Banner
University Health Plans

800-582-8686 • TTY 711 • Fax 520-874-5555
www.BannerUHP.com

January 2022 Provider Update

Plan Materials Available on Website

2022 plan materials for Banner Medicare Advantage plans are now available on our website at the following URL:

https://www.bannerhealth.com/medicare/our-plans

On our website, you can find plan materials for:

- Banner Medicare Advantage Prime HMO
- Banner Medicare Advantage Plus PPO
- Banner Medicare Advantage Dual HMO D-SNP (formerly known as Banner-University Care Advantage)
- Banner Medicare Rx Prescription Drug Plans

Materials include the Annual Notice of Changes, Evidence of Coverage, Summary of Benefits, Drug Formulary and Provider and Pharmacy Directories.

Please take note of these important plan materials.

Important Note:
Federal law prohibits Medicare providers from charging individuals in the Qualified Medicare Beneficiary (QMB) program for Medicare cost sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copayments for any Medicare-covered items and services.

Changing Primary Care Providers (PCP)

Members have the right to select a new PCP at any time. They can contact the Customer Care Call Center and a representative will be able to assist with their request. Our representatives will ask the member if they have already scheduled an appointment with the PCP of their choice; this is to ensure a provider is able to accommodate a member's timely request for an appointment. A representative will also verify if the PCP has the proper panels in place to make the requested change.

- If there is a Closed panel – We will verify with the provider's office representative that it is acceptable to add a member to their respective panel.

- No panel listed for provider - We will notify the member. If a provider believes this is incorrect information, they can update their information by clicking on the following link https://www.banneruhp.com/materials-and-services/provider-data-update-form

How can you verify PCP assignments?
Providers can always verify a member's PCP assignment by visiting eServices, https://eservices.uph.org
For more information about eServices, contact your Care Transformation Specialist.

Customer Care
Banner – University Family Care ACC Phone: 800-582-8686
Banner – University Family Care ATLCS Phone: 833-318-4146
Banner Medicare Advantage Dual Phone: 877-874-3930

Protect Yourself & Others from Getting COVID-19

Take steps to protect older adults and those who live with them. These steps should be followed by people who visit or provide care for them and even themselves, in preventing the spread of COVID-19.

- Get vaccinated as soon as possible.
- COVID-19 Vaccines are effective in preventing COVID-19. The CDC recommends for everyone 5 years and older get a COVID-19 vaccine. The Pfizer vaccine is recommended for children ages 5 to 17. Individuals 18 or older may get any of the vaccines.
- Booster Shots are recommended for all adults 18 years and older at least 6 months after completing the initial 2 shot dosing for the Pfizer and Moderna shots and 2 months after the initial Johnson & Johnson's Janssen shot.
- Teens 16-17 years of age can get a Pfizer booster if desired and for age 18 and older, any of the COVID-19 vaccines can be taken as a booster shot.
- Even if you are fully vaccinated, because of the new variants, social distancing and use of masks indoors should be encouraged, and you must conform to federal, state, local, tribal, territorial laws, rules, and regulations. This can also include local business and workplace guidance. It is important to continue to be vigilant.
- People are considered fully vaccinated 2 weeks after the second 2 dose series of Pfizer and 2 weeks after the single dose Johnson & Johnson. Since boosters have now been recommended, it is expected that a booster will be needed to be considered fully vaccinated soon. The CDC is currently recommending that individuals who are just starting to be vaccinated receive either the Pfizer or Moderna vaccine over the Johnson & Johnson vaccine, because of the new variants that are currently active.
- If you are not fully vaccinated, you should wear a mask in indoor public places. Local conditions may require masks even if vaccinated.
- Most of the time you do not need to wear a mask outdoors.
- In the areas with high numbers of COVID-19 case, you may want to consider wearing a mask. If you are in a crowded outside activity or in close contact with others who are not fully vaccinated, use of a mask should be strongly considered.
- People who have a condition or taking medications need to be careful. This may weaken their immune system. And they may NOT be protected even if they are fully

vaccinated. They should continue to take precautions until advised otherwise by their healthcare provider.
- Limit your in-person interactions (when indoors).
- Keep space between yourself and others. Stay 6 feet away and about 2 arm lengths away.
- Wash your hands often. If soap and water are not readily available, then use a hand sanitizer that contains at least 60% alcohol.
- Avoid touching your eyes, nose, and mouth.
- Cover coughs and sneezes. Use a tissue or the inside of your elbow and then wash your hands.
- Clean with disinfectants. Clean things you touch often.

Get vaccinated as soon as possible.
COVID-19 vaccines are effective in preventing COVID-19.
For information, please call our Customer Care Center at 833-318-4146, TTY 711.
Visit our website at www.BannerUFC.com/ALTCS.

COVID-19 Vaccine for Medicare Advantage CY2022 Notification

If you participate in the Centers for Disease Control (CDC) COVID-19 Vaccination Program, please remember:

- You must administer the vaccine with no out-of-pocket cost to your patients for the vaccine or administration of the vaccine.
- The administration of the vaccine does not require a physician's order or supervision.
- You should vaccinate everyone, including the uninsured, regardless of coverage or network status.
- You cannot balance bill for COVID-19 vaccinations.
- You cannot charge your patients for an office visit or other fee(s) if the COVID-19 vaccination is the only medical service provided.

Beginning January 1, 2022, Banner Health will pay for the COVID-19 vaccine administration and booster for beneficiaries enrolled in one of our Medicare Advantage plans (Banner Medicare Advantage Prime HMO, Banner Medicare Advantage PPO and Banner Medicare Advantage Dual HMO D-SNP). For all other plans, please visit the plan's website for COVID-19 vaccine billing guidance.

<u>Cost Sharing does not apply to:</u>

- COVID-19 vaccine administration
- Booster doses

Billing

- Continue to bill on single claims and submit it to the appropriate Medicare Advantage plan electronically or via mail.
- Place of Service (POS) is where you provided the vaccine.
- Bill only for the vaccine administration.
  - You would not bill for the COVID-19 vaccine itself since it's provided by the government.
- At Home administration of vaccine may be billed with code M0201.

- M0201 will be reimbursed at $35 in addition to the administration code.

- CMS, FQHC/RHC's should bill the all-inclusive, per visit (PPS) rate for COVID-19 vaccine administration performed by FQHC/RHC's.
  - Must be within the provider's scope of practice.
  - Only service provided at that time.
  - If vaccine is provided as part of an office visit, the administration will be considered incidental to that visit and not a separate PPS-eligible visit.
    - FQHC pharmacy billing remains under the pharmacy provider type and not eligible for receiving the all-inclusive, pre visit rate

For more information about COVID-19 vaccine policies and guidance or Original Medicare's payment for COVID-19 vaccine administration in the home, please visit the sites listed below:

https://www.cms.gov/COVIDvax
https://www.cms.gov/files/document/vaccine-home.pdf

Psychiatry for Non-Psychiatrists - CME Credit

For more information or to register for this event please use this link:
https://psychiatry.arizona.edu/Psych4PCPs

In response to the alarming rise in mental illnesses such as depression, anxiety, insomnia, addiction, and suicide – and the dearth of mental health providers – we have created a

conference to train Primary Care Physicians to confidently care for their patients with these conditions.

This fully virtual conference, "Psychiatry for Non-Psychiatrists: The University of Arizona Update in Behavioral Medicine for Primary Care" on Saturday, Mar. 12 will provide practical and actionable knowledge to help PCPs effectively manage these conditions in primary care settings.

Access to mental health care is a right, not a privilege. We aim to empower PCPs and other specialty health providers with new clinical skills to enhance access to care, improve comorbid medical conditions, and reduce the stigma of seeking treatment for mental illness.

This is a planned CME event. Cost: $100 for physicians, $75 for nurses/physician assistants, $50 community members (not CME eligible), $10 for residents/trainees/students (not CME eligible).

- View the speakers and topics https://psychiatry.arizona.edu/Psych4PCPsSpeakers
- See the schedule https://psychiatry.arizona.edu/psych-pcps/schedule
- Thank You to our sponsor, Banner University Health Plans https://psychiatry.arizona.edu/Psych4PCPsSponsors

Registration: https://www.eventbrite.com/e/psychiatry-for-non-psychiatrists-behavioral-medicine-for-primary-care-tickets-215766361997

Questions? Email Event Coordinator Jamie Manser at jlmanser@psychiatry.arizona.edu

Service Plan Documentation Tips

The behavioral health chart audits are tentatively scheduled to restart sometime in 2022 after a two-year moratorium. Until then, here's a few helpful reminders for keeping service plans and assessments current (valid):

- Service plans must include the member or guardian signature
- If a *residential or inpatient* service plan is completed by a behavioral health technician (BHT), it must be reviewed and signed by a behavioral health professional (BHP) within 24 hours of the BHT signature. This timeframe is 72 hours if the treatment plan is for *outpatient* services
- BHP signatures MUST include the person's credentials (licensure type) and the signature date
- Current service plans are based on a current assessment. For an assessment to be current, they must include the following:
    - Timeframes for BHP reviewer signatures are followed as stated above
    - Completed within 48 hours after admission (residential or inpatient) or dated within 365 days from admission if the assessment was received from an outpatient behavioral health provider
    - Not dated more than 365 days if the person is receiving outpatient services
    - Assessments are completed before (or on the same day) as treatment plans. This is to ensure the member's most current needs are included in service planning.

In addition to the above, it's also important to include the member/guardian/family's recovery vision in service plans. This supports the member/family's voice and choice in service planning while encouraging their motivation to achieve wellness goals.

For more information on AHCCCS documentation requirements, please refer to the AHCCCS Medical Policy Manual Section 320-O, Behavioral Health Assessments and Treatment Service Planning or contact Jennifer.Lewusz@bannerhealth.com for further technical assistance.

Making the Rounds Podcast

The next episode of Banner Health's **Making the Rounds** podcast focuses on hip preservation. Guest experts include John Ebinger, PT, DPT, SCS, sports medicine physical therapist at Banner Physical Therapy and Laura Vogel, MD, hip preservation orthopedic surgeon at TOCA at Banner Health, who discuss the evolution of hip preservation treatment.

Please see below to listen:
Anchor - https://anchor.fm/makingtherounds/episodes/Embracing-the-evolution-of-joint-preserving-surgery-e1cjuh7

Flu Focus: Be Safe and Vaccinate

Remind your patients that although the flu season is different during the COVID-19 pandemic, one thing stays the same. The flu shot continues to be the strongest defense against the flu.

For more information on how the COVID-19 pandemic has affected the flu season, please direct patients to the following article- https://www.bannerhealth.com/healthcareblog/better-me/how-is-flu-season-different-during-the-covid-19-pandemic.

Office of Individual and Family Affairs (OIFA)

Committee and Council Recruitment!

Banner University Health Plans (BUHP) is committed to engaging members and their families in conversations regarding health policy, access to care, and system improvements. To demonstrate our continued commitment to a member-centric culture, we are always working toward increasing our member and family representation on the following B –UHP committees and councils: Member and Family Advisory Council (MAC), Governance Committee, Neighborhood Community Advisory Council (CAC), and three of our Health Plan Committees: Cultural Competency Committee, Complete Care Oversite Committee, and Grievance and Appeals Committee. We are also looking to increase youth voice on the Neighborhood Community Advisory Councils (CAC).

Committee and Council participation is a way to further bring our members, peers, family members, providers, and community partners together to discuss issues impacting care while collaboratively building local solutions. Additionally, this is also a way to ensure that member and family voices are heard at every level of BUHP's organization and leadership.

Below are links to our Committee and Council Application and Attachments:

Member Advocacy and Advisory Council Application: https://www.bannerufc.com/acc/-/media/files/project/acc/oifa/bufc-acc_member-advocacy-advisory-council-app_dec2021.ashx?la=en and https://www.bannerufc.com/acc/-/media/files/project/acc/oifa/bufc-acc_member-advocacy-advisory-council-app-spa_dec2021.ashx?la=en

Member Council Descriptions Attachment: https://www.bannerufc.com/acc/-/media/files/project/acc/oifa/bufc-acc_council-resources_and-descriptions_eng_apr2020.ashx?la=en and https://www.bannerufc.com/acc/-/media/files/project/acc/oifa/bufc-acc_council-resources_and-descriptions_spa_apr2020.ashx?la=en

Library Resources Attachment: https://www.bannerufc.com/acc/-/media/files/project/acc/oifa/bufc-acc_council-resources_libraries_bil_apr2020.ashx?la=en

You can also find this information on our website at www.bannerufc.com/acc. Just click on **Plan Information** then click on **Office of Individual and Family Affairs (OIFA)** and scroll down to **Join a Council**. You can download a committee application (PDF) from this page, have the interested individual fill out the form, save it and email it to the Office of Individual and Family Affairs at: OIFATeam@bannerhealth.com.

If you would like OIFA to speak at one of your agency's Advisory Councils regarding this opportunity and/or if you have additional questions on how to connect your BUHP members and family members to one of our councils or committees, please contact BUHP OIFA through our general mailbox: OIFATeam@bannerhealth.com.

Provider Case Management

AMPM 570

Effective 10/1/21 AHCCCS established AMPM 570. This policy establishes requirements for provider case management for behavioral health providers. Case management is supportive service provided to improve treatment outcomes and meet individuals' Service or Treatment Plan goals.

Additional information can be found on the roles and responsibilities of behavioral health providers.

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/570.pdf

Banner University Health Plans support ACC members through the utilization of case management services. BUHP is collaborating with the other ACC plans to streamline deliverable and reporting processes. All ACC health plans have expressed an interest in a collaborative approach to the collection and reporting of data required by the AMPM 570 process. More information will come as it relates to the General Mental Health/Substance Use population (GMH/SU). BUHP intent is to proactively meet the needs of the members while minimizing the administrative workload on the provider network.

Maternal & Child Health

OB, Pediatric and CRS Care Coordination

The BUHP Maternal Child Health (MCH) team is available to coordinate with both members and providers, offering a fully integrated and multi-disciplinary care management programs to those who need help navigating the health care system.

• Our OB Care Management team works to coordinate care and support those with increased risks or unmet needs in pregnancy. We can help resolve barriers to care and address social determinants of care throughout the member's pregnancy and postpartum periods. Care Managers help link mothers to medical as well as community-based resources. We provide direct member support and promote compliance with prenatal care appointments, prescribed medical care regimens and postpartum follow-up. BUHP places a critical importance on early and regular maternity health care. A provider's early submission of the NOP or "Notification of Pregnancy" form to the Health Plan is the key step to ensuring our most expedient and effective maternal outreach and support. An electronic fillable PDF of the NOP form is available in the Banner University Health Plans Provider Manual at: https://www.banneruhp.com/-/media/files/project/uahp/maternity-care/buhp_notice-of-pregnancy-form_oct2018.ashx?la=en

• The Pediatric Care Management team supports any member under 21 years of age. Our team of experienced Pediatric RN Care Managers coordinate with providers and facilitate, support and guide members/guardians to positive health outcomes, working closely with the health plan's Children's Behavioral Health team to effectively co-manage and coordinate the complex combination of both physical and behavioral healthcare needs.

• Children's Rehabilitative Services – The health plan's MCH department has a special team of coordinators who focus on supporting our current and former CRS-enrolled members, their families, and their providers.

REFERRALS or requests for assistance with any OB, Postpartum, Pediatric or CRS member can be sent to: BUHPMaternalChildHealth@BannerHealth.com or simply call our Customer Care line (800-582-8686) and ask to speak with the Maternal & Child Health team.

EPSDT (Early Periodic Screening Diagnosis and Treatment)

Well Child Visits & Sick Visits

We understand that members/parents may not want to return to the clinic for an EPSDT/Well-Child visit after being seen for a sick visit. Including EPSDT/Well-Child Visits, screenings and vaccinations at the time of a sick visit will help maximize completion of EPSDT services and improve overall health care outcomes.

Billing of a "SICK VISIT" (CPT Codes 99201-99215) at the same time as an EPSDT/Well-Child Visit is acceptable as a separately billed service if:

- The "SICK VISIT" is documented on a separate note
- Modifier 25 is added to the Office/Outpatient code, indicating that a significant, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventative or Well-Child service.

Banner – University Family Care (BUFC) DOES NOT limit the number of medically necessary billed EPSDT / Well-Child visits.

Vaccinations
EPSDT coverage includes all child and adolescent immunizations in accordance with the CDC recommended childhood immunization schedules. All usual schedule vaccinations should be provided as part of the EPSDT / Well-Child visits.
Providers administering vaccines to EPSDT aged members, shall be registered as a Vaccines for Children (VFC) provider AND must use VFC vaccines.

ADHS has a "Pandemic Vaccine Provider Onboarding" program. If a provider wishes to administer future COVID-19 vaccines, visit https://redcap.link/onboard for information, tools, and forms.

Tracking forms for EPSDT / Well-Child Visits

In accordance with AHCCCS policy [AMPM Policy 430 Early and Periodic Screening, Diagnostic and Treatment (ESPDT) Services, Attachment E – AHCCCS EPSDT Tracking Forms] – All providers offering care to AHCCCS members under 21 years of age MUST use the AHCCCS EPSDT Tracking Forms to document age-specific, required information related to the EPSDT / Well-Child screenings and visits.

Alternatively – The provider's Electronic Health Record may be used, so long as it includes ALL components present on the age-specific AHCCCS EPSDT form.

- To download EPSDT Tracking forms, navigate directly to the AHCCCS website at: www.azahcccs.gov à shared à Medical Policy Manual à 430_AttachmentE Or, click on the link AHCCCS EPSDT Well-Child Visit Forms.
- For each EPSDT/Well-Child visit, a copy of the completed and signed (by the clinician) EPSDT
Tracking Form (or appropriate EHR), must be:
    - Placed in the member's medical record AND
    - Sent to the member's Health Plan

Timely submission of EPSDT/Well-Child visit forms is very important to member care coordination. Submitting the visit forms (or copy of suitable EHR equivalent) to the Health Plan soon after the well-child visit allows us to:

- Outreach to members and caregivers, evaluate for and mitigate potential barriers to care
- Identify, follow-up and facilitate referrals initiated during the well-child visit.

Submitting EPSDT / Well-Child Visit Forms

There are three easy ways to submit your EPSDT forms or EHRs after a visit. Secure email: BUHPEPSDTForms@BannerHealth.com
Secure Fax: 520-574-7184
US Mail: Banner University Health Plans
Attn: EPSDT
2701 E. Elvira Rd.
Tucson, AZ 85756

Provider Services & Support

Provider with Members in Long-Term Care

Please share the survey link below with your patients to participate in this important survey:

The **Sonoran Center for Excellence in Disabilities** is exploring the experiences of members in long term care settings, and their families. This survey will ask questions about feeling safe and protected. Your individual answers will not be shared. Thank you for completing the survey.

Note to mobile device users: this survey works best in landscape mode.

Sign language translation is available. Click the link found in survey instructions.

English Language version https://redcap.uahs.arizona.edu/surveys/?s=PYPPKJMAFL8HHHFJ

Provider Self-Service Functions

Member Rosters

To access member enrollment information and obtain member rosters, please visit 34Thttps://eservices.uph.org/34T. For more information about eServices, contact the Provider Experience Center.

For inquiries related to obtaining information regarding the provider's assigned membership, please send to our dedicated inbox at BUHPProviderInquiries@bannerhealth.com.

Notify the Health Plan Data Department of any updates to the information below.

According to provider standards and responsibilities, providers must notify plan with any changes to:

- Provider and Provider Group Adds
- Provider or Group Location demographic updates (except terms)
- Provider Panel Changes
- Telephone numbers
- Provider (Group) Term

This notification should occur within 30 days of any of the above changes. Please send all updates and changes via the online Provider Update Form located at https://www.banneruhp.com/materials-and-services/provider-data-update-form or you may email to BUHPDataTeam@bannerhealth.com.

Access to Timely Care

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks patients to report on and evaluate their experiences with health care and their provider. One important component focuses on getting appointments and care quickly. AHCCCS also has a set of required appointment standards. Ensuring your office meets these standards increases the patients positive experience with your office and healthcare. Ease of getting needed care impacts overall health care quality for our members.

BUHP has made a commitment to meet appointment availability standards as set forth by AHCCCS, Medicare and community standards; Chart of standards follows the end of this newsletter.

In accordance with AHCCCS and Medicare standards, appointment standards/wait time audits are conducted regularly to ensure members have timely access to care. Should providers not meet appointment or wait time standards, a Corrective Action Plan will be issued.

Note: BUHP utilizes a contracted vendor (Contact One) to conduct appointment availability surveys on a quarterly basis. Please share the appointment standards below with your staff. You may designate a representative in your office to complete the quarterly appointment availability survey with Contact One to alleviate confusion.

If you have any questions on implementing this in your office, please reach out to your Care Transformation Specialist or Consultant.

Provider Manuals: All Banner University Health Plans provider manuals can be accessed on the Health Plans website: 34Thttps://www.banneruhp.com. A printed copy of the Provider Manual(s) will be made available at no charge upon request, please contact your Care Transformation Specialist or Consultant.

Compliance Corner

Balance Billing and Charging Members

For providers who receive funds from Banner-University Family Care/ACC (B-UFC/ACC) or Banner-University Family Care/ALTCS (B-UFC/ALTCS) on behalf of AHCCCS (Medicaid) there is a requirement to complete AHCCCS registration.

In this process, providers agree to not bill or attempt to collect payment directly or through a collection agency from anyone claiming to be AHCCCS eligible without either verifying that the individual was not eligible on the date of service or the services provided were not AHCCCS-covered services. The providers must comply with Arizona Revised Statute *§36- 2903.01* and Arizona Administrative Code R9-22-702. Registered providers must accept payment as payment in full.

There are only a few exceptions for a provider to demand or collect payment from a member including:

- Collecting a copayment.
- Recovering from the member funds provided to the member from a third party for an AHCCCS covered service.
- Obtaining payment from a member for medical expenses incurred when the member intentionally withheld or provided inaccurate information regarding AHCCCS enrollment or eligibility that caused the provider's payment to be reduced or denied.

- Providing a service that is not covered or excluded if the member signs a document in advance indicating the understanding that the service is not covered, and they will be responsible for payment.
- Submitting a prior authorization that is denied by the Health Plan and the member signs a document in advance of receiving the services that the service was denied, and they are responsible for payment.
- Requesting services by a non-contracted provider under the circumstances where the Health Plan is not responsible for "Out of Network" services and the member signs a document prior to receiving the services that they agree to be financially responsible.

There are different types of Medicare Health Plans. Banner Medicare Advantage Dual is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. Banner Medicare Advantage Dual is designed specifically for people who have Medicare and who are also entitled to assistance from AHCCCS (Medicaid). Because a BMA-Dual member gets assistance from AHCCCS (Medicaid) with the Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), the member may pay nothing for Medicare health care services. AHCCCS (Medicaid) may also provide other benefits to the member by covering health care services that are not usually covered under Medicare.

A member can enroll in BMA-Dual if they are in one of these Medicaid categories:

• Qualified Medicare Beneficiary Plus (QMB+): AHCCCS (Medicaid) provides full Medicaid coverage and pays the Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). The member may still have copayments for Part D prescription drugs.

• Specified Low-Income Medicare Beneficiary Plus (SLMB+): AHCCCS (Medicaid) provides full Medicaid coverage and pays the Medicare Part B premium. Generally, if the service or benefit is covered by Medicare and AHCCCS (Medicaid), the cost share is paid by AHCCCS (Medicaid). The member may have cost sharing for services or benefits not covered by AHCCCS (Medicaid).

• Full Benefit Dual Eligible (FBDE): AHCCCS provides full Medicaid coverage and may provide some assistance with the Medicare cost sharing. Generally, if the service or benefit is covered by Medicare and AHCCCS (Medicaid), the member's cost share is paid by AHCCCS (Medicaid). The member may have cost sharing for services or benefits not covered by AHCCCS (Medicaid).

For Banner Medicare Advantage Prime and Plus Health Plans, an important protection for members is they only pay their cost-sharing amount when they receive services covered by BMA. BMA does not allow providers to add additional separate charges, called "balance billing." This protection (that the member never pays more than their cost sharing amount) applies even if BMA pays the provider less than the provider charges for a service and even if there is a dispute and BMA doesn't pay certain provider charges.

HIPAA and Disclosures of Protected Health Information for Extreme Risk Protection Orders

The Office of Civil Rights (OCR) issued guidance to assist in clarifying how HIPAA Privacy Rules allow covered health care providers to disclose protected health information (PHI) to support applications for extreme risk protection orders which temporarily prevent a person in crisis who

poses a danger to themselves or others from accessing firearms. This recent update from OCR provides new guidance to support an extreme risk protection order on how HIPAA allows covered health care providers to disclose information about an individual, without that individual's authorization. The Guidance of HIPAA and Disclosures of Protected Information for Extreme Risk Protection Orders can be found at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/extreme-risk-protection-orders/index.html

If you identify or suspect FWA or non-compliance issues, immediately notify the Banner Insurance Division Compliance Department:

24-hour hotline (anonymous reporting): 888-747-7989

Email: BHPCompliance@BannerHealth.com

Secure Fax: 520-874-7072

Compliance Department Mail:
Banner Medicaid and Medicare Health Plans Compliance Department
2701 E Elvira Rd
Tucson, AZ 85756

Contact the Medicaid Compliance Officer Terri Dorazio via phone 520-874-2847(office) or 520-548-7862 (cell) or email Theresa.Dorazio@BannerHealth.com

Contact the Medicare Compliance Officer Linda Steward via phone 520-874-2553 or email Linda.Steward@BannerHealth.com

Banner Medicaid and Medicare Health Plans Customer Care Contact Information
B-UHP Customer Care
Banner - University Family Care/ACC 800-582-8686
Banner - University Family Care/ALTCS 833-318-4146
Banner - Medicare Advantage/Dual 877-874-3930

Banner Medicare Advantage Customer Care
Banner Medicare Advantage Prime HMO – 844-549-1857
Banner Medicare Advantage Plus PPO -1-844-549-1859
Banner Medicare RX PDP – 1-844-549-1859

AHCCCS Office of the Inspector General
Providers are required to report any suspected FWA directly to AHCCCS OIG:
Provider Fraud -602-417-4045 or 888-487-6686
Website -www.azahcccs.gov (select Fraud Prevention)
Mail:
Inspector General
701 E Jefferson St.
MD 4500
Phoenix, AZ 85034
Member Fraud 602-417-4193 or 888-487-6686

Medicare

Providers are required to report all suspected fraud, waste, and abuse to the Banner Medicare Health Plans or to Medicare
Phone: 800-HHS-TIPS (800-447-8477)
FAX: 800-223-8164
Mail:
US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026