payment of code 96110, the provider must have satisfies the training requirements and have completed an AHCCCS approved developmental screening tool.

A list of available training resources may be found in the Arizona Department of Health Services website at www.azdhs.gov/clinicians/training-opportunities/developmental/index.php

See *Chapter 5* for details.

Americans with Disabilities Act (ADA)

Members with disabilities who are receiving services may request special accommodations from their providers, such as interpreters, alternative formats, or assistance with physical accessibility. Under Title III of the Americans with Disabilities Act (ADA) public accommodations, such as a physician's office, must be accessible to those with disabilities. Under the provisions of the ADA, no qualified individual

with a disability may be excluded from participation in, or be denied the benefits of, services, programs, or activities of a public entity, or be subjected to discrimination by any such entity. Physicians should ensure that their offices are as accessible as possible to persons with disabilities, and should make efforts to provide appropriate accommodations such as large print materials or easily accessible doorways. To assist in meeting these requirements, CMDP offers sign language and over-the-phone interpreter services at no cost to the provider or member. Civil Rights Act of 1964

The provider shall not discriminate against any person on the grounds of race, color, religion, sex, national origin, age, or disability, or exclude any person from participation in, or allow a person to be subjected to, discrimination under any program or activity receiving federal financial assistance.

Civil Rights Act of 1964

The provider shall not discriminate against any person on the grounds of race, color, religion, sex, national origin, age, or disability, or exclude any person from participation in, or allow a person to be subjected to, discrimination under any program or activity receiving federal financial assistance.

Vaccines for Children Program

The provider must participate in the Vaccines for Children (VFC) Program to obtain no-cost vaccines. The Centers for Disease Control and Prevention (CDC) requires providers to renew their certification each year. A Provider Profile and Varicella Verification Statement are completed and returned to the Arizona Immunization Program.

Failure to maintain current standing as a VFC provider may be grounds for termination as an AHCCCS/CMDP provider. For details about the VFC Program, call (602) 364-3642. Current pediatric immunization standards are found on the CMDP website, <https://dcs.az.gov/cmdp>.

False Claims Act (FCA)

The AHCCCS Office of Program Integrity, Deficit Reduction Act (DRA) Policy outlines the health plan requirements for eliminating fraud, waste, and abuse of Medicaid dollars.

Written Policies

Any entity that receives or makes annual Medicaid payments under the state plan, of at least \$5 million, must ensure that:

- Appropriate written policies are in place; and
- All employees and management, including contractors and agents, receive written information regarding the False Claims Act.

The False Claims Act (FCA), United States Code Title 31 § 3729-3733, also known as “Lincoln’s Law,” dates back to the Civil War. The original law included *qui tam* provisions that allowed private persons to sue those who defrauded the government and receive a percentage of any recovery from the defendant.

Activities Covered by the FCA

- Knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment;

- Knowingly using (or causing to be used) a false record or statement to get a claim paid by the federal government;
- Conspiring with others to get a false or fraudulent claim paid by the federal government; and
- Knowingly using (or causing to be used) a false record or statement to conceal, avoid, or decrease an obligation to pay money or transmit property to the federal government.

In general, the False Claims Act covers fraud involving any federally funded contract or program, with the exception of tax fraud.

Liability for Violating the FCA

Penalties under the FCA may include 3 times the dollar amount that the government is defrauded (i.e. treble damages) and civil penalties of \$5,500 to \$11,000 for each false claim.

The *relator*, one who reports the alleged fraud, must file a *qui tam* lawsuit. Merely informing the government about the FCA violation is not enough. A relator who files an FCA suit receives an award only if and after the government recovers money from the defendant.

Generally, the court may award between 15 and 30 percent of the total recovery from the defendant, whether through a favorable judgment or settlement.

The amount of the award depends, in part:

- On whether the government participates in the suit; and
- The extent to which the person substantially contributed to the prosecution of the action.

Under Section 3730(h) of the FCA, any employee who is discharged, demoted, harassed, or otherwise discriminated against because of lawful acts by the employee in furtherance of an action under the Act is entitled to any relief necessary to make the employee whole.

The following are Arizona statutes relating to false claims:

- Arizona Revised Statutes (ARS) 13-1802: Theft
- ARS 13-2002: Forgery
- ARS 13-2310: Fraudulent schemes and artifices
- ARS 13-2311: Fraudulent schemes and practices; willful concealment
- ARS 36-2918: Duty to report fraud

Each organization should provide detailed written information and training to all employees, contractors, and agents regarding:

- Policies and procedures for detecting fraud, waste, and abuse
- Specific discussions regarding the False Claims Act
- The rights of employees to be protected as whistleblowers
- The detection of fraud, waste, and abuse

Web Sites:

- Arizona Revised Statutes www.azleg.gov/ArizonaRevisedStatutes.asp
- Deficit Reduction Act – Public Law 109-171 <https://www.gpo.gov/fdsys>
(Insert public law 109-171 in the quick search box)

Culturally Competent Health Care

- Culture includes the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about a problem are expressed, who should provide treatment for the problem, and what type of treatment should be given.
- Competence is having the capacity to function effectively as an individual, and as an organization, within the context of cultural beliefs, behaviors, and needs presented by members and their communities.
- Cultural competence, as defined by AHCCCS, is an awareness and appreciation of customs, values, and beliefs (culture) and the ability to incorporate them into the assessment, treatment, and interaction with any individual.
- CMDP is aware that health care providers and their staff face challenges in delivering services to Arizona's children in out-of-home care. We also recognize that these children come from a culturally diverse population. Their culture may differ from the dominant culture in regards to language, background, values, beliefs, lifestyles, and attitudes.
- These differences can affect the way people handle illness and communicate to health care providers how they feel, what they need, and what help they will accept.
- It is up to the health care community (health plans and health care providers) to have a culturally competent approach to providing care.
- By understanding, valuing, and incorporating the cultural differences of Arizona's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of, populations whose cultures may be different from the prevailing culture.
- A health care provider who is culturally competent is aware of these cultural differences, and of the individual child and his or her personal needs.
- Members and caregivers with limited English proficiency may need more time and our patience to express their thoughts and concerns in English. For their benefit, it is best to speak slowly and use simple vocabulary words.
- We strongly encourage you to use a professional translator, one that can comprehend and speak a language well enough to manage medical terminology, rather than use family members or friends in medically sensitive cases. If a professional translator is not available, over-the-phone translation services are appropriate.
- It is important for your office to have easily understood patient care handouts available in the languages of the commonly encountered groups represented in the service area.
- It is important to identify the views and beliefs regarding health and illness of each child, if the child is of an age to communicate such, or from their family members or the caregivers. Health care providers can use a cultural assessment to gather this information. The

assessment can be in the form of a checklist, a questionnaire, or both.

- The following are types of questions that can be used to gather culturally specific information:

General Data:

- Where were you born? If born outside of the USA, how long have you resided in this country?
- What languages do you speak?
- Can you read and write in your language(s)?
- What is the first thing you do when you feel ill?
- Do you ever see a native healer or another type of practitioner when you do not feel well?
- If so, what does that person do for you?
- Do you ever take any herbs or medicines that are commonly used in your native country?
- If so, what are they and what do you take them for?
- What foods do you generally eat? How many times do you eat a day

Health Beliefs:

- What do you call your problem or illness?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Will it have a short or long course?
- What do you fear most about your disorder?
- What are the main problems that your sickness has caused for you?
- What type of treatment do you think you should receive? What are the most important results you hope to get from the treatment?

Cultural issues regarding the child:

- Do individuals in this culture feel comfortable answering questions?
- Does the child feel uncomfortable due to the gender of the provider?
- Does the child prefer to feel the symptoms or mask them?
- Does the child prefer 1 solution or multiple choices of treatment?
- Does the child want to hear about the risks associated with the illness or treatment options?
- Are there some health care concerns that have not been addressed by this office?
- Are there health or illness concerns involving the culture of the child to consider that have not been addressed?

Provide the information in your cultural assessment to CMDP Member Services so we can be aware of the cultural needs of CMDP members.

A guide to culturally competent healthcare has been developed for you and your staff to assist you with meeting the challenges of caring for culturally diverse patient populations. The guide is on the CMDP website, <https://dcs.az.gov/cmdp>.

For assistance with cultural needs for CMDP members, please contact the Provider Services or Member Services units at (602) 351-2245 or (800) 201-1795.

Advance Directives

Hospitals, nursing facilities, home health agencies, hospice agencies, and organizations responsible

for providing personal care must comply with federal and state laws regarding advance directives for adult members 18 years of age or older. These providers are encouraged to provide a copy of the member's executed advance directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record. These providers must:

- Maintain written policies for adult members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive;
- Provide written information to adult members regarding the provider's policies concerning advance directives;
- Document whether the adult member has executed an advance directive;
- Prevent discrimination against a member, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive; and
- Provide education for staff on issues concerning advance directives.

This requirement does not apply to the majority of CMDP members.

Medical Records

AHCCCS requires that the medical records of CMDP members be maintained in a detailed and comprehensive manner with a complete health record for each assigned CMDP member.

Medical records may be documented on paper or in an electronic format. Records documented on paper must be written legibly in blue or black ink, signed and dated. If records are physically altered, the stricken information must be identified as an error and initialed by the person altering the record—whiteout is not allowed. If kept in an electronic file, the provider must establish a method indicating the initiator of information and a method to assure that information is not altered inadvertently. A system must be in place to track when, and by whom, revisions to information are made.

The medical record must be legible, up-to-date, well organized, and comprehensive with sufficient detail to promote effective patient care and quality review. A member may have numerous medical records kept by various health care providers that have rendered services to the member. However, the PCP must maintain a comprehensive record that incorporates at least the following component(s):

- Behavioral health information when received from the behavioral health provider about an assigned member, even if the PCP has not yet seen the assigned member (in lieu of actually establishing a medical record, such information may be kept in an appropriately labeled file but must be associated with the member's medical record as soon as one is established);
- Member identification information on each page of the medical record (i.e. name or AHCCCS identification number);
- Documentation of identifying demographics including the member's name, address, telephone number, AHCCCS identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative;
- Initial history for the member that includes family medical history, social history, and preventative laboratory screenings (the initial history for members under the age 21 should also include prenatal care and birth history of the member's mother when pregnant with

the member);

- Past medical history for all members that include disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries, and emergent/urgent care received;
- Immunization records (required for children, recommended for adult members if available);
- Dental history if available, and current dental needs and/or services;
- Current problem list;
- Current medications;
- Current and complete EPSDT forms (required for all members age 0 through 20 years);
- Documentation, initialed by the member's PCP, to signify review of:

Diagnostic information, including:

- Laboratory test and screenings
- Radiology reports
- Physical examination notes
- Other pertinent data

Reports from referrals, consultations, and specialists;

- Emergency/urgent care reports;
- Hospital discharge summaries;
- Behavioral health referrals and services provided, if applicable, including notification of behavioral health providers, if known, when a member's health status changes or new medications are prescribed; and
- Behavioral health history and behavioral health information received from a RBHA behavioral health provider who is also treating the member.
- Documentation as to whether or not an adult member has completed advance directives and location of the document;
- Documentation that the PCP responds to behavioral health provider information requests pertaining to behavioral health recipient members within 10 business days of receiving the request (the response should include all pertinent information, including, but not limited to, current diagnoses, medications, laboratory results, last PCP visit, and recent hospitalizations, as well as the PCP's initials signifying review of member behavioral health information received from a behavioral health provider who is also treating the member);
- Documentation related to requests for release of information and subsequent release; and
- Documentation that reflects that diagnostic, treatment, and disposition information related to a specific member was transmitted to the PCP and other providers, including behavioral health providers, as appropriate to promote continuity of care and quality management of the member's health care.

Forward a copy of requested part(s) of the medical record for an assigned member at the request of CMDP, or upon receipt of a signed release of records form.

When a member changes PCPs, his or her medical records or copies of medical records must be forwarded to the new PCP within 10 business days from receipt of the request for transfer of the medical records.

Provider Termination from CMDP

Registration with CMDP will be terminated if the provider's license to practice in the State of Arizona or residing state is:

- Revoked
- Limited
- Suspended
- Placed on probationary status or otherwise diminished

CMDP providers must notify Provider Services at least 30 days prior to any:

- Change
- Cancellation
- Termination of their professional malpractice insurance coverage
- Suit or claims alleging malpractice or malfeasance against them (within 10 days of notice)

CMDP or any registered provider may terminate association, with or without cause, upon providing 30 days written notice to the other party of intent to terminate the association. Providers who have not provided services to a child in out-of-home care within a 24 month period may also be terminated.

Provider Registration

Medical professionals who register with CMDP must comply with CMDP policies and procedures for provider participation. All providers, including out-of-state providers, must register with AHCCCS to be reimbursed for covered services provided to CMDP members.

CMDP requires the National Provider Identifier (NPI) to be used as the healthcare provider identifier in all claim submissions. Additional information and education about NPI can be found at <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>.

PPN providers are required to:

- Complete an application;
- Sign a provider agreement;
- Sign all applicable forms; and
- Submit documentation of their applicable licenses and/or certificates.

Information and registration materials may be obtained by calling CMDP Provider Services unit at (602) 351-2245 or (800) 201-1795

CMDP is a Medicaid Health Plan and Title XIX funded through federal dollars. Any provider who renders services to our children must be an AHCCCS registered provider in order to receive reimbursement for CMDP services. CMDP can assist your office in completing the AHCCCS Provider Registration Packet (found on the AHCCCS website, <https://www.azahcccs.gov/>). Although providers are required to register with CMDP using the AHCCCS Provider Packet, they are not required to see AHCCCS clients outside of CMDP. CMDP verifies the provider is in AHCCCS by querying the AHCCCS database. If the

provider is not in the AHCCCS database, a registration packet is sent.

Once the completed Provider Registration packet has been received and approved by AHCCCS, CMDP will enter the provider's AHCCCS identification number into the CMDP database. The AHCCCS ID number and the provider's NPI number must be used on all correspondence and claims submitted to CMDP. When the provider is a member of a group practice, and if all providers within the group practice will be seeing CMDP members, each provider of the practice must be listed on the CMDP/AHCCCS Provider Registration form in order for CMDP to use the AHCCCS identification number correctly for each provider. Inclusion of current licensing information and signatures in all indicated areas in the packet are required for the packet to be considered complete.

CMDP must be notified of changes in name, address, or tax identification numbers, within 7 days of the change. This will allow CMDP to update its system to eliminate incorrect reimbursements.

CHAPTER APPENDIX

Provider Registration Packet

<https://www.azahcccs.gov/PlansProviders/NewProviders/registration.html>

Information/Instruction

Enrollment Forms

Out of State Provider-Waiver of Registration Requirements Policy

Urgent Care Listings

A listing of urgent care providers can be searched on the CMDP Provider Search webpage, <https://dcs.az.gov/cmdp>

Other

AAP policy statement: Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, October 2015

<http://pediatrics.aappublications.org/content/136/4/e1131>

AAP Technical Report: Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, October 2015

<http://pediatrics.aappublications.org/content/136/4/e1142>

ADHS/DBHS Policy and Procedure Manual Policy Form 103.1, Referral for Behavioral Health Services

https://www.azahcccs.gov/PlansProviders/Downloads/GM/BHSPolicy/bhs-policy-form-103_1.pdf

Behavioral Health Contractor/RBHA Point of Contact Information

<https://www.azahcccs.gov/Members/Downloads/Resources/BHSChildreninFosterCarebilingual10-2017.pdf>

Behavioral Health Contractor/RBHA Crisis Services Contact Information

<https://www.azahcccs.gov/Members/Downloads/Resources/CrisisServicesforChildreninFosterCare10-17bilingual.pdf>

Behavioral Health Clinical Guidelines

Child ADHD

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixE_ChildADHD.pdf

Child Anxiety

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixE_ChildAnxiety.pdf

Child Depression

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixE_ChildDepression.pdf

Postpartum Depression

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixF_PostpartumDepression.pdf