

Provider Manual



COMPREHENSIVE MEDICAL & DENTAL PROGRAM

"Serving Foster Care Children in Arizona"

**Provider Services Department
P.O. Box 29202
Phoenix, Arizona 85038-9202**

(602) 351-2245 or 1-800-201-1795

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Chapter 1

WELCOME TO CMDP

The Comprehensive Medical Dental Program (CMDP) welcomes you as a provider of health care for Arizona's children in foster care.

The State of Arizona, through the Department of Economic Security (DES), provides comprehensive medical and dental coverage for children in the custody of DES, the Arizona Department of Juvenile Corrections and the Arizona Juvenile Probation Offices, who are placed in foster care settings. Children may be placed in Arizona or out-of-state.

CMDP believes that Arizona's commitment to children's health care is an investment in the future of Arizona. Thank you for your help as we work together to provide quality and timely health care services for Arizona's children in foster care.

Program Mission

The Comprehensive Medical and Dental Program promotes the well being of Arizona's children in foster care by ensuring, in partnership with the foster care community, the provision of appropriate and quality health care services.

CMDP's primary objectives are to:

- Proactively respond to the unique health care needs of Arizona's children in foster care.
- Ensure the provision of high quality, clinically appropriate and medically necessary health care, in the most cost effective manner.
- Promote continuity of care and support caregivers, custodians and guardians through integration and coordination of services.

Program Overview

CMDP is a program administered by the DES, Division of Children, Youth and Families (DCYF). CMDP provides medical and dental services for children in:

- Foster homes;
- The custody of DES and placed with a relative;
- The custody of DES and placed in a certified adoptive home prior to the entry of the final order of adoption;
- The custody of DES and in an independent living program as provided in Arizona Revised Statutes (A.R.S.) § 8-521;
- The custody of a probation department and placed in foster care;

CMDP complies with Arizona Health Care Cost Containment System (AHCCCS) regulations to cover children in foster care who are eligible for Medicaid (Title XIX) services. CMDP also covers children in foster care who are not Medicaid eligible.

- CMDP covers a full scope of services, ranging from immunizations and prescriptions to surgery and hospitalizations. *See Chapter 5 for covered and non-covered services.*
- CMDP professional staff and consultants perform consultation, peer review, prior authorization, utilization and quality management functions to optimize the delivery of high quality services appropriate to the needs of each child.
- Providers are reimbursed for medically necessary services at the AHCCCS fee-for-service schedule. For foster children residing outside of Arizona, CMDP is responsible for reimbursing any medically necessary service not otherwise covered by the receiving state's Medicaid program.
- CMDP members residing in Arizona must select a Primary Care Provider (PCP). CMDP encourages the selection of a PCP from providers in CMDP's Preferred Provider Network (PPN). The PPN includes primary care physicians, primary care obstetricians and dentists, as well as a number of specialists who provide services often utilized by children in foster care.
- CMDP is the acute care AHCCCS health plan for Arizona's children in foster care, and in accordance with the Deficit Reduction Act (DRA), we cannot reimburse providers for more than the state Medicaid fee schedule. All providers (including out of state) must register with AHCCCS and are required to accept the AHCCCS fee schedule.

CMDP Support

The following is a summary of some ways in which CMDP staff assist and support providers:

- Assist in management of members who do not follow through on appointments and/or treatment;
- Provide assistance regarding member, provider or agency concerns;
- Act as a liaison with the member's agency representative in order to obtain health care history and or legal consent to perform procedures;
- Facilitate clean claims for authorized services within thirty (30) days;
- Provide information regarding referrals to CMDP registered providers;
- Assist with member referrals to community programs (e.g. Women, Infants and Children Program [WIC], Headstart, Children's Rehabilitative Services [CRS], Regional Behavioral Health Authority [RBHA], and the Arizona Early Intervention Program [AzEIP]);

- Perform inpatient reviews;
- Coordinate medical care for at-risk children;
- Facilitate prior authorization for urgent conditions within three (3) business days, and for non-urgent conditions within fourteen (14) calendar days;
- Process all informal and formal grievances for members and providers;
- Conduct periodic site and chart reviews.

CMDP Provider Manual

The *CMDP Provider Manual* has been developed to assist you in providing care to CMDP members and obtaining reimbursement. The key to success in any working relationship is good communication between all the parties involved. This manual is intended to be a communication tool and reference guide. CMDP is committed to working with our providers and keeping you informed. We are always available to assist you.

Provider Services staff members are the liaison between your office and CMDP. We will assist you with any situation that may arise with provider issues. This can include, but is not limited to, keeping you informed of any changes in AHCCCS or CMDP policy and programs, and answering or researching your questions about claims and covered services. We will also assist you in accessing additional resources necessary for the effective and appropriate medical, dental, and behavioral health treatment of a member.

Member Services staff is also available to verify eligibility of CMDP members, and assist in problem resolution with members who do not keep appointments or follow medical directions. Member Services staff can be reached at (602) 351-2245 or (800) 201-1795.

CMDP develops and maintains written policies and procedures applicable to each functional area of CMDP. All policies and procedures have been written to implement state and federal laws and regulations as well as AHCCCS rules and policies. The *CMDP Provider Manual* policies and procedures apply to all network and non-network providers. Copies of specific CMDP policies are available upon request by calling Provider Services at (602) 351-2245 or (800) 201-1795.

The Provider Manual will be updated on an on-going basis. CMDP Provider Services will formally communicate these updates to you.

DEPARTMENT OF ECONOMIC SECURITY
Comprehensive Medical and Dental Program
Site Code 942C
P.O. Box 29202
Phoenix, Arizona 85038-9202

602-351-2245; 1-800-201-1795
 English - Option 1, Spanish - Option 2,
 Translation services other than Spanish - Option 3

CUSTOMER SERVICE PHONE LIST

Pharmacy Services
Option 1
Provider Services
Option 2

Eligibility	Option 1
Claims	Option 2
Dental PAs	Option 3
Medical PAs	Option 4
Behavioral Health	Option 5
Hospital Information	Option 6
Provider Questions	Option 7

Member Caregiver or Case Manager
Option 3

Eligibility, ID Cards, Member Questions	Option 1
Behavioral Health	Option 2
Provider Services	Option 3
Medical Questions	Option 4
Member Claims	Option 5

Policy & Training

Grievances, Policy, HIPAA Privacy Officer	x18795
Community Relations, Training	x13725

FAX LINE NUMBERS:

Claims	602-265-2297
Member, Provider Services	602-264-3801
Medical Services, including Behavioral Health and Dental	602-351-8529

CMDP Website: <http://www.azdes.gov/cmdp>

Chapter 2

UNIQUE FEATURES OF CMDP

All CMDP members have an assigned custodial agency representative, parole or probation officer, or a representative from one of the following custodial agencies:

- DES/Child Protective Services (CPS)
- DES/Division of Developmental Disabilities (DDD)
- Arizona Department of Juvenile Corrections (ADJC)
- Administrative Office of the Courts (AOC)/County Juvenile Probation Offices (JPO)
- Casey Family Program

The custodial agency representative is the member's case manager/legal guardian. These representatives are not medical managers for the members. CMDP has Care Coordinators who assist with coordinating care for members. *Please refer to Chapter 5 for additional information.*

Custodial Agency's Role

The custodial agency's responsibility is to give consent to, or to assist with obtaining consent for, treatment of the member. In some cases, court orders or state laws delegate the responsibility of consent to treatment to the foster caregivers. The custodial agency representative can provide clarification on a case-by-case basis. The custodial agency representative can also assist medical providers with accessing services the child needs. The custodial agency representative may be able to provide additional medical history information about the member.

CMDP Provider Services staff can assist you with contacting the child's custodial agency representative.

Court-Ordered Treatment

In certain circumstances, the court may dictate specific treatment for children under the court's jurisdiction. Prior authorization may be required for some of the services, and authorization should be attained prior to rendering services. The child's custodial agency representative will inform CMDP of court-ordered treatment, which may include specific timeframes for completion. Please submit standard claim forms to CMDP Claims, Attn: Claims Manager.

CMDP Provider Services can assist you with claims questions.

Dual Enrollment with an AHCCCS Health Plan

Children placed in foster care may be enrolled in another AHCCCS Health Plan (i.e., APIPA, Mercy Care) at the time services are rendered. While the child is transitioning from another AHCCCS Health Plan to CMDP, the providers must seek reimbursement for AHCCCS covered services from the AHCCCS Health Plan assigned to that child. To confirm the correct payor, please refer to the AHCCCS website at www.azahcccs.gov.

Member Services staff can assist with identifying in which health plan the child is enrolled, and whom to call regarding prior authorization and claims submission.

Dual Eligible Members

AHCCCS members who are eligible for Medicare and Medicaid services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible. If a member is dual eligible, Medicare is considered the primary payer and CMDP is the secondary payer. CMDP pays the members deductible, coinsurance, and co-payments.

CMDP payment will be the difference between the AHCCCS fee-for-service schedule and the amount paid by Medicare. CMDP shall have no cost-sharing responsibility if the Medicare payment exceeds the AHCCCS fee-for-service schedule for services rendered.

NOTE: Services covered by AHCCCS that are not covered by Medicare, such as certain home health services, may be reimbursed by CMDP provided the services are medically necessary and all reimbursement/prior authorization requirements have been met.

Coordination of Benefits (COB) / Third Party Liability (TPL)

CMDP is the payor of last resort. Providers are required to bill any known primary insurer prior to submitting a claim to CMDP. Upon receipt of reimbursement or denial from the third party, submit the claim and the explanation of benefits (EOB) from the third party to CMDP. If a third party insurer (other than Medicare) requires the member to pay any co-payment, coinsurance or deductible, **CMDP is responsible for making these payments.**

CMDP members and foster parents, representatives, legal guardians, and birth parents are not responsible for payment of any fees or co-pays.

In accordance with A.R.S § 36-2903.01(L) billing or attempting to collect payment through a collection agency is prohibited and any action is to be terminated immediately. Failure to do so is in violation of federal and state law and is just cause for assessing a civil penalty.

Additionally, Arizona Administrative Code (A.A.C.) R6-5-6006(2) states that the Department shall not pay for that portion of the cost of any covered service which exceeds the charges set by the fee schedule and that the medical/dental provider is

prohibited from rendering a bill for additional amounts to the Department, its representatives, the member, foster parents, legal guardians and birth parents.

If you have any questions regarding third party coverage, please contact Provider Services at (602) 351-2245 or (800) 201-1795.

Consent to Treat

A custodial agency representative must give consent for treatment of a CMDP member.

The CMDP member's custodial agency representative or legal representative must give consent, or obtain consent through the court, for any non-routine service including, but not limited to:

- HIV and/or STD testing for those under age 13 (*see Chapter 5*);
- Pregnancy termination (*see Chapter 5*);
- Procedures requiring general anesthesia; and
- Hospitalizations.

For HIV testing, the child may give his/her own consent if thirteen (13) years of age or older. Testing for HIV status must be recommended by a physician and performed to identify the child's medical needs. Testing of infants and children shall take place only when one of the following conditions exists:

- Upon recommendation of a physician, when the child displays symptoms or the child or parent presents high risk factors;
- A child is born to a mother who is known to be HIV positive during pregnancy; or
- A child has been involved in sexual activity where an exchange of bodily fluids has likely occurred.

If available, and possible, DES shall seek the parent's consent for testing if the child is twelve (12) years of age or under.

Pregnancy Termination

Pregnancy terminations must be *medically necessary*. AHCCCS Medical Policy defines the termination as medically necessary 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.

- The pregnancy is a result of rape or incest.
- 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 with obtaining the necessary documentation.

Provider Services staff are always available to assist you in delivering covered services to CMDP members. Effective communication between medical providers and CMDP is essential to the delivery of appropriate medical services to our children. If you have any questions, please call Provider Services or Medical Services units at (602) 351-2245 or (800) 201-1795.

Chapter 3

PROVIDER EXPECTATIONS

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 three major functions in CMDP. Representatives participate in network development and monitoring activities. They also have roles as both provider educator and advocate, and they often serve as intermediaries between the provider and other departments 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.

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 (ARS §13-3620).
- PCP shall submit claims to CMDP as soon as possible, but no later than six months, after service has been provided. *See Chapter 9.*

Primary Care Providers

PCP Responsibilities

Primary care providers include, but are not limited to, family practitioners, general practitioners, pediatricians, internists, nurse practitioners or physician assistants). All PCPs must have an AHCCCS Registration Number and a National Provider Identifier and shall conduct their office operations to comply 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 twenty-four (24) hours per day, seven (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 / (800) 201-1795 Monday - Friday 8:00 a.m. to 5:00 p.m.

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

- Participating PCP means a health care provider as defined above, including *locum tenums*, 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 record, which contains documentation of all health risk assessments and health care services.
- Primary care covered services refer to basic or general health care traditionally provided by family practice, pediatrics, and internal medicines.
- Office wait time shall not be longer than forty-five (45) minutes from the appointment time, except when the provider is unavailable due to an emergency.
- Phone availability shall be within five (5) rings to answer and less than five (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 twenty-four (24) hours a day, seven (7) days a week. It is the PCP's responsibility to notify CMDP of all providers sharing twenty-four (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 twenty-four (24) hours a day.
- PCP shall develop a treatment plan for members having complex or serious medical conditions. The treatment plan should involve appropriate medical personnel and be communicated to the CMDP Care Coordinator, allowing their assistance in coordinating covered benefits.
- PCP 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.
- PCP shall maintain an office that is clean, safe, accessible, and ensures member privacy and confidentiality.
- PCP shall maintain staff membership and admission privileges in good standing at a given hospital.
- PCP shall maintain a current DEA number and CMDP encourages the PCP to record the DEA number on all prescriptions.
- PCP shall prescribe and authorize the substitution of generic pharmaceuticals and agree to abide with CMDP's policies.
- PCP 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 shall provide immunizations and tuberculosis screening (but not immunizations solely for travel) and other measures for the prevention and detection of disease, including instruction in personal healthcare 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 eighteen (18) years of age to the Arizona State Immunizations Information System (ASIIS). ASIIS also allows providers to query the registry for current and historical patient immunization records. If you have any questions, please contact the ASIIS technical support line at (602) 364-3899 or toll free at (877) 491-5741.

- PCP shall provide Early and Periodic Screening Diagnosis and Treatment (EPSDT) services to members according to the federally mandated EPSDT Periodicity Schedule.
- Providers must 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. EPSDT providers must enter immunizations into ASIIS, and enroll every year in the Vaccines for Children (VFC) Program.
- PCP shall refer members to specialty providers or hospitals that are AHCCCS registered as appropriate, or if necessary, refer 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 record, 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). Screening tools 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 www.azdes.gov/dcyf/provider
- 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 foster child's foster parents, his/her biological parent/relative or any party as a result of services rendered. **Foster parents 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.
- 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 twenty-one (21) days for a routine appointment. Members shall not be required to wait longer than forty-five (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 twenty-one (21) days of request.
- Urgent Care PCP appointments - within two (2) days of request.
- Emergency PCP appointments - same day of request.

DES requires that each member receive an initial medical examination within thirty (30) days after the initial foster care placement.

Specialty Appointment Standards

- Emergency appointments will be available within twenty-four (24) hours of referral.
- Urgent care appointments will be available within three (3) days of referral.
- Routine appointments will be available within forty-five (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, www.azdes.gov/cmdp. See Chapter 5 for information on prior authorization requirements.

Dental Appointment Standards

- Emergency appointments will be available within twenty-four (24) hours of request.
- Urgent care appointments will be available within three (3) days of request.
- Routine appointments will be available within forty-five (45) days of request.
See section on dental coverage in Chapter 5.

Prenatal Care Appointment Standards

- First trimester appointments will be available within fourteen (14) days of request.
- Second trimester appointments will be available within seven (7) days of request.
- Third trimester appointments will be available within three (3) days of request.
- Appointments for high-risk pregnancies will be available within three (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 College of Obstetrician 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 two 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 foster 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 foster 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 one hour before the appointment; does not have to wait more than one hour after making the call to be picked up; nor have to wait for more than one hour after conclusion of the appointment for transportation home.

CMDP actively monitors the adequacy of its 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 twenty-one (21) years of age who have been diagnosed with medically-eligible CRS diagnoses. Questions may be directed to the current CRS contractor, the Arizona Physicians Independent Physicians Association (APIPA), at 1-800-445-1638. See Chapter 5.

Behavioral Health Services

Behavioral health services for Title XIX members in the State of Arizona are administered by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS). The agency 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.

The procedure for PCP referral to Behavioral Health services through the RBHA system:

- The CMDP Behavioral Health Coordinator (BHC) may assist the PCP with coordinating the referral for behavioral health care. A PCP 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.
- If the member is not already RBHA enrolled, the PCP may arrange for a referral directly to the RBHA. The BHC or the member's custodial agency representative may assist in completing the ADHS referral form. This form specifies if ongoing RBHA services are indicated.

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 at least ten 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 Medical 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.
 - Testing for HIV status for children 12 years of age and under must be recommended by a physician, and performed to identify the children's medical needs. Testing of infants and children shall take place only when one of the following conditions exist:
 - Upon recommendation of a physician, when the child displays symptoms or the child or parent has high risk factors;
 - A child is born to a mother who is known to be HIV positive during pregnancy; or
 - A child has been involved in sexual activity where an exchange of bodily fluids has likely occurred.
 - Children age 13 or older may request HIV testing without meeting the above requirements.
 - If available, the Division of Children, Youth and Families (DCYF) shall seek the parent's consent for testing if the child is twelve (12) years of age or younger. The child may give his/her own consent if thirteen (13) years of age or older.

EPSDT

The AHCCCS EPSDT Periodicity Schedule (*located at www.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 time frames outlined on the Periodicity Schedule. This includes performing the newborn visit within fourteen (14) days of the baby's birth.

CMDP encourages all providers to schedule the next periodic screen at the current office visit, particularly for children twenty-four (24) months of age and younger. **Providers must use the standardized AHCCCS EPSDT tracking forms or an electronic version.**

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

Description

See Chapter 5 for a complete description of EPSDT requirements.

Developmental Screening Using the PEDS Tool

For CMDP members only, the PEDS tool may be used to screen infants and children up to the age of 8, who are at risk of or are identified as having developmental delays. These children may be screened at each EPSDT visit. Providers who bill for this service must complete training on the use of the tool and must submit the PEDS Tool Score Form and PEDS Tool Interpretation Form with the EPSDT Tracking Form and the CMS 1500 form for reimbursement of services. 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. Physician 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, and 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, www.azdes.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 shall establish the following:

- Written policies;
- All employees and management, to include contractors and agents, must 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 three 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
www.gpoaccess.gov/plaws/index.html
(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 the 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 foster 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 they 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 foster 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 these children, if the child is of an age to communicate such, or from their family members or the foster 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 the 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 one solution or choices of treatment?
- Does the child want to hear about the risks?

- Are there some health care concerns that have not been addressed by this office?
- Is 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, www.azdes.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, kept 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, and
 - 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. Documentation must also include 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 releases, 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, or
- Placed on probationary status or otherwise diminished.

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

- Change
- Cancellation, or
- Termination of their professional malpractice insurance coverage, and
- Within ten (10) days of notice of any suit or claims alleging malpractice or malfeasance against them.

CMDP or any registered provider may terminate association, with or without cause, upon providing thirty (30) days written notice to the other party of intent to terminate the association. Providers who have not provided services to a foster child within a twenty-four (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 www.cms.gov/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, 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

www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx

[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://app.azdes.gov/dcyf/cmdpe/provider/provdirectory.aspx>

Chapter 4

MEMBER SERVICES

Introduction to CMDP Member Services

The health care of our members is very important to us. To ensure their needs are met, CMDP Member Services serves as the coordinating unit for all member activities. Member Services provides assistance to members, foster caregivers, and custodial agency representatives.

The primary functions of Member Services include:

- Verification of member eligibility;
- Resolving eligibility and enrollment issues;
- Primary care physician (PCP) assignment and changes;
- Answering questions about member benefits;
- Responding to and resolving member complaints;
- Arranging translation services including hearing impaired and sign language.

CMDP Member Services is available from 8:00 a.m. - 5:00 p.m., Monday through Friday. Please call (602) 351-2245 or 1-800-201-1795.

Member Rights

All CMDP members have the following rights:

- To be treated with respect and recognition of the member's dignity and need for privacy.
 - The right to privacy includes protection of any information that identifies a particular member except when otherwise required or permitted by law.
- To not be discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- To have services provided in a culturally competent manner, with consideration for members with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, and 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.

- 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.
- The right to refuse care from specified providers.
- To participate in decision-making regarding his or her health care, including:
 - The right to refuse treatment (42 CFR 438.100), and/or
 - To have a representative facilitate care or treatment decisions when the member is unable to do so.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- To be provided with the information about formulating advance directives that involves the member or his/her representative in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment within the requirements of federal and state laws with respect to advance directives [42 CFR 438.6].
- To receive information, in a language and format that the member understands, about member rights and responsibilities, the amount, duration and scope of all services and benefits, service providers, services included and excluded as a condition of enrollment, and other information including:
 - Provisions for after-hours and emergency health care services, including the right to access emergency health care services from a provider without prior authorization, consistent with the member's determination of the need for such services as prudent;
 - Information about available treatment options (including the option of no treatment) or alternative courses of care;
 - 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 PCP;
 - Procedures for obtaining services outside the CMDP Preferred Provider Network (PPN);
 - Provisions for obtaining AHCCCS covered services that are not offered or available through CMDP, and notice of the right to obtain family planning services from an appropriate AHCCCS registered provider; and
 - A description of how CMDP evaluates new technology for inclusion as a covered benefit.
- To be provided with information regarding grievances, appeals and requests for a hearing about CMDP or the care provided.

- The right to file a complaint to CMDP about inadequate *Notice of Action* letters.
- The right to file a complaint to AHCCCS, Division of Health Care Management, Medical Management Unit if CMDP does not resolve the complaints about the *Notice of Action* letter to the member's satisfaction.
- The right to file a complaint about CMDP.
- The right to a summary of member survey results.
- To review his/her medical records in accordance with applicable federal and state laws.
- To request annually and receive at no cost a copy of his/her medical records, as specified in 45 CFR 164.524:
 - The member's right of access to inspect and obtain a copy of his/her medical records may be denied if the information is:
 - Psychotherapy notes
 - Compiled for, or in reasonable anticipation of, a civil, criminal or administrative action, or
 - Protected health information that is subject to the Federal Clinical Laboratory Improvements Amendments of 1988, or exempt pursuant to 42 CFR 493.3(a)(2).
 - An individual may be denied access to read or receive a copy of medical record information without an opportunity for review in accordance with 45 CFR Part 164 (above) if:
 - The information meets the criteria stated in section I (1) above;
 - The provider is a correctional institution or acting under the direction of a correctional institution as defined in 45 CFR 164.501;
 - The information is obtained during the course of current research that includes treatment and the member agreed to suspend access to the information during the course of research when consenting to participate in the research;
 - The information was compiled during a review of quality of care for the purpose of improving the overall provision of care and services
 - The denial of access meets the requirements of the Privacy Act, 5 United States Code (5 U.S.C.) 552a; or
 - The information was obtained from someone other than a health care provider under the protection of confidentiality, and access would be reasonably likely to reveal the source of the information.

- Except as provided above, an individual must be informed of the right to seek review if access to inspect or request to obtain a copy of medical record information is denied when:
 - A licensed health care professional has determined the access requested would reasonably be likely to endanger the life or physical safety of the member or another person; or
 - The protected health information makes reference to another person and access would reasonably be likely to cause substantial harm to the member or another person.
- CMDP must respond within 30 days to the member's request for a copy of the records. The response may be the copy of the record or, if necessary to deny the request, the written denial must include the basis for the denial and written information about how to seek review of the denial in accordance with 45 CFR Part 164.
- To request amendment or correction of his/her medical records as specified in 45 CFR 164.526. CMDP may require the request be made in writing.
- To obtain, at no charge, a directory of health care providers in the PPN.
- To receive information on available treatment options and alternatives, in a manner appropriate to the member's condition and ability to understand.
- To obtain a second opinion from a qualified health care professional within the PPN, or have a second opinion arranged outside the PPN only if there is not adequate in-network coverage, at no cost to the member.
- To know about providers who speak languages other than English.
- To request information CMDP physician incentive plans, if any, that affect referrals from doctors.
- The right to know about the type of compensation arrangements with providers, and whether stop-loss insurance is required of providers.
- The right to contact Member Services if there are any questions regarding member rights.

Member and Foster Caregiver Responsibilities

Members and foster caregivers are responsible for:

- Providing as much information as possible to professional staff working with the member.
- Following prescribed treatment instructions and guidelines given by those providing health care.
- Knowing the name of the member's PCP or doctor.

- Scheduling appointments with the doctor during office hours whenever possible, before using urgent care or a hospital emergency room.
- Scheduling appointments outside of school hours whenever possible.
- Taking the member to medical appointments, or contacting the assigned worker, or CMDP if you cannot provide transportation.
- Arriving at appointments on time.
- Notifying the provider at least one day in advance when unable to keep an appointment.
- Carrying the CMDP ID card (or *Notice to Provider* form, if the card has not arrived) at all times, and presenting it to the health care provider.
- Bringing all available immunization (shots) records and medical history information to the doctor or PCP.
- Taking the member for well-child checkups.
- Taking the member for a dental exam at least twice a year.
- Using Children’s Rehabilitative Services (CRS) when asked to do so by CMDP or the PCP.
- Working with CMDP, the custodial agency representative and the PCP to make certain the member is receiving the best care possible.
- Ensuring that each member has all childhood and teenage immunizations (shots) appropriate to the child’s age and health.
- Always listing DES/CMDP as the responsible party, and the CMDP address for billing (**CMDP - 942C, P.O. Box 29202, Phoenix, AZ 85038-9202**).

Services Foster Caregivers Cannot Authorize

- General anesthesia;
- HIV testing, if the member is 12 years old or younger (members over age 12 can self-consent);
- Blood transfusions;
- Abortions;
- Any surgery or medical treatment that is not routine.

Language Line Services

Language Line automated access offers a fast and efficient way to connect to a professional interpreter; anytime, anywhere. This service provides interpretation in over 140 languages as well as written translation. This service is provided to CMDP members only. To access this service please call CMDP Provider Services at (602) 351-2245 or (800) 201-1795.

Member Enrollment Packets

CMDP complies with AHCCCS policy to communicate with new members by mailing a New Member Enrollment Packet to all new members.

Because CMDP members are age 0-21 years, New Member Enrollment packets will be mailed to the custodial agency representative.

The new member packet consists of:

- Welcome letter
- CMDP member ID card
- Information on choosing a healthcare provider
- Cultural competency information
- EPSDT notice
- Family planning notification letter (age appropriate)
- Notice of privacy practices
- CMDP Preferred Medication List
- *CMDP News* newsletter

The *CMDP Member Handbook* is revised once a year. The Member Handbook and *CMDP Provider Directory* are mailed to foster caregivers/members upon request. The Member Handbook and the Provider Directory information is available on the CMDP website.

PCP Assignment

CMDP makes every effort to ensure a primary care provider (PCP) is assigned to its members. Foster caregivers, custodial agency representatives or members may choose any AHCCCS and CMDP registered PCP who is enrolled in the Vaccine for Children (VFC) Program. CMDP prefers that members choose a PCP from the CMDP Preferred Provider Network (PPN). PCPs are generally family practitioners, general practitioners, pediatricians, internists, registered nurse practitioners, and physician assistants. A specialty provider may be assigned as a member's PCP depending upon the member's medical condition.

CMDP has methods to ensure PCPs are assigned to members. Foster caregivers, custodial agency representatives, and members have the option to request PCP assignment changes at any time.

CMDP Member ID Cards

Temporary Member ID cards/documents are e-mailed to the custodial agency representative within one day that the enrollment notification is received by CMDP. This temporary card includes the member's name, date of birth and identification number.

Permanent Member ID Cards are included in the member’s new enrollment packet and mailed in care of the custodial agency representative in approximately two weeks of the enrollment notification. This permanent card includes the following information:

- Member Name
- Member ID Number
- Date of birth
- Name of the Regional Behavioral Health Authority (RBHA) assigned for behavioral health services
- RBHA telephone number

Providers should request to see the member’s ID card each time the member receives services. If the member does not have his/her card available at the time of service, he/she may not be denied treatment. Call Member Services to verify enrollment. The ID card does not guarantee enrollment.

The CMDP ID number is not the same as the AHCCCS ID number. Make a copy of the member’s CMDP ID card to ensure use of the correct CMDP ID number.

Other means of identification for a CMDP member may include:

- A generic ID card presented by the CPS custodial agency representative, group home or shelter. This ID card is used to identify the member prior to receipt of CMDP ID card. Call CMDP Member Services during business hours to obtain the Member ID number to submit on your claim.
- A foster caregiver may present a Notice to Provider form, in lieu of the member’s ID card. A sample of this form is included at the end of this chapter. This form contains the member’s name and ID number.

CMDP Member ID Card Sample

COMPREHENSIVE MEDICAL & DENTAL PROGRAM (CMDP)
 Arizona Department of Economic Security
 P.O. Box 29202 (942C) • Phoenix, AZ 85038-9202
 www.azdes.gov/cmdp • (602) 351-2245 • 1-800-201-1795

Member: _____

DOB: _____ ID#: _____

For behavioral health or substance abuse services call:
 RBHA: _____ Phone No. _____

MedImpact Member Helpline: 1-800-788-2949
 (For non-business hours)

Front of Card

Claims: Send appropriate claim form to address on front. Payment for eligible members follows AHCCCS FFS schedule. CMDP is payer of last resort. Bill other insurance plans first and submit EOB with claim.

Pharmacy: MedImpact is not responsible for payment of claims at non-participating pharmacy.
 RxBIN: 003585 RxPCN: ASPROD1 RxGRP: ACS03
 Pharmacy Helpline: 1-800-788-2949

All Other Medical Services: Call 1-800-201-1795 for authorization PRIOR to service delivery.
 Do not charge co-pays or any other charges to the member. Bill CMDP.

CMD-1007A (9-13)

Back of Card

Dual Eligibility

AHCCCS members who are eligible for Medicare and Medicaid (AHCCCS) services have dual eligibility. They may be classified as a Qualified Medicare Beneficiary (QMB) or as non-QMB eligible. QMB eligible members receive coverage for all Medicaid services, inpatient psychiatry, psychology, respite and chiropractic services.

QMB and Non-QMB members must use health care providers registered with CMDP. Medicare is always the payor of first resort for these children. CMDP pays only for deductibles and copays.

Other Insurance

If a child comes into foster care with prior health insurance, CMDP is the payer of last resort. Any other insurance coverage a member has should pay for medical care before CMDP pays. CMDP will assist in coordinating benefits. The member and the custodial agency (CPS, JPO, ADJC) should inform CMDP of any other insurance the member has at enrollment.

Member Grievances

Members have the right to file a grievance. A provider may file a grievance on behalf of a member, with the written consent of the member's legal representation, which is defined by the custodial agency. A grievance is an expression of dissatisfaction about any matter, which can include but not limited to:

- The quality of care or services provided;
- Failure to respect the member's rights;
- Aspects of interpersonal relationship such as rudeness of a provider or an employee.

Grievances may be filed either orally or in writing and a final disposition will be provided either orally or in writing, within 90 days after the grievance was received. Members are not entitled to a State Fair Hearing on a grievance.

CMDP reviews member grievances data to identify service issues and make improvements in the quality of care and service. Member satisfaction is dependent upon member cooperation with these activities. Our goal is to work in partnership with members to maintain member satisfaction.

Verifying Member Enrollment

If you have any questions about member identification, contact CMDP Member Services at (602) 351-2245 or (800) 201-1795. Contact Member Services prior to the member's appointment. This will enable us to resolve any enrollment issues so that the member may be seen as scheduled.

You can verify eligibility by logging into our website at www.azdes.gov/cmdp. Once you have logged into the website click on Provider Services, then click on Member Lookup. You will need to use the CMDP Member ID number, your AHCCCS ID number and the dates of service.

Member eligibility can also be verified by contacting Member Services. Please have the member's ID number, name and date of birth. Document the enrollment verification information you receive over the telephone including the name of the Member Services representative, and the date and time of call.

CHAPTER APPENDIX

FC-069 Notice to Provider-Educational and Medical

www.azdes.gov/InternetFiles/InternetProgrammaticForms/pdf/FC-069sample.pdf

Chapter 5

MEDICAL SERVICES

The Comprehensive Medical and Dental Program provides full coverage for medical and dental services necessary to achieve and maintain the optimal level of health for children in foster care. Covered services are based upon a determination of medical necessity and clinical appropriateness.

Covered Services

Covered services include, but are not limited to, the following medical services:

- Doctor office visits
- Well-child check-ups, Early Periodic Screening, Diagnosis and Treatment (EPSDT), adolescent screenings and treatment
- Behavioral health services (*see Chapter 6*)
- Hospital services
- Specialist care, as needed
- Family planning services
- Rehabilitative services such as physical, occupational, and speech therapies
- Home and community-based services
- Laboratory and X-ray services
- Pregnancy care
- 24-hour emergency medical care
- Dental care
- Emergency transportation
- Vision care and eyeglasses
- Medically-needed transportation
- Pharmacy services, medical supplies and equipment

Non-Covered Services

Non-covered services include, but are not limited to:

- Any hospital admission, service or item requiring prior authorization for which prior authorization has not been obtained.
- Pregnancy terminations that are not medically necessary.
- Pregnancy termination counseling.
- Services or items for cosmetic purposes.
- Services or items furnished free of charge, or for which charges are not usually made.
- Services provided in an institution for the treatment of tuberculosis.
- Services determined by the CMDP Medical Director to be experimental or provided primarily for the purpose of research.
- Services of private or special duty nurses other than when medically necessary and prior authorized.
- Physical, occupational or speech therapy as a maintenance regimen only.
- Routine circumcision for an eligible newborn male infant, unless medical necessity is documented.
- Care for Temporomandibular Joint (TMJ) related disorders, unless determined medically necessary.
- Medical services to an inmate of any public institution or state mental health facility.
- Outpatient or inpatient psychiatric, psychological or other counseling services provided to AHCCCS eligible foster children residing in Arizona. These services are provided through the Regional Behavioral Health Authorities (RBHAs).
- That portion of the cost of any covered service, which exceeds allowable charges in the CMDP fee schedule. Determination and payment **shall represent PAYMENT IN FULL for the services rendered. Any additional charge to the foster caregiver is prohibited by law.**
- The cost of care, services or items in excess of that paid by other programs.
- Services for which claims have not been re-submitted within twelve (12) months of the date of service.
- Care provided by individuals who are not properly licensed and/or certified.
- Treatment of the basic conditions of alcoholism and drug addiction. Alcohol and substance abuse treatment is an AHCCCS-covered service that AHCCCS-eligible members should receive from the RBHA.

Prior Authorization Requirements and PA Matrix

Please refer to the CMDP website at www.azdes.gov/cmdp for the most up-to-date version of the *Prior Authorization (PA) Matrix*.

Service Type	PA Required	PA Not Required
Behavioral Health		
Inpatient	<p>Requires PA to determine if patient is enrolled or eligible to receive services from Regional Behavioral Health Authority (RBHA). CMDP requests notification within 24 hours of admission for case management purposes.</p> <p>For Title XIX and Title XXI members, behavioral health services are provided through the RBHA. For state only members, CMDP provides behavioral health services.</p>	
Outpatient	<p>Requires PA to determine if patient is enrolled or eligible to receive services from RBHA. Psychological testing requires PA and documentation to support medical necessity of an acute or chronic brain disorder.</p>	
Psychotropic Prescriptions	<p>Prescriptions from RBHA providers must be filled at RBHA contracted pharmacies using the member's RBHA ID number.</p> <p>For non-Title XIX (state only) eligible members, refer to CMDP's Preferred Medication List (PML) for current information about covered psychotropic medications and PA requirements.</p>	<p>PCP may write prescriptions for patients with minor depression, anxiety disorders and treatment of ADHD without co-morbidity. See the Behavioral Health Tool Kit on the CMDP website.</p>

Service Type	PA Required	PA Not Required
Dental		The American Association of Pediatric Dentistry recommends dental visits begin by age one. Routine and preventive dental services do not require PA. CMDP allows two (2) oral examinations and two (2) oral prophylaxis and fluoride treatments per member per year [i.e., one every six (6) months]. Emergency services to relieve pain, suffering or infection, do not require PA. May be retro-spectively reviewed.
Orthodontics	PA required for all services. A preorthodontic treatment visit must be completed before authorization can be given for X-rays, tracings and models. Submit documentation to support medical necessity.	Once approved, CMDP provides a one-time benefit for medically necessary orthodontics. Refer to the Dental Matrix for fees and services.
Orthognathic surgery	PA required to determine if patient is CRS enrolled or eligible.	
Other Dental: Periodontal pro- cedures, bridge and crown restoration, root canals	PA required. Must submit documentation to support medical necessity and include x-rays.	
Durable Medical Equipment (DME) and Supplies; Prosthetics and Orthotics	PA required for all rentals. Total cost of the rentals must not exceed the purchase price. Purchases valued at \$300 or more require PA. Nutritional supplements/formulas require PA, and completion of the "Certificate of Medical Necessity for Commercial Oral Nutritional Supplements."	Medically necessary items following hospital discharge for a period of 30 days or less and equipment ordered on an emergency basis for short term use do not require PA.
Emergency Room and Urgent Care Services		No PA required. CMDP requests notification within 24 hours of ER visit for case management purposes.
Family Planning	PA required for surgical interventions. IUDs are not usually considered medically appropriate for the sexually active teen because of the significant risks of morbidity and mortality.	This includes emergency contraception. STD and HIV/AIDS testing do not require a PA. See HIV Testing section below.

Service Type	PA Required	PA Not Required
HIV Testing		HIV/AIDS Testing does not require PA. HIV testing requires signed consent by the child's custodial agency if the child is 12 years of age or younger, child age 13 + may self-consent.
Home Health / Hospice	Requires PA and documentation to support medical necessity. Written plan of care must accompany the request.	
Inpatient Services	Notification to CMDP required within first 24 hours.	
Obstetrical Services (OB)	PA and American College of Obstetricians and Gynecologists (ACOG) Health Record required for OB package authorization. OB package includes: prenatal visits, 2 ultrasound, delivery and postpartum visit. Any further testing requires separate PA.	
Pregnancy Termination	Requires PA and must meet AHCCCS guidelines and have proper documentation to support the request. The child's custodial agency representative must provide or obtain proper consents.	
Synagis, Growth Hormones	Requires PA and documentation to support medical necessity. Refer to the Preferred Drug List (PDL) at www.azdes.gov/cmdp/	
Anti-Hemophiliac Medications	Requires PA. Contact Medical Services for arrangements.	
Psychotropic Medications	See Behavioral Health section above regarding psychotropic medications.	
Diapers	Diapers require PA and documentation to support medical necessity. Diapers for members over the age of 3 may be covered if medically necessary.	

Service Type	PA Required	PA Not Required
OTC Meds		OTCs do not require a PA but must be written on a prescription from a provider. Vitamins and over-the-counter analgesics are not covered. The foster caregiver is given money in the monthly stipend to cover such costs.
Medication not on PML (CMDP formulary)	Any medication not on the PML requires PA and documentation to support medical necessity.	As a rule, most generic medications are covered.
Specialist Referrals	Treatment beyond the initial consultation requires PA. Include documentation to support medical necessity and plan of care.	Initial consultation does not require PA, but obtain referral from child's PCP. Application and/or removal of casts and splints does not require PA.
Transportation		
Emergency		CMDP requests notification within 10 days of service for case management purposes.
Medically Necessary - Non-Emergent	Contact the child's custodial agency initially. If all other means of obtaining transportation are unsuccessful, the child's custodial agency must contact CMDP. After contacting the child's custodial agency, they must notify Member Services for arrangements and authorization. An adult must accompany the child.	
Vision Services		
Eyeglasses	Sports glasses and tinted lenses require PA and documentation to support medical necessity.	Frames, lenses, and scratch coating do not require a PA, if the cost is within the AHCCCS fee schedule. Bifocals and repairs do not require a PA.
Contact Lenses	Requires PA and documentation to support medical necessity.	

All routine medically necessary vaccines are covered under the Vaccines for Children (VFC) Program. If billing for a non-VFC vaccine, please submit documentation of medical necessity.

Providers must NOT use immunization administration CPT codes 90465, 90466, 90467, 90468, 90471, 90472, 90473 and 90474 when billing for vaccines under the federal VFC Program. *See Chapter 9 for more information on VFC Program billing.*

Dental

CMDP covers all AHCCCS covered dental services for members. This includes preventive and restorative care. An oral health screening should be part of an EPSDT screening done by a PCP. It does not take the place of an exam done by a dentist. Members do not need a referral from their PCP and can see any dentist listed in the Provider Directory. The American Academy of Pediatric Dentistry recommends dental visits begin by the age of **one year old**. All members by the age of three should see the dentist **twice a year for routine exams, and more often if needed**. Routine dental services are covered by CMDP. A dentist needs prior approval for major dental services.

The following is a list of covered dental services:

- Dental exams and X-rays
- Treatment for pain, infection, swelling and dental injuries
- Cleanings and fluoride treatments
- Dental sealants
- Fillings, extractions and medically necessary crowns
- Pulp therapy and root canals
- Dental education

Dentists are part of the CMDP Preferred Provider Network (PPN). Contact Provider Services to inquire about PPN dentists.

CMDP must receive complete and accurate records for reviewing services requiring prior authorization. This will assist the dental consultant, who is a state-licensed dentist, in making an appropriate determination. Refer to the *CMDP Dental Matrix* on the CMDP website for the list of eligible dental services and prior authorization requirements. Determination of prior authorization must be in writing and must be granted **before** the proposed procedure is begun. Denial of prior authorization and member non-eligibility on the date of service will result in denial of reimbursement.

Orthodontia

CMDP covers orthodontia if it is medically necessary. Orthodontic services require medical necessity for the purpose of controlling or eliminating infection, pain and disease, and restoring facial configuration or function necessary for speech, swallowing or chewing. The *Dentist's Certification of Medical Necessity (CMD-1006A)*, found at the end of this chapter, must be completed and signed to request orthodontic treatment.

A member must meet the medical and social criteria in order for CMDP to approve orthodontic services. Social criteria are detailed by a CPS specialist via the *Consideration Factors for Orthodontic Services (CMD-1039A)* form. Medical criteria are indicated by the PCP via the *PCP Statement of Medical Necessity (CMD-1060A)* form.

CMDP must receive complete and accurate records for reviewing services requiring prior authorization. This will assist the dental consultant, who is a state licensed dentist, in making an appropriate determination. Refer to the *CMDP Dental Matrix* for the list of eligible dental services and prior authorization requirements. Prior authorization is necessary for appropriate tracings, photographs, and orthodontia models, prior to submitting the request for orthodontia. Determination of prior authorization must be in writing and must be granted before the proposed procedure is begun. Denial of prior authorization and member non-eligibility on the date of service will result in denial of reimbursement.

Payment for orthodontia treatments may only be made for children who are continuing members of CMDP. The child's foster placement is not financially responsible for the remaining cost of services. The dentist is responsible for verifying the child's enrollment status at the time of treatment.

Orthodontists are part of the CMDP PPN. Contact Provider Services to inquire about PPN orthodontists.

Charges are reimbursed according to the AHCCCS Fee-for-Service Schedule.

Contact Medical Services for any forms or questions, at (602) 351-2245 or (800) 201-1795.

Emergency Services

CMDP covers emergency medical services provided by qualified medical professionals for all members, as specified in Arizona Administrative Code (A.A.C.) R9-22-210. Emergency medical services are those services provided after the sudden onset of an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

- Placing the member's health in serious jeopardy,
- Serious impairment of bodily functions, or
- Serious dysfunction of any bodily organ or part.

For utilization review purposes, the test for appropriateness of the request for emergency services is whether a prudent layperson, if in a similar situation, would have requested such services.

Emergency medical services covered without prior authorization include, but are not limited to, all medical services necessary to rule out an emergency condition and emergency transportation. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

CMDP monitors emergency service utilization by both providers and members, and has established guidelines for addressing inappropriate use.

Per the Balanced Budget Act of 1997, and 42 CFR 438.114, CMDP may not deny payment for treatment obtained under either of the following circumstances:

- A member had an emergency medical condition, including cases in which the absence of medical attention would not have resulted in the outcomes identified in the definition of emergency medical condition (42 CFR 438.114).
- A representative of CMDP instructs the member to seek emergency medical services.

Additionally, CMDP may not:

- Limit what constitutes an emergency medical condition as defined in 42 CFR 438.114, on the basis of lists of diagnoses or symptoms.
- Refuse to cover emergency services based on the failure of the provider, hospital, or fiscal agent to notify CMDP of the member's screening and treatment within 10 calendar days of presentation for emergency services. This notification stipulation is only related to the provision of emergency services.

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

EPSDT

Early Periodic Screening, Diagnosis and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid recipients in effectively utilizing these resources. EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include

screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in federal law 42 USC 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered under the AHCCCS state plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness do not apply to EPSDT services.

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

Amount, Duration and Scope

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

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

EPSDT Screening Requirements

Comprehensive periodic screenings must be conducted according to the time frames identified in the periodicity schedule, and inter-periodic screenings must be completed as appropriate for each member. The periodicity schedule is based on federal mandates and is closely aligned to Arizona Medical Association (AMA) and American Academy of Pediatrics (AAP) guidelines. The following is a summary of what is included in EPSDT screens. Additional information may be obtained from CMDP Medical Services.

- A comprehensive health and developmental history (including physical, nutritional and behavioral health assessments).
- A comprehensive unclothed physical examination.

- Appropriate immunizations according to age and health history.
NOTE: The immunization schedule can be viewed on the CMDP website at www.azdes.gov/cmdp.
- Laboratory tests (including blood lead screening assessment appropriate to age and risk, tuberculosis screening appropriate to age and risk, anemia testing and if appropriate, diagnostic testing for sickle cell trait). The Newborn Screen for all infants born in Arizona includes screening for abnormal hemoglobin. The Sickle Cell Anemia Society of Arizona has educational programs to help people with sickle cell anemia. The phone number is (602) 254-5048.
- Health education.
- Appropriate dental screening.
- Appropriate vision, hearing and speech testing.
- Developmental screening.
- Immunizations. Providers must coordinate with the Vaccines For Children (VFC) Program in the delivery of immunization services. The Arizona Department of Health Services (ADHS) manages the VFC Program. ADHS operates the Arizona State Immunization Information System (ASIIS), a registry designed to collect immunization data on individuals within the state. Call them at (877) 491-5741 to learn about the system and how to obtain the web-based program to connect your office to ASIIS.

EPSDT providers are asked to complete the screenings listed for each period and complete the EPSDT Tracking Form appropriate to the age of the child. Additional tracking forms may be obtained from your CMDP Provider Services representative or on the CMDP website. CMDP staff will review EPSDT tracking forms for completeness and quality, identify referrals made for evaluation and treatment and missed opportunities for immunizations. CMDP staff may contact provider offices to schedule a record audit of EPSDT services and offer provider education about the program.

Providers are requested to notify CMDP Member Services when CMDP members fail to make or keep EPSDT appointments.

Developmental Screening Using the PEDS Tool

Use of the Parent's Evaluation of Developmental Status (PEDS) Tool for other health plans is limited to infants born after January 1, 2006 who have had stays in the Newborn Intensive Care Unit (NICU). For CMDP members only, the tool may be used to screen all infants and children up to the age of 8 who are at risk or identified as having developmental delays. These children may be screened at each EPSDT visit. Providers who bill for this service must complete training on the use of the tool and **must submit the PEDS Tool Score Form and PEDS Tool Interpretation Form** with the EPSDT Tracking Form and claim form for reimbursement of services.

PEDS Tool

Providers can utilize an on-line PEDS Tool training session provided by the Arizona Chapter of the American Academy of Pediatrics (AzAAP) at <https://azpedialearning.org/test1.asp>. Providers who complete the training may bill CMDP for use of the tool.

CMDP requirements for reimbursement of the developmental screen are as follows:

- Verified completion of the PEDS Tool training program;
- For CMDP members only, the tool may be used to screen children up to the age of 8 who are at risk or identified with developmental delays; and,
- Copies of the PEDS Tool Score and Interpretation forms are submitted in the same manner that the EPSDT tracking forms are submitted with the CMS 1500 claim form.

Use billing code 96110 with an EP modifier. Refer to the AHCCCS Fee-For-Service web page for reimbursement rates (azahcccs.gov/commercial/ProviderBilling/rates/Physicianrates/Physicianrates.aspx). For questions, please contact Provider Services at (602) 351-2245 or (800) 201-1795.

Arizona State Immunization Information System (ASIIS)

By state law, all providers are required to be connected to the Arizona State Immunization Information System (ASIIS), and to report to this system all immunizations administered. **Provider staff should enter all immunization data timely and completely to comply with state laws and eliminate unnecessary revaccinations.**

ASIIS allows providers to query immunization records on individual children or groups of children. In addition, it generates reminder notices for the provider to indicate when immunizations are due or past due for individual children. CMDP also has access to ASIIS to verify immunization records.

Contact ASIIS directly at (877) 491-5741 for information on the ASIIS software program or instructions on using the web-based system. ASIIS will provide hands-on training for providers.

Providers who are unable to determine a child's immunization status may contact the EPSDT Coordinator at CMDP Medical Services. We will make every effort to verify the immunization history in question.

Maternal Health / Family Planning

Family Planning

Family planning services are covered services for CMDP members. Members aged 12 and older must be notified each year of available family planning services, verbally by their PCP or primary care obstetrician (PCO), and in writing by CMDP. Members may receive the following medical, surgical, pharmacological, and laboratory family planning services:

- Natural family planning education, counseling, and referral to qualified health professionals, including information on the prevention and spread of sexually transmitted diseases (STDs).
- **STD testing, including HIV testing. This testing requires signed consent from the member's custodial agency representative, if the child is twelve (12) years or younger. If the child is 13 years of age or older, he/she may consent to HIV testing.**
- Contraceptive counseling, medication supplies, including, but not limited to: oral and injectable contraceptives, diaphragms, condoms, foams, and suppositories. Prescriptions for over-the-counter methods may be filled at CMDP pharmacies.
- Intrauterine devices (IUDs) are not usually considered a medically appropriate method of birth control for sexually active teens, because of the risk of morbidity and mortality in this population.
- Associated medical and laboratory examinations including ultrasound studies related to family planning, physical exam and pelvic exam.
- Treatment of complications resulting from contraceptive use, including emergency treatment.
- Postcoital emergency oral contraception within seventy-two (72) hours after unprotected sexual intercourse.

For questions about submitting a claim, please contact Provider Services. For questions about CMDP coverage of birth control, contact Medical Services and speak with the CMDP Maternal Health Coordinator. Both units can be reached at (602) 351-2245 or (800) 201-1795.

Pre-Teen Vaccine Campaign

As children get older, protection provided by some childhood vaccines begins to weaken. Children can also develop risks for more diseases as they get older. The CDC recommends that all 11 and 12-year-olds get the Tdap and meningitis vaccines. Girls and boys this age should also get the human papillomavirus (HPV) vaccine. All of these vaccines are covered through the VFC Program.

Human Papillomavirus (HPV)

HPV vaccine protects against the types of HPV that most commonly cause cervical cancer and genital warts. This vaccine is recommended for 11 and 12-year-old girls and boys. Ideally girls should get 3 doses of this vaccine before their first sexual contact when they could be exposed to HPV.

Meningococcal Disease

Meningococcal conjugate vaccine (MCV4) protects against these infections. Pre-teens should receive a single shot of this vaccine during their 11 or 12-year-old check-up.

Pertussis

Tetanus-diphtheria-acellular pertussis vaccine (Tdap) is an improvement to the old Td booster because it adds protection from whooping cough while still maintaining protection from tetanus and diphtheria. Pre-teens should receive a single shot of Tdap at their 11 or 12-year-old check-up.

In addition, please check the status of the following immunizations during the pre-teen EPSDT visit:

- Hepatitis B
- Measles, Mumps, and Rubella
- Polio
- Varicella

Prenatal Care

Due to the age of our members, pregnant CMDP adolescents are considered at risk. Pregnant members must be referred to a primary care obstetrician (PCO) as soon as the pregnancy is confirmed. Call CMDP Provider Services at (602) 351-2245 or (800) 201-1795 for assistance in locating a PCO. CMDP clinical staff will assist providers in coordinating care and services for the pregnant member. Notify the CMDP Maternal Health Coordinator (MHC) of the pregnancy to obtain prior authorization for prenatal care. PA requests for total obstetrical (OB) care must include a copy of the ACOG form. Please instruct pregnant members to call their custodial agency representative or CMDP Medical Services for any assistance.

Maternity care includes medically necessary services for the care of pregnancy, treatment of pregnancy-related conditions, antepartum services and postpartum care. Access to low cost/no cost family planning services is available after members leave CMDP.

Pregnancy Termination

Pregnancy termination (including the use of mifepristone) is a covered service for CMDP members 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, that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
- The pregnancy is a result of rape or incest.
 - 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.

Prior authorization (PA) is required from the CMDP Medical Director before performing a pregnancy termination, including provision of mifepristone. To obtain PA, the attending physician must complete the AHCCCS *Certificate of Medical Necessity for Pregnancy Termination Form* (a web link to the form is available at the end of this chapter; the form may be photocopied) certifying that, in the physician's professional judgment, one or more of the above criteria have been met. The completed and signed form must be faxed to CMDP Medical Services, with a copy of an informed consent form for the termination, signed by the CMDP member if 18 years or older.

If the member is under age 18, or is 18 years of age or older and considered an incapacitated adult, a dated signature of the member's parent or legal guardian indicating approval of the pregnancy termination procedure is required. The following documentation must accompany the AHCCCS *Certificate of Medical Necessity for Pregnancy Termination Form*.

- When the pregnancy is the result of rape or incest, documentation that the incident was reported to the proper authorities, including the name of the agency, report number and the date the report was filed.
- Signature of the legal guardian approving the termination procedure and copy of the court order if someone other than the legal guardian has been given authorization to approve the termination procedure.

In medical emergencies, the provider must submit all documentation of medical necessity to CMDP within two (2) working days of the date on which the termination of pregnancy procedure was performed.

Hysterectomy

Hysterectomy or other means of sterilization is not covered unless medically necessary. Prior authorization is required. If the procedure can be substantiated as medically necessary, in addition to the supporting medical documentation, the following requirements must also be met:

- The member and legal guardian must sign a consent form, which includes information that the hysterectomy will render her incapable of bearing children. Providers may use the sample AHCCCS hysterectomy consent form in this chapter.
- The provider is not required to complete a consent to sterilization form prior to performing hysterectomy procedures and the thirty (30) day waiting period required for sterilization does not apply to hysterectomy procedures.
- Unless an emergency, a second opinion may be required.
- In an emergency, PA is not required, but the physician must certify in writing that an emergency or life-threatening illness or disease exists.

Contact Medical Services for assistance in obtaining the necessary prior authorization at (602) 351-2245 or (800) 201-1795.

Pharmacy

In order to maintain the quality and cost-effectiveness of the pharmacy benefit program, CMDP implemented a Preferred Drug List (PDL). This PDL (sometimes referred to as a formulary) is a list of medications preferred by CMDP. All the medications on the PDL have received U.S. Food and Drug Administration (FDA) approval as safe and effective. A committee of physicians and pharmacists has chosen all medications on this list.

Use the PDL to locate brand and generic medication alternatives that are covered under the CMDP plan. Some medications or classes require prior authorization and/or have a limited allowable quantity. These are shown on the PDL. Please complete the *Prior Authorization for Medications (CMD-026-C)* for all requests for non-formulary medications. Medications that are experimental and/or investigational in nature are not covered.

NOTE: For assistance with prior authorization, please refer to the PDL or contact Medical Services. The PDL can be accessed on the CMDP website at www.azdes.gov/cmdp

CMDP's formulary encourages generic substitution whenever possible. If a brand name drug must be prescribed, documentation to support the specific drug must be submitted to CMDP Medical Services for prior authorization.

Over-the-counter (OTC) medications may be covered, when written on a prescription. Note that all prescriptions are required to be written on tamper-proof prescription pads. Examples of covered OTC products may include medications that are used for the treatment of scabies

and lice, or antihistamines and decongestants used for the treatment of chronic allergies. These medications must be written on a prescription and signed by the physician. Examples of non-covered OTC items include vitamins (with the exception of prenatal vitamins for pregnant teens). If you have questions, contact CMDP Medical Services at (602) 351-2245 or (800) 201-1795.

Psychotropics for limited behavioral health diagnoses (*see Chapter 6*) may be prescribed by a PCP. Prescriptions written by a RBHA psychiatrist must be filled through RBHA contracted pharmacies, using the RBHA identification number. Medications to treat major depressive disorders must be obtained through the RBHA providers. RBHA enrolled members receive their medications through the RBHA. Contact the Medical Services Behavioral Health Coordinator for assistance.

Refills

Due to the transitory nature of CMDP members, physicians may be requested to write new prescriptions for drugs before the previous supply has expired. Physicians are requested to comply with these requests, yet be aware of attempts to fraudulently obtain drugs. Suspected attempts to obtain drugs fraudulently must be immediately reported to CMDP Provider Services at (602) 351-2245 or (800) 201-1795.

Therapies (Occupational Therapy, Physical Therapy, Speech Therapy, Audiology Services, Respiratory Therapy)

CMDP covers therapies that are medically necessary to improve or restore functions that have been impaired by illness, injury or disability. CMDP Medical Services authorizes therapy services in the amount, frequency, and duration as are determined medically necessary and clinically appropriate. Authorization determinations are based on the AHCCCS Medical Policy Manual. If the member is enrolled in CRS, CMDP coordinates therapy benefits with CRS. CMDP also pays for medically necessary therapies arranged through the Arizona Early Intervention Program (AzEIP).

A prior authorization is not required for a therapy evaluation. However, actual therapy services require PA.

For authorization to provide therapy, either the therapist or the PCP/specialist must document and submit in writing to CMDP the evaluation results and treatment plan, including goals, rehabilitation potential, location of services (home or office), length of time (from and through dates), and number of sessions requested. Continued authorization will require the PCP/specialist's statement of medical necessity and submission of the therapist's progress notes and/or updated evaluation with new treatment plan. The number of visits cannot exceed member's eligibility span.

Transplants

Providers must obtain prior authorization from CMDP for all organ and tissue transplantation services. All transplant services are coordinated by CMDP with the AHCCCS Division of Health Care Management and the services of AHCCCS contracted transplant specialists, when available.

CMDP covers medically necessary transplantation services as outlined by AHCCCS, and related immunosuppressant medications. Covered transplants must be non-experimental and non-investigational for the specific organ/tissue and specific medical condition. Solid organ transplantation services must be provided in a Centers for Medicare and Medicaid Services (CMS) certified and United Network for Organ Sharing (UNOS) approved transplant center that is contracted with AHCCCS, unless otherwise approved by the AHCCCS Chief Medical Officer or designee. Bone marrow transplantation services should be provided in a facility which has achieved Foundation for the Accreditation of Cellular Therapy (FACT) accreditation as a bone marrow transplant center and that is contracted with AHCCCS, unless otherwise approved by the AHCCCS Chief Medical Officer or designee.

Questions regarding coverage and procedures for transplants should be immediately directed to CMDP Medical Services at (602) 351-2245 or (800) 201-1795.

Hospital Utilization

CMDP's inpatient hospital services refer to those medically necessary services provided by, or under the direction of, a primary care physician, practitioner or a specialty physician on referral from a primary care physician, which are ordinarily furnished in a hospital.

Concurrent review is performed on admission and at frequent intervals during inpatient hospital stays. Reviews assess the appropriate usage of ancillary resources, levels of care (LOC) and service, according to professionally recognized standards of care using InterQual criteria. Concurrent review validates the medical necessity for continued stay and evaluates quality of care. Discharge planning begins upon admission.

Concurrent review is initiated within one (1) business day of notification and continues at intervals appropriate to patient condition, based on the review findings. During review, the following are considered:

- Necessity of admission and appropriateness of service setting;
- Quality of care;
- Length of stay;
- Discharge needs; and,
- Utilization pattern analysis.

CMDP Medical Services coordinates with the Medical Director in determining the appropriateness of continued services, in consultation with physician advisors as necessary.

Continued hospital services may be denied when:

- A member no longer meets intensity and severity criteria;
- A member is not making progress in a rehabilitative program; or
- A member can be transferred safely to a lower level of care.

Contact the Concurrent Review Nurse at CMDP Medical Services with any inpatient concerns.

The hospital must notify CMDP Medical Services within twenty-four (24) hours of admission at (602) 351-2245 or (800) 201-1795.

Transportation

Emergency Transportation

Emergency transport by ground or air ambulance to the nearest clinically appropriate hospital or emergency department is covered if medically necessary based on the member's medical condition at time of transport, and if no other transport is appropriate and available. The ambulance provider must notify CMDP within ten (10) days of the transport or the claim may be denied. Use of emergency transportation for non-emergent reasons will not be paid.

Non-emergency Medically Necessary Transportation

Transportation to medical providers and pharmacies (for prescription drugs or medical supplies) is provided to CMDP members or foster placements who are unable to provide their own transportation.

Most CMDP members reside in licensed foster placements such as foster family homes, emergency shelters, and group homes. These licensed placements are expected, and in some cases required through contracts, to provide routine transportation and accompany the member to routine health care appointments. Licensed placements receive a monthly maintenance payment for routine transportation. The rate of the maintenance payment is adjusted when the needs of the member, including transportation, are greater than average. In some instances, a member's case manager or a case aide may accompany and transport a child to medical appointments. Given these alternatives, assistance from CMDP in providing routine transportation is rarely needed.

To request non-emergency, medically necessary transportation, contact CMDP Member Services and be prepared to discuss the destination and reason for the transport. CMDP requires that a responsible adult accompany minors.

Transportation Standards

If a member needs non-emergency medically necessary transportation, CMDP requires its transportation provider to schedule the transportation so that the member arrives on time for the appointment, but no sooner than one hour before the appointment; does not have to wait more than one hour after making the call to be picked up; nor have to wait for more than one hour after conclusion of the appointment for transportation home.

Transportation to Behavioral Health Providers

Transportation to behavioral health providers is the responsibility of the RBHAs for enrolled members. CMDP is responsible for transporting the member to the first appointment to the RBHA, if necessary. If there is any question about responsibility for transportation to behavioral health providers, contact the CMDP Behavioral Health Coordinator.

Medically Necessary Transportation Outside the Member's Service Area

For services that are only available outside the member's service area (generally the county), transportation may be reimbursed by CMDP. Additionally, meals and lodging may be reimbursed for the member and one attendant during the travel time required to the medical provider and again upon return home. Services of an attendant (responsible adult) may be reimbursed. These services must receive prior authorization. Contact Medical Services with any questions.

Ambulance Transfer Between Medical Providers

Transfer by ambulance between medical providers (i.e., between treating hospitals or hospital to nursing facility) is covered with prior authorization from CMDP. The hospital requesting the transfer must contact the CMDP Concurrent Review Nurse to coordinate the transportation.

At a minimum, hospital to hospital or hospital to specialty only transportation should be reimbursed at the Basic Life Support rate. If the member's medical condition meets criteria for medical necessity, this could also be reimbursed at Advance Life Support rate.

Vision

CMDP covers vision care including refractions, eyeglasses, and care of medical conditions of the eye. Appointments for refractions do not require prior authorization (PA). Eyeglasses meeting the conditions set forth in the *CMDP PA Guidelines* do not require PA. Repair and replacement of eyeglasses is covered.

Contact lenses are covered only when needed after cataract surgery, or when determined medically necessary. Prescriptions for contact lenses require PA and must state why these are medically necessary instead of glasses.

Initial referral to an ophthalmologist does not require PA. Ongoing treatment does require prior authorization.

Children's Rehabilitative Services (CRS)

Children's Rehabilitative Services (CRS) is a carve-out program administered through AHCCCS, that provides diagnostic, surgical, hospitalization, rehabilitation, pharmacological, and allied services. CRS contracts with Arizona regional physicians who are experts in their fields to treat CRS enrolled patients. The current contract is with Arizona Physicians Independent Physicians Association (APIPA).

Eligibility for CRS is based on specific medical illnesses, disabilities, congenital anomalies, or potentially disabling conditions that have the potential for functional improvement through medical, surgical or therapeutic intervention. Most CMDP members are financially eligible for CRS; however, they must become enrolled with CRS to have a condition treated there. CMDP members must receive services for medically eligible conditions through CRS, unless they have a private insurance payor and/or Medicare.

CRS is not an acute care provider. Each CRS patient must have a PCP through CMDP to provide general care and immunizations. Infectious diseases and acute trauma are not treated by CRS unless there is a direct relationship between these and the CRS-eligible condition. The CRS Administration determines coverage through CRS.

Anyone may *refer* a child for CRS services. Application for services is by completion of the *CRS Pediatric History and Referral Form* and documentation of the child's primary diagnosis supporting the application. CMDP can complete the CRS application with the assistance of the child's custodial agency representative. Whenever possible, pertinent X-rays and test results and other related medical records should accompany the referral form.

The *Pediatric History and Referral Form* may be photocopied and used to initiate an application for CRS. Clean copies may be requested from APIPA at 1-800-445-1638.

For more information about specific eligible conditions and covered services, please contact CMDP Medical Services. The unit will assist providers in identifying CMDP members who may be eligible for CRS. Once CRS determines the child medically eligible, the child is enrolled in CRS. CRS enrolled members must receive CRS covered services through CRS providers.

CHAPTER APPENDIX

AHCCCS Forms

www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf

Arizona Health Care Cost Containment System (AHCCCS) Periodicity Schedules

- EPSDT Periodicity Schedule
- Dental Periodicity Schedule
- Vision Periodicity Schedule
- Hearing and Speech Periodicity Schedule

Recommended Childhood and Adolescent Immunization Schedules

- Ages 0-6 years
- Ages 7-18 years
- Children and adolescents who start late or who are more than 1 month behind

AHCCCS Certificate of Medical Necessity for Commercial Oral Nutritional Supplements

AHCCCS Certificate of Necessity for Pregnancy Termination

CMDP Forms

www.azdes.gov/appforms.aspx?type=6&category=125

CMD-013 DES/CMDP Physician's Certification of Medical Necessity

CMD-026 DES/CMDP Prior Authorization for Therapies

CMD-026-A DES/CMDP Prior Authorization for Medical/Surgical Services

CMD-026-B DES/CMDP Prior Authorization for Medical Equipment
and/or Supplies

CMD-026-C MedImpact Prior Authorization for Medications

CMD-078 CMDP Family Planning Services

CMD-1006A CMDP Dentist's Certification of Medical Necessity

CMD-1039A Consideration Factors for Orthodontic Services

CMD-1060A PCP Statement of Medical Necessity - Orthodontia

Chapter 6

BEHAVIORAL HEALTH

Behavioral health services in the State of Arizona are administered by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS). ADHS/DBHS 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 health maintenance organizations.

Medicaid (Title XIX) funds are paid by AHCCCS to ADHS/DBHS for distribution to the RBHAs to provide covered behavioral health services to AHCCCS (Title XIX) and KidsCare (Title XXI) members. RBHAs contract with a network of service providers to deliver a full range of behavioral health care services, including prevention programs for adults and children, a full continuum of services for adults with substance abuse and general mental health disorders, adults with serious mental illness, and children with serious emotional disturbance. The state is divided into six geographical service areas (GSAs) served by four RBHAs.

Regional Behavioral Health Authorities (RBHA)

RBHA	Counties Served	Member Services Telephone No.
CPSA (Community Partnership of Southern Arizona)	Pima	(800) 771-9889
Cenpatico	Cochise, Gila, Graham, Greenlee, LaPaz, Pinal, Santa Cruz, Yuma	(866) 495-6738
NARBHA (Northern Arizona Regional Behavioral Health Authority)	Apache, Coconino, Mohave, Navajo, Yavapai	(800) 640-2123
Magellan	Maricopa	(800) 564-5465

Children 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.

72 Hour Urgent Response

The RBHA is responsible for responding to urgent referrals for all children who are taken into the custody of the Department of Economic Security/Child Protective Services (DES/CPS) within 72 hours of notification that they are or will be removed from their

homes. This urgent response for CMDP members does not depend on Medicaid (Title XIX) or KidsCare (Title XXI) eligibility.

Children and youth in foster care have a high prevalence of behavioral health disorders. Quality of care issues may exist when the child or youth is not receiving services through the RBHA. This limits access to comprehensive behavioral health planning and services, and family-directed case planning.

AHCCCS (Title XIX) and KidsCare (Title XXI) Members

Referrals

The PCP must ensure that developmental and behavioral health screenings are completed for members up to 21 years of age in compliance with the federal EPSDT Program.

CMDP members are automatically enrolled in the RBHA at the time they are found eligible for Medicaid. However, PCPs should ensure that members who need services are actually receiving those services from the RBHA.

Covered Services

Covered services provided by the RBHA include:

- Behavior management (behavioral health personal assistance, family support/home care training, self-help/peer support)
- Behavioral health case management services (limited)
- Behavioral health nursing services
- Emergency behavioral health care
- Emergency and non-emergency transportation
- Evaluation and assessment
- Individual, group and family therapy and counseling
- Inpatient hospital services (the contractor may provide services in alternative inpatient settings that are licensed by ADHS/DLS/OBHL, in lieu of services in an inpatient setting. The cost of the alternative settings will be considered in capitation rate development.)
- Non-hospital inpatient psychiatric facilities (level I residential treatment centers and sub-acute facilities)
- Behavioral health residential services, level 2 and level 3
- Laboratory and radiology services for psychotropic medication regulation and diagnosis
- Opioid agonist treatment

- Partial care (supervised day program, therapeutic day program, and medical day program)
- Psychosocial rehabilitation (living skills training, health promotion, supportive employment services)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Rural substance abuse transitional agency services
- Screening
- Behavioral health therapeutic home care services

AHCCCS (Titles XIX and XXI) eligible members placed outside of Arizona for behavioral health treatment purposes receive behavioral health services paid for through the RBHA's contracted providers in the child's last county of residence in Arizona.

Medication Management Services

CMDP allows PCPs to provide medication management services (prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of behavioral disorders) to members with diagnoses of uncomplicated depression, anxiety and attention-deficit hyperactivity disorder (ADHD) without co-morbidities. CMDP lists available medications for the treatment of these disorders on its formulary.

Behavioral Health Tool Kits, developed jointly by AHCCCS, health plans and ADHS, are available on the CMDP website and can be used by PCPs to direct behavioral health care for these members. The Tool Kits list formulary medications agreed upon by every AHCCCS acute care health plan and every RBHA.

The CMDP Behavioral Health Coordinator (BHC) may assist the PCP with coordinating the transition of behavioral health care. This occurs when a PCP has initiated medication management to treat behavioral health disorders (uncomplicated depression, anxiety and ADHD disorders), and it is subsequently determined by the PCP that the member should go to the RBHA for evaluation and/or continued medical management of more complex behavioral health disorders.

Coordination of Behavioral Health Services Between the PCP and the RBHA

CMDP requires the PCP to respond to the RBHA provider's request for medical records pertaining to AHCCCS (Title XIX) and KidsCare (Title XXI) enrolled members within 10 business days of receiving the request.

The behavioral health information received from the RBHA is to be placed in the member's medical chart or may be kept in a labeled file that is associated with the member's medical record as soon as one is established, regardless if the PCP has seen the member. CMDP requires the PCP to document or initial the medical record signifying review of member's behavioral health information that has been received from the RBHA. For additional information contact the CMDP Behavioral Health Coordinator.

Transfer of Care from RBHA to PCP

Members with uncomplicated depression, anxiety, or ADHD may be transferred from the RBHA back to a **willing** PCP, if they have been stabilized at the RBHA and do not require any ancillary RBHA services such as counseling or other supports. In these cases, the RBHA must inform CMDP of the returning member, including what stabilizing medication the member is taking, and must coordinate with the receiving PCP. This coordination must ensure that the member does not run out of prescribed medications prior to the first appointment back with the PCP. The PCP should not change the medication or the dose of the member's stabilizing medication unless there is a change of condition. If the member's condition becomes unstable, the PCP should consider referring the member back to the RBHA. The medications on which the member has been stabilized at the RBHA will be paid for by CMDP once the child transfers back, even if the medication is not on the CMDP formulary.

Psychiatric Consultations

For non-Title XIX (State only) Members

- CMDP Medical Services staff must provide an initial prior authorization for a psychiatric consultation.
- The behavioral health provider submits supporting documentation to establish medical necessity for ongoing psychiatric consultation to Medical Services.
- Clinical staff review the submissions to determine medical necessity.
- Authorizations, per documentation of medical necessity, may be issued up to a maximum of 6 months.
- Authorization renewals are based on ongoing documentation of services delivered, eligibility, and medical necessity for continuation of psychiatric consultations and behavioral health services.
- Non-psychiatric behavioral health services such as counseling will be paid through the CPS district offices. Coordinate with the CPS Specialist if you believe the child/youth would benefit from such services.

Psychotropic Medications

PCPs may provide medication management services (prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of behavioral disorders) to members with diagnoses of uncomplicated depression, anxiety and attention deficit hyperactivity disorder (ADHD). CMDP makes available on the Preferred Medication List (PML) medications for the treatment of these disorders. Medications prescribed by the PCP for AHCCCS (Title XIX) and non-AHCCCS (non-Title XIX) members should be filled by a CMDP contracted pharmacy.

If a RBHA network provider has prescribed a behavioral health medication for an AHCCCS (Title XIX) or KidsCare (Title XXI) member, this medication must be filled by a RBHA contracted pharmacy, using the **RBHA ID number**, not the CMDP ID card.

Transportation to Behavioral Health Providers

Transportation to behavioral health providers is the responsibility of the RBHA for members enrolled in the RBHA, if the foster caregiver is unable to provide transportation. After the member is enrolled in the RBHA, the RBHA becomes responsible for arranging non-emergency transportation, and emergency transportation when there is an imminent threat of harm to the child if care is not rendered expeditiously. CMDP is responsible for transporting the member to the first appointment with the RBHA, if necessary. If there is any question about responsibility for transportation to behavioral health providers, contact the CMDP Behavioral Health Coordinator (BHC).

Emergency Services and Prior Period Coverage

The RBHAs are responsible for providing all necessary emergency behavioral health services during prior period coverage.

Appeal of a Denied Service

Outpatient Services

If an outpatient service (e.g., psychiatric care) is denied by the RBHA, refer to the RBHA's appeal process. If you need assistance, contact the CMDP Behavioral Health Coordinator.

Inpatient Services

If an inpatient admission is denied by the RBHA, contact the CMDP Behavioral Health Coordinator or the child's custodial agency representative. If the patient is non-AHCCCS (non-Title XIX/XXI, State only), CMDP will provide behavioral health services until the member is eligible for AHCCCS (Title XIX/XXI) and enrolled in the RBHA.

State Only Members (Non Title XIX/XXI)

Non-AHCCCS eligible (non-Title XIX/XXI) members receive medically necessary behavioral health services directly through CMDP registered behavioral health providers. A prior authorization is required and the CMDP Behavioral Health Coordinator must assist

in arranging these services. These services are regularly reviewed by CMDP to assure that they are delivered in the most appropriate level of care and least restrictive setting. Additional behavioral health services may be provided by the custodial agencies, such as CPS.

CMDP Provider Intake Standards

All behavioral health professionals are requested to adhere to the following AHCCCS mandated standards:

- Children presenting for inpatient hospitalization or emergency services must be assessed within twenty-four (24) hours of notification of the emergency.
- Children referred for non-emergent services must be assessed within seven days of the referral.

Referrals

To obtain behavioral health services for a non-AHCCCS (non-Title XIX/XXI) child through the Preferred Provider Network, contact the CMDP Behavioral Health Coordinator or Provider Services for assistance.

Services

The following behavioral health services are covered for non-AHCCCS (Non-Title XIX/XXI) eligible members, with **prior authorization** from CMDP:

- Inpatient psychiatric hospitalization
- Outpatient psychiatric treatment
- Psychiatric evaluations
- Medication monitoring

Providers

CMDP reimburses behavioral health professionals who deliver authorized covered services.

Appeal of a Denied Service

For appeal process, please refer to *Chapter 10*.

State Only Members Placed Out Of State

If a non-Title XIX eligible child is placed out of state but remains in the custody of the State of Arizona with the intention to return to Arizona, the child remains eligible for CMDP services. If the child is placed out-of-state by the RBHA for services not available in Arizona, the RBHA is responsible for all behavioral health services. CMDP would be responsible for all medical services, and the legal guardian would be responsible for finding out-of-state medical providers interested in providing medical care for the children. These providers must register with AHCCCS and CMDP in order to be paid by CMDP.

Referrals

To obtain behavioral health services for a child placed in foster care outside the State of Arizona, contact the CMDP Behavioral Health Coordinator for assistance.

Services

The following behavioral health services are covered for members placed in foster care outside the State of Arizona and must receive prior authorization from CMDP:

- Inpatient psychiatric hospitalization
- Outpatient psychiatric treatment
- Medication monitoring
- Psychotropic medications

Additional services may be covered for certain members placed out of state on a case-by-case basis. The CMDP Behavioral Health Coordinator will work with the member's custodial agency representative and the out-of-state courtesy custodial agency representative to arrange for behavioral health services.

Appeal of a Denied Service

For a description of the appeal process please refer to *Chapter 10*.

Claims

CMDP reimburses health professionals who deliver authorized covered services. CMDP can only reimburse providers who are registered with CMDP and AHCCCS.

Please contact CMDP for the registration and claims payment procedures at (602) 351-2245 or 1 (800) 201-1795.

See the Claims section in *Chapter 9* for more about claims coding instructions for all services.

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Chapter 7

AUTHORIZATION GUIDELINES

CMDP has established a Quality Management/Performance Improvement (QM/PI) program to monitor, evaluate, and improve the continuity, quality, accessibility, and availability of health care services provided to all its members. The program is designed to assess members' care, delivery systems and satisfaction while optimizing members' health outcomes and managing medical resources. QM/PI activities are integrated with other systems, processes and programs throughout the health plan and the child welfare system.

The QM/PI program is responsible for the development of authorization guidelines and policies related to quality management. Whenever possible, CMDP adopts authorization guidelines from national organizations known for their expertise in the area of concern. Links are available on the CMDP website, **www.azdes.gov/cmdp**

Authorization guidelines are used to determine when services meet the definition of medical necessity. The guidelines govern decision-making on prior authorization requests. Subjects of current authorization guidelines include but are not limited to:

- Circumcision
- Use of Human Growth Hormone in Children
- Considerations for Wart Removal
- Vision Therapy
- Criteria for the Determination of Medically Necessary Orthodontia
- Allergy Testing via Skin-Prick Testing
- Sensory and Auditory Integration Training and Facilitated Communication for Children with Autism
- Cranial Banding (Cranial Orthosis)
- Intrauterine Devices (IUDs)
- Myringotomy and Tympanosotomy Tube Insertion
- Pediatric Procedural Sedation
- Synagis Administration
- Therapy Services
- These guidelines are available under Prior Authorization on the CMDP Provider Services webpage, **www.azdes.gov/dcyf/provider**

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Chapter 8

MEDICAL MANAGEMENT AND QUALITY MANAGEMENT/ PERFORMANCE IMPROVEMENT (MM/QM/PI)

Medical Management (MM)

CMDP uses several mechanisms to manage service utilization.

Preferred Provider Network (PPN)

CMDP recruits PCPs and specialty physicians statewide. These providers agree to provide quality medical care to CMDP members, striving to reduce duplication of services to children and working within the regulations governing service delivery to children in foster care.

Prior Authorization

Obtaining prior authorization (PA) is the act of requesting a service prior to its delivery. CMDP's PA requirements help to ensure regulations governing service delivery to CMDP members are followed, care and services are coordinated and communicated to those involved, and only medically necessary services are provided. Prior authorization nurses use InterQual criteria, AHCCCS and CMDP policy, and state regulations to guide service authorizations. Inpatient concurrent review standards are based on InterQual criteria.

A prior authorization is generally requested via fax to CMDP (602-351-8529). To know whether a particular service requires prior authorization, please see the *Prior Authorization Matrix*, found online at www.azdes.gov/dcyf/provider. The PA forms can also be found online.

Documentation substantiating medical necessity for the service should be included with the PA form. If the patient is an eligible member and meets medical necessity criteria, a PA number will be given to the provider's office. The service requested must be a covered service that is medically necessary, and the provider must be AHCCCS and CMDP registered. The PA number should be used when submitting claims to ensure prompt processing.

If additional documentation is needed to justify medical necessity, the provider will be asked to fax the required documents to CMDP. Additional information for PA requests must be submitted to CMDP within fourteen (14) days of the initial request for service, or the PA request will be denied due to lack of sufficient documentation. An extension of 14 days may be granted by CMDP, for a total of 28 days to obtain the appropriate documentation.

Elective Admissions

Elective hospital admissions require PA. All laboratory and x-ray procedures required for elective inpatient or outpatient surgery shall be done on an outpatient basis at least 72 hours prior to the scheduled surgery.

Emergency Services

Emergency services do not require PA. Notification to CMDP is requested within these identified time lines:

- Emergency department visit within 10 days of service delivery (voluntary)
- Emergency admission within 24 hours of admission
- Ambulance transportation within 10 days of transport (nonemergency medical transport requires prior authorization)

Concurrent Review

CMDP staff conducts concurrent review weekdays between 8:00 a.m. and 5:00 p.m. Concurrent review of hospitalized members generally occurs on a daily basis by telephone between the CMDP Concurrent Review Nurse (CRN) and the utilization management/discharge planning staff of the inpatient facility. The CRN may make an on-site visit, as determined necessary, based on the member's hospital stay.

Medical Services nurses use InterQual intensity of service (IS) and severity of illness (SI) criteria, AHCCCS and CMDP policy, and state regulations to guide service delivery decisions. When the CRN determines that continued stay is no longer medically necessary, the case will be reviewed with the Medical Director, attending physician, and the member's custodial agency representative as appropriate. The attending physician may contact the CMDP Medical Director at any time to justify a medically necessary continued stay. The Medical Director may involve a peer reviewer as needed.

Discharge Planning

The CRN also coordinates discharge planning (see Concurrent Review section above). Medical Services uses InterQual standards, AHCCCS and CMDP policy, and state regulations to guide service delivery decisions. Discharge planning begins upon admission.

Care Coordination

CMDP's care coordination functions provide added support by assisting members with health risk factors or special care needs. In addition to the member's PCP, care coordination is available to help members use medical, social or community resources effectively, with the goal of self-management of their conditions and optimal medical and cost effectiveness. Medical care coordinators in Medical Services are responsible for carrying out the care coordination functions under the direction of the Director of Medical Services and/or the Medical Director.

Care coordination is available to all CMDP members. Typical candidates include special needs children and youth, such as:

- Members entering out-of-home placement who are known to be under-immunized or lacking immediate medical or behavioral health services.
- Members with behavioral health disorders.
- Medically complex or fragile infants, children or youth.
- Pregnant members.
- Members with known HIV and/or sexually transmitted diseases (STDs).
- Substance exposed newborns (SEBs).
- Members who are at risk of or have known developmental delays and for whom use of the PEDS Tool is appropriate.
- Members with serious or chronic conditions such as asthma or diabetes.
- Members who are non-compliant with treatment or appointments.
- Members receiving services through CRS or RBHA.
- Members transitioning to another AHCCCS health plan (in order to coordinate services to ensure a smooth transition) or those being placed out of state.

CMDP monitors special needs members through an integrated in-house information system and through online access to the Arizona State Immunization Information System (ASIIS) to determine immunization status, forecast due/past due immunizations and enter historical immunization data into the system. Each EPSDT tracking form is assessed for potential referral (i.e., oral health, CRS, DDD, ALTCS, AzeIP, Head Start or other specialty referrals). Information on members and ordered referrals may be entered into a database for monitoring and follow-up. These are tracked to assure that the appointment has occurred. Members who are noncompliant are identified and custodial agency representatives are contacted. If you have a CMDP member who would benefit from this care coordination, please contact Medical Services.

Medical Director Review

The CMDP Medical Director is involved in all cases when a Medical Services staff member questions the appropriateness of care, or when services do not or no longer meet medical necessity for authorization or certification criteria. Only the Medical Director can deny, reduce, suspend, or terminate services. Any provider delivering care to a CMDP member may contact the Medical Director by calling CMDP Medical Services.

The Medical Director and CMDP staff also works with a contracted dental consultant. The CMDP dental consultant assists in identifying high quality, cost-effective, and appropriate dental and orthodontic services for CMDP members.

Retrospective Claims Review

Claims are selected for retrospective review according to written criteria. A nurse and/or the Medical Director review claims data reflecting high cost, questionable billing practices or excessive utilization. CMDP may recoup money paid inappropriately, after notice to the involved provider. The provider has the opportunity to appeal CMDP's recoupment decision.

Provider Education

CMDP may prepare periodic provider profiles, based on claims or other data, comparing individual provider utilization to other providers statewide for selected categories of service. The purpose of this provider profiling is to provide feedback to providers about their practice patterns related to services delivered to CMDP members. If services provided are contrary to CMDP standards compared to other physicians of the same specialty, the Medical Director may discuss this with the provider to determine alternatives.

CMDP also distributes a quarterly newsletter to update providers about CMDP procedures and other helpful tips.

Quality Management/Performance Improvement (QM/PI)

CMDP maintains a Quality Management/Performance Improvement (QM/PI) program and committee. The committee is chaired by the Medical Director and meets quarterly. The committee includes members from both inside and outside CMDP, including preferred provider network PCPs. Annually, CMDP evaluates its QM/PI program to determine its effectiveness, what quality initiatives are appropriate, and what systemic changes are needed to improve plan performance.

If you would like to join the QM/PI Committee, please contact the CMDP Medical Director or the Director of Medical Services.

Peer Review and Quality of Care Concerns

The peer review process is conducted as a supportive process to improve quality of medical care and services provided to CMDP members. The peer review process is under the leadership of the QM/PI Committee Chairperson (Medical Director). It is conducted under applicable state and federal laws, and protected by the immunity and confidentiality provisions of these laws. All members of the Peer Review Subcommittee are licensed physicians in Arizona. They review all issues involving licensed health care professionals who have delivered or want to deliver services to CMDP members.

CMDP providers are responsible for delivering medically necessary services to members, in compliance with AHCCCS and other appropriate guidelines. CMDP reviews potential quality of care issues using the peer review process. The Peer Review Subcommittee evaluates potential quality of care issues and makes recommendations. These recommendations may include, but are not limited to, corrective action plans, external peer review and/or provider disciplinary action.

The peer review process is also applied to the credentialing of providers. CMDP utilizes a modified credentialing procedure, which is detailed in CMDP's Credentialing Policy. Questions regarding the peer review process should be directed to Medical Services.

Customer Satisfaction

As part of the QM/PI program, CMDP conducts periodic member and provider satisfaction surveys. The results are used to identify areas where improvement is needed.

Medical Record Audits

CMDP Medical Services nurses periodically conduct medical record and EPSDT audits for compliance with the standards found in the AHCCCS Medical Policy Manual and CMDP policy. This information is used to conduct performance improvement projects, review referral patterns and PA requests, and may identify opportunities to educate providers and their office staff about CMDP policies and standards.

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Chapter 9

CLAIMS PROCESSING AND PAYMENT

CMDP foster caregivers and CMDP members are not responsible for any medical or dental bills incurred for the provision of medically necessary services. Please note that requesting payment from, sending a bill to, or initiating collection against a foster caregiver or member is prohibited and is in violation of federal and state laws, in accordance with Arizona Administrative Code R6-5-6006. Civil penalties may be assessed if a provider continues billing or pursuing collection actions toward a CMDP foster caregiver or CMDP member for charges.

The CMDP Claims Unit adjudicates providers' claims, and is responsible for claims inquiries and research. In addition to paying providers, the Claims Unit is responsible for sending encounter information to AHCCCS. Accuracy is extremely important in filing claims to ensure timely and accurate payment. Providers must meet CMS and AHCCCS standard reporting requirements.

Provider Information

It is important that CMDP has accurate billing information for providers on file. Please confirm with CMDP Provider Services that the following information is current in our system:

- Provider Name (as noted on the current W-9 form)
- AHCCCS Provider ID
- National Provider Identifier (NPI)
- Physical name and address
- Billing name and address (if different)
- Tax Identification Number

Physician/Mid-Level Practitioner Registration

Hospitals and clinics may not bill CMDP or the other AHCCCS health plans for physician and mid-level practitioner services using the hospital or clinic AHCCCS Provider ID number. Physicians and mid-level practitioners must register with AHCCCS and bill for services under their own AHCCCS Provider ID number. Services provided by nurse practitioners and physician assistants cannot be submitted using the doctor's provider registration.

Mid-level practitioners include:

- Physician assistants
- Registered nurse practitioners

- Certified nurse-midwives
- Certified registered nurse anesthetists (CRNAs)
- Surgical first assistants

Note: Physician assistants, certified nurse-midwives, and nurse practitioners are reimbursed at 90 percent of the AHCCCS Fee-For-Service (FFS) rates. Surgical first assistants are reimbursed at 70 percent of the AHCCCS FFS rates, and CRNAs are reimbursed at 100 percent of the rates.

Hospitals and clinics may register as group billers, and bill as an agent for physicians and mid-level practitioners. In these cases, the claims submitted to CMDP must include both the physician's/mid-level practitioner's ID number as the service provider and the hospital or clinic's group billing ID number.

Providers with questions about their CMDP registration may contact CMDP Provider Services at (602) 351-2245 or (800) 201-1795.

PCP Enhanced Rates

Qualifying physicians who attest to AHCCCS and provide certain evaluation and management (E/M) services or vaccination administrations may qualify for enhanced rates, in accordance with Section 1202 of the Affordable Care Act. The attestation process must be completed with AHCCCS at the following website: <http://www.azahcccs.gov/commercial/ProviderRegistration/pcpattestation.aspx> CMDP will automatically process billed E/M and vaccination administration codes for attesting providers according to the enhanced rate schedule.

CMDP Member ID Number

This unique identifying number assigned by CMDP is found on the member's ID card. This number starts with 00. AHCCCS eligible (Title XIX) members will also have an AHCCCS ID number which starts with the letter A.

Be sure to include the CMDP ID number on all claims and documentation.

Missed Appointments

CMDP does not pay for missed appointments. Foster caregivers are requested to notify providers at least one day in advance when a foster child is unable to keep an appointment. Please inform CMDP Provider Services if a foster child repeatedly fails to appear for appointments. CMDP will make every effort to resolve the problem.

Out of State Coverage

A member who is temporarily out of the state is entitled to receive benefits under any of the following conditions:

- Medical services are required because of a medical emergency,
- A particular treatment is required that can only be obtained in another state, or
- A chronic illness necessitating treatment during a temporary absence from the state, or the condition must be stabilized before returning to the state.

Providers can check CMDP member eligibility on-line at www.azdes.gov/dcyf/provider. Click on the “Claim Look-up” link under Provider Resources. Providers may also contact CMDP Member Services to verify eligibility prior to the member’s appointment.

Acceptable Claim Forms

CMDP requires all providers to use one of three forms when billing for services, per AHCCCS requirements and guidelines.

Please note:

- The **CMS 1500** form is used to submit claims for all professional services, including ancillary services, ambulatory surgery centers, urgent care centers, professional services billed by a hospital and other providers as required by AHCCCS.
- A **UB-04** form is used to submit claims for hospital inpatient and outpatient services, dialysis services, skilled nursing homes inpatient services, long term care facilities, hospice services and other providers as required by AHCCCS.
- Claims for dental services should be submitted on the American Dental Association **ADA 2006** or **ADA 2012** claim forms. (The ADA 2006 will be phased out when ICD-10 is implemented on October 1, 2014.)

CMDP will not process claims received on any other type of claim forms. All AHCCCS billing guidelines and requirements must be followed. Instructions on completing the claim forms are found in these chapters of the *AHCCCS Fee-For-Service Service Provider Manual* (www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSProviderManual.aspx)

- CMS 1500 form - Chapter 5
- CMS UB-04 form - Chapter 6
- ADA 2006 form - Chapter 7

General Billing Information

Claims will be considered for reimbursement only if billing requirements are met and the member is enrolled with CMDP on the date the service was performed. If prior authorization was required, the PA number must be entered in the appropriate field on the claim form. Submitting a prior authorization with the claim does not guarantee reimbursement.

Reimbursement for services depends on the member's enrollment on the date(s) of service (DOS), medical necessity, limitations and exclusions as stated in Article 60 of Title 5, Chapter 6 of the Arizona Administrative Code (A.A.C.).

- Claims must be legible and suitable for imaging and record retention purposes. Complete ALL required fields, and include additional documentation when necessary.
- The claim form will be returned unprocessed if illegible or required documentation is missing. This could result in the claim being delayed or denied.
- Submit original claims through the mail. Facsimiles and emailed images are not accepted. To include supporting documentation, such as members' medical records, clearly label and send to the CMDP Claims Unit with the appropriate claim form.
- Electronic Data Interchange (EDI) is also available. To submit claims electronically go to the DES Trading Partner website, egov.azdes.gov/dcyf/cmdpe/DESTradingPartnerWeb to register. If you need assistance becoming a trading partner, contact Provider Services at (602) 351-2245 or (800) 201-1795.
- When submitting electronic claims, include PA or PD numbers, EPSDT/PEDS forms, NDC codes, anesthesia units/times, etc., in the appropriate fields.

Prior Authorization (PA) / Predetermination (PD) for Service

See the Prior Authorization Requirements section in *Chapter 5* for additional information on PA requirements, and the medical and dental PD matrices. The medical and dental matrices are located on-line at www.azdes.gov/dcyf/provider. Click on the PA Matrix or Dental Matrix links on the left side of the page.

Prior authorization is required for, but not limited to, the following:

- All rentals of durable medical equipment (DME)
- Medically necessary nonemergency transportation
- Specialty treatment follow up (initial consultation does not require a PA)
- Therapy treatment services for physical occupational or speech therapies (initial consultation does not require a PA)
- Certain diagnostic testing (see medical PA Matrix for details)
- Genetic testing
- Outpatient surgeries
- Ambulatory surgery centers (PA separate from physicians)
- All inpatient hospital stays
- Total OB package

- All behavioral health services
- All orthodontia
- Certain dental procedures as described in the A.A.C. R6-5-6006 (17).
- Services over AHCCCS-allowed units or frequencies.

The issuance of a PA/PD does not guarantee payment. The medical condition for which the authorization was issued must be supported by medical documentation, and the claim must be clean and submitted timely.

Codes to Use

CMDP accepts national standardized coding, which includes the Current Procedural Terminology (CPT Expert), the International Classification of Diseases, 10th Revision (ICD-9), HCFA Common Procedure Coding System (HCPCS), and the American Dental Association (ADA) Current Dental Terminology.

- **CPT:** Reporting medical services and procedures performed by physicians
- **ICD-9-CM:** Reporting diagnoses/conditions, report out to the 4th or 5th digit, as required. ICD-10 will be required after October 1, 2014.
- **HCPCS:** Reporting non-physician procedures, such as ambulance services, durable medical equipment and specific supplies
- **ADA:** Reporting of dental procedures

Clean Claims and Timely Claims Filing

Providers are encouraged to bill for services as soon as possible after the services have been provided. Claims must be received within **six (6) months from the date of service**. A *clean claim* must be received within twelve (12) months of the date of service. CMDP will adjudicate clean claims within 30 to 45 days of receipt.

Per A.R.S. § 36-3401, a *clean claim* means a claim that can be processed without obtaining additional information from the service provider or from a third party. Clean claim does not include claims under investigation for fraud or abuse, or claims under review for medical necessity.

Claims lacking information necessary for entry into the CMDP data processing system will be denied, and a remittance advice will be mailed explaining reason for denial.

Proof of Timeliness

Proof of timeliness for claims generally includes the following data elements:

- Member name, date(s) of service, CPT/HCPCS codes
- Proof of address mailed to

- Proof of date mailed
- Proof of electronic or paper submission

Claims Submission

All claims submitted on hard copy should be an original and must be legible. Claims can also be submitted via Electronic Data Interchange (EDI), if you are a trading partner. For additional information on how to become a trading partner and submit claims electronically, visit the DES Trading Partner website, egov.azdes.gov/dcyf/cmdpe/DESTradingPartnerWeb.

Paper claims should be submitted to:

**DES/CMDP
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202**

Resubmission

CMDP informs providers regarding the disposition of the claim through the Provider Remittance Advice. Claims will be denied if submitted with incomplete and/or inaccurate information. Providers have 12 months from the date of service to resubmit a denied claim using the following process:

- *CMS-1500 and UB-04*
 - Claims should resubmitted in entirety, to include all original lines if the claim contained more than one line. **Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.** An attached cover memo can also be used to clarify resubmitted information.
 - Corrected lines for UB-04 claims should be indicated in box 19 of the CMS-1500, or mark notations in the grid area of the claim form.
 - Resubmitted claims should be clearly marked “Resubmission” or “Corrected Claim.”
 - **Claim Reference Number and PA number (if applicable) should be written on the resubmitted claim.**
 - Remittance advices for any paid or denied claims that pertain to the resubmission should be attached.
 - Requested documentation must be attached to ensure there is no delay in processing the resubmission.

- *Dental Claims ADA 2006*
 - Resubmitted claims should include all original lines if the claim contained more than one line. **Failure to include all lines of a multiple-line claim will result in recoupment of any paid lines that are not accounted for on the resubmitted claim.** An attached cover memo can also be used to clarify resubmitted information.
 - Corrected lines for UB-04 claims should be indicated in box 19 of the CMS-1500, or mark notations in the grid area of the claim form.
 - Resubmitted claims should be clearly marked “Resubmission” or “Corrected Claim.”
 - **Claim Reference Number and PD number (if applicable) should be written on the resubmitted claim.**
 - Remittance advices for any paid or denied claims that pertain to the resubmission should be attached.
 - Requested documentation must be attached to ensure there is no delay in processing the resubmission.
 - X-rays are not required with the claim unless requested by CMDP.

Coordination of Benefits (COB)

Per Arizona Revised Statutes (A.R.S.) §8-512(G), the Department of Economic Security (DES) shall require that the hospital pursue other third party payors before submitting a claim to the DES. Arizona Administrative Code (A.A.C.) R6-5-6006(4) states that the department shall not pay for the cost of care and services payable through an insurance carrier which provides coverage for the eligible foster child.

As an AHCCCS contractor, CMDP is considered the payor of last resort. Providers are required to bill any known primary insurer prior to submitting a claim to CMDP. Upon receipt of reimbursement or denial from the third party, submit the claim and the explanation of benefits (EOB) from the third party insurance company to CMDP. Website queries are not considered appropriate documentation.

Overpayments

A provider must repay CMDP for an overpayment received on a claim, in accordance with A.A.C. R9-22-713. Providers should attach documentation substantiating the overpayment (for example, the EOB if the overpayment was due to payment received from a third party payor).

Recoupment

Under certain circumstances, CMDP may find it necessary to recoup or take back money previously paid to a provider. Overpayments and erroneous payments are identified through reports, medical record review, grievance and appeal decisions, internal audit review, and provider-initiated recoupments.

CMDP will offset/recoup any monies owed from previous overpayments against future claims submissions, if possible. The remittance advice will show claims with the original claim numbers plus an “R” and/or “A” to show the Reversal and/or Adjustment. If an amount is due to CMDP and no future claims submissions are received within 30 days, CMDP will send a Refund Request letter with an explanation of the action, date of the action, recipient, date of service, date of original remittance advice, and reason for the refund request. If payment is recouped for a reason other than third party recovery (e.g., technical claims issue or no medical documentation to substantiate services rendered), the provider will be given additional time to provide the necessary information.

Billing Members

Per A.R.S. § 8-512(E), providers are reimbursed using AHCCCS fee-for-service rates. *By report* fees are established according to usual and customary rates. More information about the AHCCCS Fee-For-Service Schedule is found on the AHCCCS website, <http://www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx>

In accordance with A.R.S. § 36-2903.01(L) and 42 CFR 447.21, billing a member, financially responsible relative or member’s authorized representative for any amounts exceeding what CMDP has reimbursed is in violation of federal and state law, and is just cause for assessing of civil penalty. There are no payments, fees, or co-payments for members or foster caregivers. CMDP payments are considered payment in full. CMDP’s non-payment or denial of a claim does not allow the provider to bill member or caregivers.

Claims Status Inquiries

Providers can track the status of claims via the CMDP Provider Services webpage, www.azdes.gov/dcyf/provider. Click on the Claim Lookup link under Provider Resources.

For assistance in checking claims status, payment status or requesting an additional EOB, email the Claims Unit at CMDPClaimsStatus@azdes.gov

Well Child Health, Preventative Medicine and EPSDT Visits

The EPSDT program, which includes oral health screenings and required oral health/dental services, applies to all eligible children enrolled in CMDP. In accordance with United States Code 42 USC 1396d(r), 1396a(a), 1396d(a) and A.A.C. R9-22-213, the EPSDT program provides primary prevention, early intervention, diagnosis and medically necessary treatment of physical and behavioral health problems. **EPSDT exams are required for children every year after the child is 24 months of age.**

Billing codes 99381-99395 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic, comprehensive medical examination.

Immunizations and ancillary studies involving laboratory, radiology or other procedures are reported separately.

The following evaluation and management (E/M) codes are used to report the well child/ EPSDT (preventive medicine) evaluation and management of infants, children, and adolescents. The appropriate well-child care diagnosis code (V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, or V70.9) must be used or the claim will be denied.

CODE	DESCRIPTION (Office Visit, Health History and Physical Examination)
New Patient	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures:
99381	New patient, Infant age - under 1 year
99382	New patient, Early Childhood – age 1 to 4 years
99383	New patient, Late Childhood – age 5 to 11 years
99384	New patient, Adolescent age - 12 to 17 years
99385	New patient, Adult age - 18 to 20 years
Established Patient	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/ risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures:
99391	Established patient, Infant age - under 1 year
99392	Established patient, Early Childhood – age 1 to 4 years
99393	Established patient, Late Childhood – age 5 to 11 years
99394	Established patient, Adolescent age - 12 to 17 years
99395	Established patient, Adult age - 18 to 20 years

EPSDT Tracking Forms

Providers must document all age-specific required information relating to EPSDT screenings, and must use the AHCCCS EPSDT Tracking Forms or an electronic record that contains all the required elements of an EPSDT. EPSDT forms for the various age groups are found in the AHCCCS Medical Policy Manual, Appendix B. A link to the forms within the web-based policy manual is provided here: www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf

The forms may also be obtained by contacting your CMDP Provider Services representative. The Centers for Medicare and Medicaid Services require AHCCCS (and therefore CMDP) to provide specific services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care.

Please do NOT alter or amend these forms in any way without discussion with the Maternal and Child Health Manager at CMDP. **Electronic medical records may be accepted in lieu of the EPSDT form if they provide all the required information from the EPSDT form, including provider name, electronic treating provider's signature, date and time.**

EPSDT forms should be completed and submitted with the claim. EPSDT forms pertaining to claims submitted electronically should be mailed to:

**DES/CMDP
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202**

Completed EPSDT forms may also be sent by:

- Fax to 602-265-2297
- Email to CMDP_ClaimsStatus@azdes.gov
- FTP Server, via the DES Trading Partner application, egov.azdes.gov/dcyf/cmdpe/DESTradingPartnerWeb.

Arizona's Vaccines for Children Program

The Vaccines for Children (VFC) Program in Arizona supplies all medically-necessary vaccines for children and adolescents to providers free of charge. The **SL modifier** is used to indicate vaccines administered under VFC, and should be coded accordingly on the CMS 1500 claim form.

NOTE: Many hospitals no longer participate in the VFC Program providing newborns with their Hep B shots at birth, and many newborns will need to receive their Hep B immunizations at their first office visit.

As of January 1, 2013, when submitting a claim for vaccines, include the cost that reflects the administration fee and not that of the vaccine. Use immunization administration CPT codes 90460, 90461, 90471, 90472, 90473 and 90474 when billing for vaccines under AHCCCS programs, including CMDP. When submitting a claim for vaccines, remember that the NDC number is required for claim processing.

The NDC number is found on the drug container, i.e. vial, bottle, tube. The NDC submitted to CMDP must be the actual NDC number on the package or container from which the medication was administered. Claims may not be submitted for one manufacturer when a different manufacturer's product was administered. It is considered a fraudulent billing practice to bill using an NDC other than the one assigned to the drug administered.

NDC Definition

The National Drug Code (NDC) is the number which identifies a drug. The NDC number consists of 11 digits in a 5-4-2 format. For example:

XXXXX-XXXX-XX

The first 5 digits identify the labeler code, representing the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product and are assigned by the manufacturer. The last 2 digits define the product package size and are also assigned by the manufacturer.

Some packages will display less than 11 digits, but leading zeros can be assumed and must be added when billing. For example:

Manufacturer's Number Format	Billing Format*
XXXX-XXXX-XX	0XXXXXXXXXX
XXXXX-XXX-XX	XXXXX0XXXXX
XXXXX-XXXX-X	XXXXXXXXX0X

***NOTE:** When submitting a claim for administering a drug, providers must submit the 11-digit NDC *without* dashes or spaces between the numbers. Claims submitted with NDCs in any other configuration may fail.

For additional information on the Vaccines for Children program, visit the AHCCCS Online webpage, www.azahcccs.gov/commercial/AHCCCSonline.aspx

Billing for Use of the PEDS Tool

Since January 1, 2006, the Parents' Evaluation of Developmental Status (PEDS) developmental screening tool has been utilized for developmental screening by all participating PCPs who care for newborn intensive care unit (NICU) graduates. Because

of the at-risk nature of the foster care population, the tool may also be used for all CMDP members up to age 8.

For PCPs to receive reimbursement for conducting the PEDS screening, the provider must:

- Complete the PEDS training program, which is coordinated by the Arizona Chapter of the American Academy of Pediatrics through statewide conferences, an on-line course, and on-site provider training. Access the on-line course at www.azpedialearning.org/test1.asp, or contact the AzAAP Best Care for Kids Program at pedstraining@azaap.org or 602-532-0137, Ext. 413, for more information about on-site training;
- Provide CMDP with a copy of the training certificate, or appear on the Arizona Chapter of the Academy of Pediatrics or AHCCCS lists of providers who have successfully completed the training; **and**
- Submit copies of the completed PEDS tools (PEDS Interpretation and the PEDS Score forms) to CMDP in the same manner that the EPSDT tracking forms are submitted with the CMS 1500 claim form. Remember:
 - An **EP modifier is required when using code 96110**.
 - Claims will be denied if the EP modifier is missing or the PEDS Tool forms are not attached when processing the claim. The results of these forms are reviewed by the EPSDT Coordinator for care coordination purposes.

Instructions for Specific Claim Types

Air and Ground Ambulance Service

Claims for ground and air ambulance service must be billed on the CMS 1500 claim form. Emergency ground transportation does not require prior authorization; however, providers must mark Box 24C to indicate emergency services on each applicable line. All other transports except emergency require the provider to notify CMDP within 10 days of the emergency transport, or the claim will be denied.

Non-emergency transportation requires prior authorization. Emergency air and ground ambulance claims are subject to medical review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:

- Medical condition, signs and symptoms, procedures, treatment;
- Transportation origin, destination, and mileage (statute miles);
- Supplies, or
- Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

Ambulatory Surgery Centers

Ambulatory surgery centers (ASCs) are defined as certified, freestanding entities that

operate exclusively for the purpose of furnishing outpatient surgical procedures. CMDP reimburses the ASCs per the AHCCCS Fee-For-Service (FFS) schedule. The facility fee covers all services provided by an ASC in connection with rendering surgical procedures, including but not limited to nursing services, medical supplies, equipment, and use of the facility.

ASC Billing Procedures

- Ambulatory surgical facilities furnishing non-emergency surgical services must obtain prior authorization (PA) from CMDP for scheduled ambulatory surgery.
- The PA for the ASC is separate from the surgeon's PA.
- ASC-covered surgical procedures must be billed on the CMS 1500 form. There must be a clear indication in Box 19 if this is a facility fee or a professional component.
- Reimbursement is based on the payment rate for that specific procedure.
- The ASC must bill the principal or primary procedure (the procedure with the highest reimbursement rate) on the first line of the CMS 1500 when multiple procedures are performed on the same member on the same day or at the same session.
 - Secondary procedures are to be billed with a modifier 51.
- If the ASC does not identify the primary procedure, CMDP will identify the first procedure listed on the claim as the primary procedure and will assign modifier 51 to the remaining procedures, identifying them as secondary.
 - Reimbursement of the primary procedure will be at the lesser of billed charges or the AHCCCS FFS rate.
 - Reimbursement for secondary procedure(s) will be the lesser of billed charges or 50% of the AHCCCS FFS rate.
- A bilateral procedure performed in one operative session is reported using modifier 50 appended to the single procedure line (not two separate lines), and is subject to the multiple surgery reduction.
- A bilateral procedure is reimbursed at no more than 150% of the AHCCCS FFS rate for a single procedure.

Dental Claims

- Claims for dental services should be submitted on the American Dental Association ADA 2006 or ADA 2012 Claim Form.
- Do NOT include X-rays with claim forms that are submitted for payment.
- Services provided by an anesthesiologist or medically-related oral surgery procedures should be submitted on the CMS 1500 form.
- AHCCCS has revised the Well Checkup allowance from *2 visits per year* to *1 visit each 180 days*.

Inpatient Hospital Services

Inpatient hospital services billed on the UB-04 are reimbursed at the facility's tiered per diem rate. The tiered per diem system consists of the following service tiers: Maternity, NICU, ICU, Surgery, Psychiatric, Nursery and Routine. An inpatient claim may split across no more than two tier levels.

Inpatient Hierarchy for Processing UB-04 Claims

Tier	Identification Criteria	Allowed Splits
Maternity	A primary diagnosis defined as maternity. 640.XX - 643.XX, 644.2X - 676.XX, V22.XX - V24.XX or V27.xx.	None
NICU	Revenue code is 174 (175 before 9/1/96) AND the provider has a level II or III NICU	Nursery
ICU	Revenue code is 200 - 204, 207-212, or 219.	Surgery, Psychiatric, Routine
Surgery	Surgery is identified by a revenue code of 36X . To qualify in this tier, there must be a valid surgical procedure code that is not on the excluded procedure list. The Surgery tier can only split with the ICU tier. All claim accommodation days that do not qualify at the ICU tier will be classified at the Surgery tier.	ICU
Psychiatric	Psychiatric revenue codes 114, 124, 134, 144, or 154 AND psychiatric diagnosis is 290.XX - 316.XX . If a routine revenue code is present and all diagnoses codes on the claim are 290.XX - 316.XX , classify as a psychiatric claim.	ICU
Nursery	Revenue codes of 17X (excluding 174)	NICU
Routine	Revenue codes of 100-101, 110-113, 116-123, 126-133, 136-143, 146-153, 156-159, 16X, 206, 213, or 214.	ICU

Observation Services

Observation services are those reasonable services provided on a hospital's premises for evaluation until criteria for inpatient hospital admission or discharge/transfer have been met. A physician, or other individual authorized to admit patients to the hospital or order outpatient diagnostic tests or treatments, must provide a written order of observation services. Medical review is performed in all cases of observation and hospital admission to determine medical necessity.

In general, observation status should not exceed 24 hours. This time limit may be exceeded if medically necessary, to evaluate the medical condition and/or treatment of a member. Exceptions to the 24-hour limit must have prior authorization.

Observation services that directly precede an inpatient admission to the same hospital must **not** be billed separately. These charges must be billed on the inpatient claim. The inpatient claim is priced at the tiered per diem rate based on the number of allowed accommodation days. Reimbursement for the observation services provided before the hospital admission is included in the tiered per diem payment.

Obstetrical Care Package

Providers are expected to bill for obstetrical care using the appropriate global packages, and file claims using the CMS 1500 claim form. Please follow the following procedures or the claim may be denied.

- Utilize CPT Evaluation and Management codes (99201-99215) or OB visits (59425-59426) to report prenatal visits.
 - The beginning date of service (DOS) is equal to the initial prenatal visit and the ending DOS is equal to the last prenatal visit prior to delivery.
 - Use one unit with the appropriate prenatal visit code.
 - Zero or the appropriate charge should be entered in the charge column.
- All OB care requires a PA.
- Two (2) ultrasounds are included in the OB package. PA is required for additional studies.
- Utilize global delivery codes (59400, 59510, 59610 and 59618)
- If the Primary Care Obstetrician (PCO) provides prenatal services but does not perform the delivery, the claim must indicate "Prenatal visits only."

Skilled Nursing Facilities (SNF)

CMDP requires a prior authorization for all SNF services. CMDP only pays from the date of admission up to, but not including, the date of discharge, unless the patient expires.

Long-term care facilities must bill for room and board services on the UB-04 claim form. The table below summarizes the allowable revenue codes and bill types:

Revenue Codes	Allowable Bill Types
190 Subacute General	86X
191 Subacute Care Level I	110-179, 211-228, 611-628
192 Subacute Care Level II	110-179, 211-228, 611-628
193 Subacute Care Level III	110-179, 211-228, 611-628
183 LOA – Therapeutic (for home visit by recipient)	211-228, 611-628
185 LOA – Bed Hold (for short-term hospitalization)	211-228, 611-628

When billing revenue codes 183 and 185, providers must split bill and submit claims on separate UB-04 claim forms, using the appropriate bill types and patient status codes.

Correct Coding Initiative

AHCCCS and CMDP follow the same standards as the Centers for Medicare and Medicaid Services (CMS) Correct Coding Initiative (CCI) policy, and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, review the information at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

HCAC and OPPC

AHCCCS implemented measures looking at Health Care Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC). There is a Medicaid rule, effective July 1, 2012, prohibiting or reducing payments when provider OPPC is identified.

National Drug Code (NDC)

Effective July 1, 2012, AHCCCS implemented billing requirements for drugs, vaccines, biological devices and other devices, including contrast for radiologic procedures provided in outpatient clinical settings. More information regarding these requirements can be found in these AHCCCS resources:

- NDC Billing Requirements (www.azahcccs.gov/commercial/Downloads/PharmacyUpdates/NDCBillingRequirementsFAQs.pdf)
- Fee-For-Service Provider Manual, Chapter 5, Billing on the CMS 1500 Claim Form (www.azahcccs.gov/commercial/ProviderBilling/manuals/)

FFSProviderManual.aspx)

- Fee for Service Provider Manual, Chapter 6, Billing on the UB-04 Claim Form (www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSProviderManual.aspx)

Ordering/Referring Provider

Effective January 1, 2012, AHCCCS began requiring identification of the ordering provider for certain CPT/HCPCS codes on 1500-type claims.

Claim submissions will be audited to ensure the ordering provider is documented for the following types of services:

- Laboratory
- Radiology
- Medical and Surgical Supplies
- Respiratory DME
- Enteral and Parenteral Therapy
- Durable Medical Equipment
- Drugs (J codes)
- Temporary K codes
- Orthotics
- Prosthetics
- Temporary Q codes
- Vision codes (V Codes) 97001-97546

Ordering providers can only be one of the following provider types:

- M.D.
- D.O.
- Optometrist
- Physician Assistant
- Certified Nurse Midwife
- Registered Nurse Practitioner
- Dentist
- Podiatrist
- Psychologist

Medical Review of Documentation Supporting Claims and Coding

Medical reviews are performed on a variety of medical record types, and include but are not limited to inpatient hospital review (concurrent review), prior authorizations, retrospective review of medical records related to claims audits, excessive utilization, and quality of care issues.

The most common claims audit scenarios where a provider is requested to submit medical records include:

- Anesthesia units exceeding allowable daily limit.
- Multiple portable X-rays or EKGs from one facility on same date of service.
- Dental and medical “house calls.”
- Excessive use of screening labs (to determine medical necessity/appropriateness).
- Behavioral health services for AHCCCS eligible members.
- Use of level 4 or 5 E/M visits on the same date of service as an EPSDT.
- Providers with consistent patterns of upcoding multiple encounters with the same patient within short time periods.

Required Documentation for Claims

1500 Billed Service	Documents Required	Notes
EPSDT (well child) visits	EPSDT form or acceptable electronic version printout (must cover all required elements of the EPSDT)	CPT 99381-99385 CPT 99391-99395
EPSDT and office visit on same DOS	EPSDT form or acceptable electronic version printout and office visit note	CPTs shown above, plus 99204, 99205, 99214, 99215.
PEDS Tool	PEDS Interpretation and the PEDS Score forms	CPT 96110 requires EP modifier.
Missed abortion, incomplete abortion	History, physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.
Anesthesia	Anesthesia records	Include begin and end times.
Non-emergency transportation	Ambulance trip report	Non emergency transportation requires a PA.

UB Billed Service	Documents Required	Notes
Inpatient, NICU/ICU, Observation, Outlier * Required ** If applicable	<ul style="list-style-type: none"> • Itemized statement* • Admission sheet (face sheet)* • Admission history and physical* • Discharge summary or interim summary* • Operative reports** • Labor and delivery report** • Emergency record** 	All related records which substantiate medical necessity.
Missed Abortion/ Incomplete Abortion	History, physical, ultrasound report, operative report, pathology report	Information must substantiate fetal demise.

Claims Dispute Process

A *claim dispute* means a dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance. It is the formal way to request a review of a payment dispute. For instructions on the claim dispute process, see *Chapter 10, Grievances and Claim Disputes* in this provider manual.

Prior to submitting a claim dispute, CMDP encourages all providers to contact the Claims Unit or Provider Services at (602) 351-2245 or (800) 201-1795 for assistance in resolving any concerns.

Claim disputes must specify in detail the factual and legal basis for the dispute and the relief requested. Claim disputes challenging claim denials must be filed in writing with CMDP no later than twelve (12) months from the date of service, twelve (12) months after the date of eligibility posting, or within sixty (60) days after the date of a timely claim submission, whichever is later.

Enclose a claim form and all supporting documentation, including a copy of the remittance advice for the claim being disputed. Mail requests to:

Arizona Dept. of Economic Security
CMDP - 942C
Attn: Grievance Coordinator
P.O. Box 29202
Phoenix, Arizona 85038-9202

Fraud and Abuse

Claims are examined for the sequencing and timing to determine if they are consistent with sound medical practice. If discrepancies are identified, a provider will be referred to the Fraud and Abuse or Quality Management units for further investigation. More information on fraud and abuse is found in *Chapter 11* of this provider manual, and on the AHCCCS Fraud and Abuse web page, www.azahcccs.gov/fraud/Default.aspx.

Other Resources

Valid place of service (POS) codes with facility or non-facility designations are shown in the table below. POS codes are entered in Box 24B of the CMS 1500 claim form.

Code	Description	Payment Rate Facility (F) or Non-Facility (NF)
03	School	NF
04	Homeless Shelter	NF
11	Office	NF
12	Home	NF
13	Assisted Living Facility	NF
14	Group Home	NF
15	Mobile Unit	NF
20	Urgent Care Facility	NF
21	Inpatient Hospital	F
22	Outpatient Hospital	F
23	Emergency Room - Hospital	F
24	Ambulatory Surgical Center (Note: Pay at NF rate for payable procedures not on the ASC list)	F
25	Birthing Center	NF
26	Military Treatment Facility	F
31	Skilled Nursing Facility	F
32	Nursing Facility	NF
33	Custodial Care Facility	NF
34	Hospice	F
41	Ambulance, Land	F
42	Ambulance, Air or Water	F
49	Independent Clinic	NF
50	Federally Qualified Health Center	NF
51	Inpatient Psychiatric Facility	F
52	Psychiatric Facility, Partial Hospitalization	F

Code	Description	Payment Rate Facility (F) or Non-Facility (NF)
53	Community Mental Health Center	F
54	Intermediate Care Facility for Mentally Retarded	NF
55	Residential Substance Abuse Treat Facility	NF
56	Psychiatric Residential Treatment Center	F
57	Non-Residential Substance Abuse Treatment	NF
60	Mass Immunization Center	NF
61	Comprehensive Inpatient Rehabilitation Facility	F
62	Comprehensive Outpatient Rehabilitation Facility	NF
65	ESRD Treatment Facility	NF
71	State or Local Public Health Clinic	NF
72	Rural Health Clinic	NF
81	Independent Laboratory	NF
99	Other Unlisted Facility	NF

CHAPTER APPENDIX

Remit Form Samples

www.azdes.gov/InternetFiles/InternetProgrammaticForms/pdf/remitSamples.pdf

CMS-1500 Health Insurance Claim Form Sample

www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSPProviderManual.aspx

UB-04 Inpatient and Outpatient Services Claim Form Sample

www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSPProviderManual.aspx

ADA 2006 Dental Claim Form Sample

www.azahcccs.gov/commercial/ProviderBilling/manuals/FFSPProviderManual.aspx

EPSDT Forms Samples

Providers must use age-specific, AHCCCS approved EPSDT forms. These forms are available on the AHCCCS website, www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/AppendixB.pdf, or through your CMDP Provider Services representative.

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Chapter 10

PROVIDER CLAIMS DISPUTES AND MEMBER APPEAL

The federal government, the State of Arizona, and the AHCCCS Administration have established laws, rules, policies and procedures that determine how CMDP processes and adjudicates appeals. The rules associated with appeals include 42 CFR 438 Subpart F, Arizona Revised Statutes (A.R.S.) Section 36 and Arizona Administrative Code (A.A.C) Title 9, Chapter 34.

Grievances

A grievance is a member's expression of dissatisfaction with any aspect of his/her care, other than the appeal of an *action*. (Action is defined in the Member Appeals section on page 10-3 of this chapter.) Grievances include, but are not limited to, the quality of care or services provided, rudeness of a provider or CMDP staff, or failure to respect member's rights.

How to File a Grievance

- A member may file a grievance at any time either orally or in writing to CMDP.
- A disposition will be completed and provided no later than ninety (90) days after receipt of the grievance.

Provider Claim Disputes

All claim disputes submitted to CMDP are investigated using applicable statutory, regulatory, contractual and policy provisions.

Prior to submitting a claim dispute, CMDP encourages all providers to check with the Claims Unit or Provider Services for assistance in resolving any concerns. When inquiring about the claims status, please note the following information:

- If a Provider Remittance Advice identifying the status of the claim has not been received, contact the CMDP Claims Unit at (602) 351-2245 or (800) 201-1795 to determine whether the claim has been received and processed.
- Please allow thirty (30) days following claim submission before making an inquiry, and do not exceed twelve (12) months from the date of service.
- If a claim is pending in the CMDP claims processing system, a claim dispute will not be investigated until the claim is paid or denied, or is over 3 months from the receive date.

How to File a Claims Dispute

Submit a claim dispute in writing to CMDP via mail or fax to:

Arizona Dept. of Economic Security
CMDP Site Code 942C
Attn: Grievance Coordinator
P.O. Box 29202
Phoenix, Arizona 85038-9202
Fax (602) 264-3801

- All claim disputes challenging claim payments or adjudication must be submitted within twelve (12) months from the date of service or within sixty (60) days after the date of the payment, denial or recoupment of a timely claim submission, whichever is later.
- State, in detail, the factual and legal basis for the dispute and the relief requested (i.e., additional payment, reversal of claim denial). Be sure to provide any and all relevant supporting documentation, including a clean claim.

Upon Receipt of Your Claim Dispute

- CMDP sends a letter of acknowledgement to the provider within 5 business days of receipt. Provider should retain this letter for reference.
- A *Notice of Decision* is communicated within thirty (30) days after the date the dispute was received, unless an extension of time has been agreed upon.
- If it is determined that the original claim denial was CMDP's error, the claim is forwarded to the CMDP Claims Unit for processing. It is not necessary for the provider to re-submit the claim.
- Upholding of a claim dispute does not constitute a guarantee of payment nor does it constitute a waiver of all claim filing requirements and conditions. Claims are subject to all routine claims processing edits and audits. If the submitted claim contains errors, omissions, or does not have the required documentation, the claim may be denied or an edit may fail, even though the claim dispute was upheld for other reasons.
- A provider may appeal a CMDP decision by submitting a request for hearing to CMDP no later than thirty (30) days after the date of receipt of the *Notice of Decision*. All information concerning the issue will be sent to the AHCCCS Office of Administrative Legal Services (OALS) for a hearing.
- A request for hearing regarding a non-AHCCCS enrolled member must be submitted by the provider no later than fifteen (15) days after receipt of the *Notice of Decision*.

- Submit any request for hearing to the address below:

Arizona Dept. of Economic Security
CMDP, Site Code 942C
Attn: Grievance Coordinator
P.O. Box 29202
Phoenix, Arizona 85038-9202

Member Appeals

Members may file an appeal of any CMDP action to deny, reduce, suspend or terminate a service. A provider may file an appeal on behalf of a member but only with the written consent of the member's authorized representative (the custodial agency representative or juvenile justice representative).

If the provider attests that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or retain maximum function, an expedited appeal may be filed. These appeals are resolved as expeditiously as the member's health condition requires, but not later than three (3) business days following the receipt.

An *action* is defined as:

- Denial or limited authorization of a requested service, including the type or level of services;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment of a service;
- Failure to provide services in a timely manner;
- Failure to act within the timeframes required for standard and expedited resolution of appeals and standard disposition of grievances; or,
- For a member residing in a rural area, denial of the member's right to obtain services outside the network.

A *Notice of Action* is CMDP's response to the member or authorized representative regarding a requested service.

How to File a Member Appeal

- Appeals can be filed either orally or in writing within 60 days of the Notice of Action. If you have any questions or require assistance, please contact the CMDP Grievance Manager.
- CMDP issues a *Notice of Appeal Resolution* within thirty (30) days for a standard appeal or no later than three (3) business days for an expedited appeal, unless the requestor and CMDP have agreed upon an extension of up to fourteen (14) days.

- The decision timeframe is calculated from the date the appeal is received by the CMDP Grievance Manager.
- The member or authorized representative may request continuation of services while the appeal is pending. The services will continue if:
 - The appeal is filed timely;
 - The appeal involves the termination, suspension or reduction of previously authorized services;
 - Services were authorized by CMDP;
 - Original period covered by original authorization has not expired;
 - The member requests and CMDP approves that services continue;
- A request for continuation of services must be filed within 10 days from the date CMDP mails the *Notice of Action*.
- A member or provider may request a State Fair Hearing if the member/provider disagrees with the CMDP member appeal decision.
- A provider cannot file a member appeal without written consent from the legal guardian (CPS case manager).
- The request must be in writing to CMDP no later than 30 days after receiving the *Notice of Appeal Resolution*.
- A request for hearing regarding a non-AHCCCS enrolled member must be submitted in writing by the provider within fifteen (15) days of receipt of the *Notice of Appeal Resolution*.
- AHCCCS Administration notifies CMDP and the requestor of the time, place and nature of the hearing.

Chapter 11

FRAUD AND ABUSE

CMDP follows the Arizona Health Care Cost Containment System (AHCCCS) fraud and abuse provisions. Reported incidents of fraud and abuse will be investigated by AHCCCS and may result in legal action.

Definitions of Fraud and Abuse

- FRAUD (by member or provider) means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. (42 CFR 455.2)
- ABUSE (by provider) means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the AHCCCS 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 recipient practices that result in unnecessary cost to the AHCCCS program. (42 CFR 455.2)
- ABUSE (of a member) means any intentional knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault. (A.R.S. § 46-451, A.R.S. § 13-3623)
- INCIDENT means a situation of possible fraud, abuse, neglect and/or exploitation as defined in the policy that has the potential for liability.

Corporate Compliance

The Corporate Compliance program formalizes and affirms CMDP's commitment to the legal and ethical behavior of our employees.

CMDP Code of Conduct

The CMDP Code of Conduct provides guiding standards for employees to make the right decision when encountering situations involving legal and ethical issues in their daily activity. The CMDP Code of Conduct cannot cover every situation, or substitute for common sense, individual judgment and personal integrity. It is the duty of each CMDP employee to follow these principles:

1. **Respect the rights, dignity and diversity of each individual.** CMDP is dedicated to providing high quality health plan services that meet the needs of our members. CMDP respects the rights, dignity and cultural diversity of each individual and prohibits discrimination in any form or context.

2. **Maintain the appropriate levels of confidentiality for information and documents.** CMDP is dedicated to protecting the privacy of our members by preserving the confidentiality of individually identifiable health information, whether or not such information is maintained electronically, in writing, is spoken or in any other medium. (HIPAA)
3. **Comply with all applicable laws.** CMDP conducts business activities in full compliance with all applicable federal, state, and local laws and regulations.
4. **Conduct CMDP affairs in accordance with the highest ethical standards.** CMDP conducts all activities in accordance with the highest ethical standards of the community and their respective professions at all times. No employee shall make false or misleading statements to any member, provider, person or entity doing business with CMDP.
5. **Ensure proper payment for services.** CMDP is committed to ensure all requests for payment for healthcare services are (i) reasonable, necessary and appropriate; (ii) provided by properly qualified persons and (iii) the claims for such services are coded and billed correctly and supported by appropriate documentation.
6. **Avoid conflicts of interest.** CMDP takes all reasonable precautions to avoid conflicts, or the appearance of conflicts, between our private interests and the performance of our official duties.
7. **Protect and properly utilize all assets.** CMDP protects and properly utilizes all assets, such as property, equipment or resources that are entrusted in their care.
8. **Provide a safe working environment.** CMDP is committed to maintaining a safe and healthy working environment, which complies with all relevant laws and regulations.
9. **Provide equal opportunity to each employee.** CMDP treats all applicants and employees fairly and equitably, and in accordance with all relevant federal, state, DES and DCYF rules and regulations, policies or procedures. CMDP is committed to employment and promotional opportunities for all persons, without regard to race; color, nationality or ethnic origin, religion, gender, sexual orientation, disability or veteran's status.
10. **Promote open communication.** CMDP encourages open and candid communication and responds to issues and concerns in a timely manner.
11. **Conduct all business with honesty and integrity.** CMDP employees shall prepare accurate financial reports, accounting records, research reports, expense accounts, time sheets and other documents so that they completely and accurately represent the relevant facts and true nature of all CMDP business transactions.

- 12. Safeguard against conflicts of interest.** All internal and external CMDP committee members sign Confidentiality and Conflict of Interest statements. The principles of these statements are reviewed at the start of each committee meeting.

Corporate Compliance Hotline

The CMDP Corporate Compliance Hotline is the confidential, 24 hours a day, 7 days a week voice mailbox of the CMDP Compliance Officer. Anyone can use this resource to report, in good faith, concerns involving CMDP employees and potential fraud, unethical, illegal or unacceptable practices or compliance violations.

All calls are kept confidential to the extent permitted by law. Although callers are encouraged to identify themselves, the call can be an anonymous report. The CMDP Compliance Officer will investigate all reports of improper conduct. Actions are taken equitably and consistently.

Reports can be made by calling the CMDP Compliance Officer at (602) 771-3555, or (800) 201-1795 Ext. 13555.

Fraud, Waste and Abuse Reporting

To report fraud, waste and abuse directly to the AHCCCS Office of the Inspector General (OIG), go to the AHCCCS Fraud and Abuse webpage, www.azahcccs.gov/fraud/reporting/reporting.aspx, and follow the instructions provided. All pertinent documentation and/or investigative reports that would assist AHCCCS in its investigation shall be attached to the forms submitted.

Examples of Fraud and Abuse

Examples of fraud and abuse include, but are not limited to:

Falsifying Claims/Encounters

- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Falsifying Services

- Billing for services/supplies not provided
- Misrepresentation of services/supplies
- Substitution of services

Administrative/Financial

- Kickbacks
- Falsifying credentials
- Fraudulent enrollment practices

- Fraudulent third party liability reporting
- Fraudulent recoupment practices

Member Issues (Abuse)

- Physical or mental abuse
- Emotional or sexual abuse
- Discrimination
- Neglect
- Financial abuse
- Providing substandard care

Member Issues (Fraud)

- Resource misrepresentation (transfer/hiding)
- Residency
- Household composition
- Citizenship status
- Unreported income
- Misrepresentation of medical condition
- Failure to report third party liability

Denial of Services

- Denying access to services/benefits
 - Limiting access to services/benefits
 - Failure to refer to a needed specialist
 - Underutilization
- Billing fraud and abuse* is an umbrella term that applies to a series of statutes and regulations designed to prevent government health programs from paying excessive and/or inappropriate claims. The United States General Accounting Office (GAO) estimates that medical billing fraud and abuse approaches 10% of all health care expenditures, or \$100 billion dollars yearly.

Provider Prevention

There are several things healthcare providers can do to help prevent allegations of billing fraud and abuse. They include the following:

- Complete claim forms accurately.
- Ensure that patient records corroborate that services were actually rendered and necessary.
- Develop and install a comprehensive internal fraud detection and compliance plan.

Healthcare providers should develop internal mechanisms to ensure compliance with complex and constantly changing Medicare and Medicaid regulations. The benefits of an internal fraud detection and compliance program include early detection of problems, prevention of submitting improper claims, subversion of employees ability and inclination

to bring a *qui tam* lawsuit, and the opportunity to voluntarily disclose fraud or mistakes, possibly reducing penalties and fines.

The Federal False Claims Act

The False Claims Act (FCA) provides a powerful legal tool to counteract fraudulent billings reported to the federal government. Any private citizen with direct knowledge of fraud can bring a false claims suit on behalf of the government. Private litigators are given standing to file civil suit on the federal government's behalf by the FCA's *qui tam*, or "whistleblower" provisions. *Qui tam* is short for *qui tam pro domino rege quam pro se ipso in hac parte sequitur* or "he who brings the action for the king as well as for himself [sic]."

To encourage whistleblowers to come forward, the FCA entitles them to a share/percentage of any money resulting from a judgment against, settlement with, or recovery from the defendant.

Healthcare providers should be aware that all employees, sub-contractors, agents, representatives, shareholders, vendors, competitors, clients and the like are potential whistleblowers or *relators*. If the government doesn't join in the case, the relator can pursue it alone.

Relevant Federal Laws

- 31 U.S.C. § 3729 et seq.: Federal False Claims Act
- 42 U.S.C. §1320A-7b(b)(1): Anti-Kickback Prohibition
- 18 U.S.C. § 1035: False Statements Relating to Health Care Matters
- 18 U.S.C. § 287: Federal Criminal False Claims Act
- 18 U.S.C. § 1001: Federal Criminal False Statements
- 18 U.S.C. § 1347: Health Care Fraud
- 18 U.S.C. § 1341: Mail Fraud
- 18 U.S.C. § 1962: Racketeer Influenced and Corrupt Organizations (RICO) Act
- 42 U.S.C. § 1395nn: Self Referral Prohibition (Stark Amendment)
- 18 U.S.C. § 1343: Wire Fraud

Related State Laws

Arizona does not specifically have a state false claims law. The state does have related statutes governing the following:

- A.R.S. § 13-1802: Theft
- A.R.S. § 13-2002: Forgery
- A.R.S. § 13-2310: Fraudulent schemes and artifices
- A.R.S. § 13-2311: Fraudulent schemes and practices; willful concealment
- A.R.S. § 36-2918: Prohibited acts

The Whistleblower Provision

A relator that files a False Claims Act suit receives an award only **if and after** the government recovers money from the defendant as a result of the suit. Generally, the court may award 15 to 30 percent of the total recovery from the defendant, whether through a favorable judgment or a settlement. The amount of the award depends, in part, upon:

- If the government participates in the suit.
- The extent to which the person substantially contributed to the prosecution of the action.

Whistleblower Protection

United States Code Title 31, Section 3730(h) provides protection to employees who are retaliated against by an employer because of the employee's participation in a *qui tam* action. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by his/her employer because the employee investigates, files or participates in a *qui tam* action.

The whistleblower protection includes reinstatement at the same seniority level and damages of double the amount of lost wages plus interest if the employee is fired, and any other damages sustained if the employee is otherwise discriminated against.

Administrative Remedies

The federal False Claims Act carries serious fines for healthcare providers who knowingly submit or cause the submission of fraudulent claims to federal payment programs, such as Medicaid or Medicare. Liability to a company or an individual for violating the FCA may include damages of up to three times the dollar amount that the government is found to have been defrauded, civil penalties of not less than \$5,500 and not more than \$11,000 for each false claim, and the attorney's fees of the relator. Individuals or companies that cause someone else to submit a false claim can also be found liable under the FCA.

Provider Training

Provider Training Resources

The CMDP Corporate Compliance program requires CMDP healthcare providers to train their staff in fraud and abuse awareness. We offer training supports through the *CMDP Provider Manual* and CMDP web site. The following aspects of the FCA are included in this information:

- An overview of the FCA;
- The administrative remedies for false claims and statements;
- Additional federal and state laws relating to civil and criminal penalties for false claims and statements;
- The whistleblower protections under such laws.

Training Web Site Links

The AHCCCS web site has a comprehensive page on fraud and abuse, which contains computer-based training courses in fraud awareness. Go to **www.azahcccs.gov/fraud/Default.aspx**, and click on the Fraud Awareness for Providers link shown on the page.

HIPAA Compliance

In 1997, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). HIPAA impacts the entire health care industry. The primary objectives of HIPAA are to ensure health insurance portability, reduce health care fraud and abuse, enforce standards for health information, and guarantee security and privacy of health information. In part, HIPAA is intended to improve the efficiency and effectiveness of the health care system through the establishment of standards, and to protect the security and privacy of health care information.

Health plans, health care clearinghouses and health care providers must comply with HIPAA requirements pertaining to the use of standardized transaction code sets (TCS), ensure privacy standards are followed, and protect the security of health information.

CMDP has assessed its obligations under HIPAA with a determination that CMDP is performing HIPAA-covered functions. Consequently, CMDP must comply with the applicable HIPAA provisions for privacy, electronic transactions, and security.

Confidentiality of health information for CMDP members has always been of the utmost importance. HIPAA emphasizes the privacy protections, and establishes specific standards for the use and disclosure of protected health information. For information about CMDP's privacy practices, or other HIPAA-related information pertaining to CMDP members, write to the CMDP Privacy Officer at:

**DES/CMDP
Attn: Privacy Officer
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202**

If you have questions relating to electronic transactions or transaction code sets, please contact the Chief Information Officer (CIO) at:

**DES/CMDP
Attn: Chief Information Officer
Site Code 942C
P.O. Box 29202
Phoenix, AZ 85038-9202**

Additional HIPAA References

For further information about HIPAA, see:

- U.S. Department of Health and Human Services, Office of Civil Rights web site, **www.hhs.gov/ocr/hipaa**
- The Department of Economic Security HIPAA web page, **www.azdes.gov/hipaa**
- Federal statutes, 45 CFR §164.534 (**www.gpoaccess.gov/cfr/**)
- State statutes, A.R.S. § 13-3620(D) (**www.azleg.gov/ArizonaRevisedStatutes.asp**)

Confidentiality

All information regarding identification and treatment of CMDP members is confidential (A.R.S. §§ 8-807, 13-3620(D), and 41-1959). Information regarding CMDP members, including records and files, may be released to:

- CMDP personnel;
- Staff of the custodial agency;
- Law enforcement personnel; or
- Other physicians and treatment staff providing medical services to the member, and foster caregivers.

All requests to the provider for confidential medical information from persons not listed above should be referred to the child's assigned custodial agency representative.

A provider may not release medical information to anyone not listed above without a signed authorization by the custodial agency representative or legal guardian.

Authorization for release of information must be a written document, separate from any other document and the signature must be obtained from the designated representative, and must specify the following:

- Information or records, in whole or in part, which are authorized for release;
- To whom the release shall be made;
- The period of time for which the authorization is valid, if limited; or
- The dated signature of the designated legal representative.

Providers may use their own medical information release forms.

GLOSSARY

The following words and phrases in addition to definitions contained in the statute have the following meanings unless the context explicitly requires another meaning:

Action –

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide a service in a timely manner as set forth in contract;
- Denial of a rural enrollee’s request to obtain services outside the CMDP network.

Acute mental health services – Inpatient or outpatient health services provided to treat mental or emotional disorders, as necessary for crisis stabilization, evaluation and determination of future service needs.

Arizona Department of Juvenile Corrections (ADJC) – The mission of the ADJC is to enhance public protection by changing delinquent thinking and behaviors of juvenile offenders committed to the Department.

Adjudicated child - A child adjudicated by the court as dependent, neglected or delinquent residing in a licensed foster family home or child welfare agency.

Arizona Health Care Cost Containment System (AHCCCS) – (*pronounced “access”*) The state agency that manages the Arizona’s Medicaid Program.

Arizona Health Care Cost Containment System Administration (AHCCCSA) – The state agency which acts as the contracting and regulatory body for the state and for Health and Human Services, Centers for Medicare and Medicaid Services (CMS), for state and federally funded health care programs.

Air ambulance – A helicopter or fixed wing aircraft licensed under the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1 as amended, to be used in the event of an emergency to transport clients or eligible persons to obtain services.

Ambulance – Any motor vehicle licensed pursuant to the Arizona Department of Health Services and A.R.S. Title 36, Chapter 21.1 especially designed or constructed, equipped and intended to be used, maintained and operated for the transportation of persons requiring ambulance services.

Ambulatory care institution – A health care institution with inpatient beds licensed by the Arizona Department of Health Services providing limited hospital services on an outpatient basis including an outpatient surgical center and an outpatient treatment center.

Ancillary services – Special services and items furnished to an institutionalized eligible client, which are separately payable in addition to the daily room and board charge. It may also be categorized as those provided by medical personnel other than physicians.

Appeal – A request for review of an action.

Authorization – An approval given by the designated Departmental representative or representative of the fiscal intermediary to a specific medical/dental provider to render services or items to a specific eligible client. In general, CMDP Medical Services staff gives authorization.

Casualty insurance – Liability insurance coverage related to injury due to accidents or negligence.

Catastrophic coverage limitation – The financial limit as determined by the Department beyond which the contractor is not at risk to provide or make reimbursement of treatment of illness or injury to foster children which results from, or is greatly aggravated by, a catastrophic occurrence or disaster including, but not limited to, natural disaster or an act of war, declared or undeclared, which occurs subsequent to being eligible for foster care.

Child in foster care – A child adjudicated by the court as dependent, neglected or delinquent or on whom the parent(s) have signed the necessary paperwork for voluntary foster care and who is residing in a licensed foster home or child welfare agency.

Child Protective Services (CPS) – A program of identifiable and specialized child welfare which seeks to: prevent dependency, abuse and exploitation of children by reaching out with social services to stabilize family life and preserve the family unit by focusing on families where unresolved problems have produced visible signs of dependency or abuse and the home situation presents actual and potential hazards to the physical or emotional well-being of children. The program shall seek to strengthen parental capacity and ability to provide good childcare.

Children's Rehabilitative Services (CRS) – A state agency that provides medical services to children meeting CRS eligibility requirements. Some CMDP members may be also eligible to receive CRS.

Claim – The invoice submitted by the medical/dental provider for reimbursement for covered services.

Clean claim – One that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Claim dispute – A dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Comprehensive Medical and Dental Program (CMDP) – The name for the health care program for children in foster care authorized by legislation and administered by the Department of Economic Security.

Concurrent review – Concurrent review is a utilization management function performed by registered nurses on each inpatient admission to acute care hospitals or extended care facilities. The concurrent review process determines the appropriateness of the hospital stay and level of care and is based on standardized review criteria.

Contract – A written agreement entered into between a person, organization or other entities and the Department to provide health care services to foster children.

Contractor – A person, organization or entity agreeing through a direct (prime) contracting relationship with the Department to provide those goods and services specified by contract in conformance with the requirements of such contract.

Coordination of Benefits (COB) – The process of using other insurance plans (families health plan, automobile or a third party) to pay for the child’s medical needs in full or in combination with CMDP.

Covered service – Covered services are necessary health services, which are delivered the CMDP members at the direction of the member’s primary care provider (PCP). Covered services for AHCCCS are listed in this manual.

Cultural competency – An awareness and appreciation of the customs, values and beliefs (“culture”) and the ability to incorporate them into the assessment, treatment and interaction with any individual.

Dentist – An individual licensed to practice dentistry and/or oral surgery by the appropriate regulatory board of the State of Arizona. The term shall include such individual only when practicing within the scope of the license.

Department of Economic Security (DES) – DES Mission Statement: The Arizona Department of Economic Security promotes the safety, well-being, and self sufficiency of children, adults, and families.

Diagnostic service – Those services provided for the purpose of determining the nature and cause of a condition, illness, or injury.

Director – The Director of the Department of Economic Security.

Division of Children, Youth, and Families (DCYF) –The purpose of the Division of Children, Youth and Families, within the Department of Economic Security is to provide opportunities and services to families so that children at risk can grow in safe, caring environments, and to advocate for children’s rights and needs.

Durable Medical Equipment (DME) – Durable items and appliances that can withstand repeated use, are designed primarily to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness, or injury. This definition includes, but is not limited to, such items as bedpans, hospital beds, wheelchairs, crutches, trapeze bars, and oxygen equipment.

Emergency ambulance service –

- a. Emergency transportation by a licensed ambulance company of persons requiring emergency medical services.
- b. Emergency medical services that are provided before, during or after such transportation by a certified ambulance operator or attendant.

Emergency medical services – Services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:

- a. Placing the patient’s health in serious jeopardy;
- b. Serious impairment of bodily functions; or
- c. Serious dysfunction of any bodily organ or part.

Emergency dental services –

- a. Those services necessary to control bleeding, relieve pain, and eliminate acute infections.
- b. Operative procedures that are required to prevent pulpal death and the imminent loss of teeth.
- c. Treatment of injuries to the teeth or supporting structures.
- d. Reduction of maxillary and mandible fractures.

EPSDT services – Early and Periodic Screening, Diagnosis, and Treatment services for person under twenty-one (21) years of age. The following meanings shall apply:

- a. *Early* – In the case of a child in foster care as early as possible in the child’s life, or in other cases, as soon as a child is in foster care.
- b. *Periodic* – At appropriate intervals established by the Department for screening to assure that a condition, illness or injury is not incipient or present.
- c. *Screening* – The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who may have a condition, illness or injury and the identification of those in need of more definitive study. For the purposes of the CMDP program, screening and diagnosis are not synonymous.
- d. *Diagnosis* – The determination of the nature or cause of a condition, illness or injury through the combined use of health history, physical, developmental, and psychological examination, laboratory tests and x-rays.
- e. *Treatment* – Any type of health care or services recognized under the State Plan submitted pursuant to Title XIX of the Social Security Act.

Eyeglasses – Frames with lenses prescribed by an optometrist, ophthalmologist or other licensed medical practitioner to aid or significantly improve visual performance.

Facility – Any premise owned, leased, used or operated directly or indirectly by or for a contractor and its affiliates for purposes related to a contract; or maintained by a provider to provide services on behalf of a contractor.

Family planning services – Family planning services are those services provided to aid eligible persons who voluntarily choose to delay or prevent pregnancy. Family planning services include covered medical, surgical, pharmacological and laboratory benefits. Family planning services also include the provision of accurate information and counseling to allow eligible persons to make informed decisions about the specific family planning methods available. All CMDP members are entitled to family planning services.

Federal Food and Drug Administration (FDA) – The FDA mission is to promote and protect the public health by helping safe and effective products reach the market in a timely way, and monitoring products for continued safety after they are in use. Our work is a blending of law and science aimed at protecting consumers.

Fee-for-service – A method of payment to registered providers on an amount-per-service basis, up to a maximum allowable AHCCCS fee.

Fee schedule – Allowable amounts established by the Department of Economic Security for medical, dental, and psychological care for children in foster care.

Foster care provider – A home or childcare agency such as a foster home, group home, or child welfare agency, which provides care and supervision for foster children.

Generic drug – The chemical or generic name, as determined by the United States Adopted Names Council (USANC) and accepted by the Federal Food and Drug Administration (FDA), of those drug products having the same active ingredients as prescribed brand name drugs.

Grievance – An expression of dissatisfaction about any matter other than an action. This can include but not limited to:

- The quality of care or services provided;
- Failure to respect the member's rights;
- Aspects of interpersonal relationships such as rudeness of a provider or an employee.

Hearing aid – Any wearable instrument or device designed for, or represented as aiding or compensating for impaired or defective human hearing, and any parts, attachments or accessories of such instrument or device.

Hearing aid evaluation – The application and interpretation of a battery of tests by an otolaryngologist, otologist, other licensed medical practitioner or audiologist to determine if amplification may be advantageous to an individual's hearing and what parameters of amplification are required to obtain a satisfactory result.

High-risk pregnancy – A pregnancy complicated by diabetes mellitus, hypertension, previous history of multiple stillborns, expected multiple birth, or a foster child under age 18 years.

Hospital – A health care institution that is licensed by the Department of Health Services pursuant to A.R.S. Title 36, Chapter 4, Article 2, as a hospital, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of such certification.

Identification card – A card for each foster child issued by the Department to establish the identity of the child eligible for the covered services.

Inpatient – A person who has been admitted into a hospital, rehabilitation, or skilled nursing facility for bed occupancy for purposes of receiving inpatient services. A person will be considered an inpatient when formally admitted as an inpatient, i.e. when admitted for a period of more than 23 hours or through the census hour.

Inpatient days – The number of days of care charged for hospital or skilled nursing facility services.

Inpatient hospital services – Those services and items furnished by the hospital for the care and treatment of inpatients under the direction of a physician or dentist.

Legal guardian, conservator, executor, or public fiduciary – Persons appointed by a court or other protective order to be in charge of the affairs of a minor or incapacitated person.

Legend drugs – Those drugs that under federal or state law or regulations may be dispensed only by prescription.

Long term care – Room and board services ordinarily provided in a licensed nursing care institution, licensed supervisory care facility or certified adult foster care facility.

Medical/Dental Provider – Any person, institution or entity, which provides covered services to an eligible foster child under the program.

Medicaid – A federal/state program authorized by Title XIX of the Social Security Act, as amended, which provides federal matching funds for a medical assistance program for recipients of federally aided public assistance, SSI benefits and other specified groups. Certain minimal populations and services must be included to receive federal financial participation (FFP). States may optionally include additional populations and services at state expense and also receive FFP.

Medical record – A single, complete record kept at the site of the client’s primary care provider that documents the medical services received by the client, including inpatient discharge summary, outpatient and emergency care.

Medical services – Services pertaining to medical care that are performed at the direction of a physician, on behalf of clients or eligible persons by physicians, dentists, nurses, or other health related professional and technical personnel.

Medical supplies – Consumable items which are designed specifically to meet a medical purpose.

Medically necessary – Those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law to:

- a. Prevent disease, disability and other adverse health conditions or their progression, or
- b. Prolong life.

Medically necessary sterilization – Sterilization to:

- a. Prevent disease, disability or adverse health conditions;
- b. Prolong life and promote physical health.

Minor – A person under eighteen (18) years of age.

Member – A person who is enrolled with CMDP.

Non-PPN providers – Health care providers who are registered but have not applied to CMDP to provide covered services to CMDP members.

National Drug Code (NDC) - An 11-digit code that identifies a drug. The first 5 digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration (FDA). The next 4 digits identify the specific drug product, and the last 2 digits define the product package size, assigned by the manufacturer.

National Provider Identifier (NPI) – A unique, government issued, standard identification number for individual health care providers and provider organizations like clinics, hospitals, schools, and group practices.

Nursing services – Those services that are performed by or under the supervision of a registered nurse at the direction of a license practitioner.

Occupational therapist – A person who has completed equivalent educational requirements and work experience required for a certificate of occupational therapy.

Ophthalmologist – A licensed medical practitioner who specializes in the diagnosis and treatment of the eye and its related structures.

Optometrist – A person registered with the State medical board to practice optometry.

Orthodontic condition – A clinically obvious physical abnormality of tooth and/or jaw relationships.

Orthopedic devices – Supportive or corrective devices used for treatment of musculoskeletal abnormality or injury.

Otolaryngologist – A licensed medical practitioner whose practice is limited to the specialty of conditions or disease of the ear, nose, and throat and who qualifies as a specialist in those areas.

Otologist – A physician who limits his practice to the specialty of conditions and diseases of the ear and who qualifies as a specialist in this area.

Outpatient health services – Those preventatives, diagnostic, rehabilitative or palliative items or services that are ordinarily provided in hospitals, clinics, physician’s offices and rural clinics, by licensed health care providers by, or under the direction of a physician or practitioner, to an outpatient.

Palliative services – Services that reduce the severity or relieve the symptoms of a condition, illness, or injury.

Parents’ Evaluation of Developmental Status (PEDS) Tool – A formal developmental screening tool that is conducted during primary care EPSDT visits to identify potential development delays

Primary Care Provider (PCP) – This term is used interchangeably with primary care physician. The CMDP PCP is a physician who is responsible for the overall management of a member’s health care. PCPs may include, but not limited to; a physician who is a family practitioner, general practitioner, internist, pediatrician, obstetrician, or gynecologist; a certified nurse midwife or nurse practitioner; or under the supervision of a physician, a physician’s assistant.

Pharmaceutical services – Medically necessary drugs prescribed by a practitioner, or other physician or dentist upon referral by a primary physician.

Pharmacist – A person licensed as a pharmacist under A.R.S. Title 32, Chapter 18.

Pharmacy – An establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist and which is registered pursuant to A.R.S. Title 32, Chapter 18.

Physical therapist – A person registered to practice physical therapy.

Physical therapy services – Those services provided by or under the supervision of a physical therapist.

Physician’s Current Procedural Terminology (CPT) – The manual published and updated by the American Medical Association, which is a nationally accepted listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and provides a uniform language that will accurately designate medical, surgical, and diagnostic services.

Physician services – Services provided within the scope of practice of medicine or osteopathy as defined by State law, or by or under the personal supervision of an individual licensed under State law, to practice medicine or osteopathy, and excludes those services routinely performed and not directly related to the medical care of the individual foster

child. The term shall also include a Christian Science practitioner recognized by the Mother Church and listed as such in the “Christian Science Journal.”

Practitioner – Physician’s assistants and registered nurse practitioners who are certified and practicing in an appropriate affiliation with a primary physician as authorized by law.

Preferred Provider Network (PPN) – Health care providers participating with CMDP to provide covered services to CMDP members. PPN providers have fewer prior authorization requirements than non-PPN providers and clean claims are paid promptly.

Pre-payment – An arrangement in which a contractor agrees to provide health care services for a prospective, predetermined, periodic, fixed subscription premium.

Prescription – An order to a provider for covered services, which is signed or transmitted by a provider authorized to prescribe or order such services.

Preventative health care – Those health care activities aimed at protection against, and early detection and minimization of, disease or disability.

Prior authorization – The process by which the Department will advance whether a covered service that requires prior approval will be reimbursed based upon the accuracy of the information received and substantiated through concurrent and/or retrospective medical review.

Provisional prior authorization – Is a temporary authorization given, pending the receipt of required documentation to substantiate compliance with CMDP.

Prosthesis – An artificial substitute for a missing body part including, but no limited to, an arm, leg, eye, tooth, etc.

Psychologist – An individual certified by the State Board of Psychologist Examiners.

Quality management – A methodology used by professional health personnel that assess the degree of conformance to desired medical standards and practices; and activities designed to improve and maintain quality service and care, performed through a formal program with involvement of multiple organizational components and committees.

Radiological services – Professional and technical x-ray and radioisotope services ordered by a physician or other licensed health professional for diagnosis, prevention, treatment or assessment of a medical condition. Radiological services include portable x-ray, radioisotope, medical imaging and radiation oncology.

Regional Behavioral Health Authority (RBHA) – (*pronounced REE-bah*) Entities contracted by the Arizona Department of Health Services (ADHS) to provide Title XIX covered behavioral health services to eligible members.

Referral – The process whereby a foster child is directed by a primary care provider to another appropriate provider or resource for diagnosis or treatment.

Rehabilitation services – Physical, occupational, speech, and respiratory therapy, audiologist services and other restorative services and items required to reduce physical disability and restore child to an optimal functional level.

Routine services – Those services and items included in an inpatient provider’s daily room and board charge.

Routine physical examinations – Medical examinations performed without relationship to treatment or diagnosis of a specific condition, illness or injury.

Service area – The geographical area designated by the Department within which a contractor shall provide, directly or through subcontract, covered health care services to foster children.

Service location – Any location at which a foster child obtains any covered health care service.

Service site – The location at which foster children shall receive services from a primary care provider.

Specialist – A Board eligible or certified physician who declares himself or herself as such and practices a specific medical specialty.

Social Security Administration (SSA) – An agency of the Federal Government responsible for administering certain titles of the Social Security Act, as amended.

Specified relative – A non-parent caretaker of a dependent child who is a grandparent, great-grandparent, brother, or sister of whole or half blood, aunt, uncle, or first cousin. (A.R.S. § 8-501.A.11).

Skilled nursing facility – A health care institution which is licensed by the Department of Health Services as a skilled nursing facility.

Speech therapist – A person who has been granted the Certificate of Clinical Competence in the American Speech and Hearing Association, or who has completed the equivalent educational requirements and work experience required for such a certificate, and who is licensed by the state.

State Fair Hearing – An administrative hearing as defined under A.R.S. Title 41, Chapter 6, Article 10.

Supplemental Security Income (SSI) – Supplemental income under Title XVI of the Social Security Act, as amended.

Therapeutic services – Those curative services required for treatment of a condition, illness or injury and includes acute, chronic and emergency care.

Third party – Any individual, entity or program that is, or may be liable to pay all or part of the medical cost of injury, disease or disability of a CMDP foster child.

Third party liability – The resources available from a person or entity that is or may be, by agreement, circumstance or otherwise, liable to pay all or part of the medical expenses incurred by a CMDP eligible foster child.

Treatment plan – That portion of the authorization process, which requires that the attending physician and other professional allied health personnel involved in the care of an eligible foster child establish and review periodically a plan of treatment and care for each eligible foster child.

United States Adopted Names Council (USANC) – The purpose of the USANC is to serve the health professions in the United States by selecting simple, informative, and unique nonproprietary names for drugs by establishing logical nomenclature classifications based on pharmacological and/or chemical relationships.

Utilization control – The overall accountability program encompassing quality assurance and utilization review.

Utilization management – A methodology used by professional health personnel that assesses the medical indications, appropriateness and efficiency of care provided.

Vaccines for Children (VFC) – The VFC Program was established in 1993 to serve children defined as “federally vaccine eligible” under Section 1928(b)(2) of the Social Security Act, which includes both “uninsured” and “Medicaid eligible” children. American Indian/Alaskan Native children, and children whose insurance does not cover immunizations, are also eligible for the VFC Program. States will continue to receive federal funding for reduced-price vaccines under this program.