Banner
University Health Plans

www.BannerUHP.com
(800) 582-8686, TTY 711
Fax: (520) 874-5555

Provider Newsletter

July 11, 2022

New Limits on Diabetic Monitoring Supplies Covered Under B – UFC/ACC Plan

Banner – University Family Care/ACC members will be impacted by new rules that go into effect Aug. 1.

How many glucometers can be prescribed and filled?
Effective Aug. 1, 2022, quantity limits for AHCCCS will be set at 1 glucometer per member annually.

What happens if a member breaks their diabetic glucometer, it is not functioning properly or it is lost or stolen?
Additional glucometers can be approved through the PA process for broken, lost or stolen devices.

How many diabetic test strips can be prescribed and covered?
Diabetic test strip quantity limits will be set at 100 test strips per 90 days for members with low risk of hypoglycemia, 150 test strips per 90 days for members with increased risk of hypoglycemia and 300 test strips per 90 days for members on insulin, or newly diagnosed.

What if a member needs a larger quantity of test strips?
Prior Authorization process should be followed for high utilizers using more than 300 test strips per 90 days including members utilizing insulin and routinely checking four or more times per day, pregnancy, high risk of severe hypoglycemia, children less than 18 years and those on an insulin pump.

Is there a maximum number of test strips that can be prescribed?
A maximum of 900 test strips every 90 days, or checking blood sugar 10 times per day, will be covered.

Newer Anti-diabetic Medication Coverage for B – UFC/ACC Members

Prior Authorization (PA) criteria has been established for SGLT-2 inhibitors, GLP-1 agonists and DPP-4 antagonists. There are various options under each of these drug classes on the AHCCCS plan and each **does** require that a PA request be completed by the physician's office. Criteria is set based of the American Diabetes Association and American Association of Clinical Endocrinologist guidelines as well as the FDA approved indications.

Brand Name Coverage Changes for B – UFC/ACC Members

We wanted to let you know that effective Aug. 1, 2022, we will no longer cover the brand name Herceptin and Rituxan products per AHCCCS guidance for our Banner – University Family Care members. Both products now have multiple biosimilar products that will be covered by our plan per AHCCCS guidance, replacing the brand name product.

The following changes are effective Aug. 1, 2022:

Updated covered product name	HCPCS code for covered product	No longer covered product name
Herzuma	Q5113	Herceptin
Kanjinti	Q5117	Herceptin
Ogivri	Q5114	Herceptin
Trazimera	Q5116	Herceptin
Riabni	Q5123	Rituxan
Ruxience	Q5119	Rituxan
Truxima	Q5115	Rituxan

Updates to our Prior Authorization grids will be available on our website at:https://www.banneruhp.com/materials-and-services/prior-authorizations-and-referrals#Prior-Authorization-Grids.

Medicare Pricing Update

Banner is implementing an updated Medicare pricing software, Burgess Source, on June 21, 2022.

This update was necessary to ensure proper payments and/or denials based on current Medicare coding and/or payment regulations. This should not affect rates for CPT/HCPC codes that are called out in your contract.

For claim denials, the Evidence of Payment (EOP) will reflect the denial message, based on Medicare guidelines.

We are not anticipating any issues during this transition. Please notify the Provider Experience Center if you find items that need to be addressed. Banner teams will work diligently to resolve any concerns that do come up.

Banner Health Invests in Atlas Healthcare Partners

Partnership Expands and Diversifies Banner's Ambulatory Delivery Platform

Atlas Healthcare Partners (Atlas), which specializes in developing and managing ambulatory surgery centers (ASCs) in partnerships with health systems and physicians, announced today

that Banner Health has invested into Atlas.

"Based on the significant growth and success that Banner and Atlas have achieved together through our Banner Surgery Center network joint venture, it was a logical next step for Banner to invest in Atlas to help the company scale and grow into a larger national partner for other health systems as well," said Scott Nordlund, Banner's chief strategy and growth officer. "Banner's decision to invest in Atlas aligns us at the management company level in addition to the regional joint venture and local ASC levels and creates a unique surgery center management company focused on creating strategic partnerships with health systems including ASC network development, investment and operations."

Atlas formed a joint venture partnership with Banner in 2018 to develop and operate a network of ASCs in Arizona, Colorado, and Wyoming. This strategy has resulted in significant growth over the last three years, expanding from eight ASCs to 26, growing volume 155 percent and growing revenue by 475 percent. The Banner Atlas joint venture expects to double in size and own and manage over 50 ASCs by the end of 2025.

"We're excited to expand our partnership with Banner" said Atlas Healthcare Partners CEO Aric Burke. "Our multi-level partnership with Banner serves as an innovative model for other health systems seeking to develop and implement a fully integrated ASC strategy that aligns all parties; health system, management company, physicians, patients and communities."

Arizona locations can be found on the Banner Health website link below.https://www.bannerhealth.com/locations?loctype=Surgery%20Center

AHCCCS Updates

Provider Participation Modifier Deadline Extended Until Oct. 1, 2022

AHCCCS has extended the deadline for providers to begin reporting the individual practitioner who rendered services on professional and dental service claims until October 1, 2022. This requirement impacts all claims for AHCCCS providers registered as integrated clinics (Provider Type IC), behavioral health outpatient clinics (Provider Type 77), and clinics (Provider Type 05).

AHCCCS and its Managed Care Organizations **will deny claims** for dates of service on and after Oct. 1, 2022 if the individual practitioner who performed the services associated with the clinic visit is not reported.

See Exhibit 10-1 of the AHCCCS Fee-For-Service Provider Billing Manual for billing instructions for proper claims submissions.

Questions? Contact David Rudnick at david.rudnick@azahcccs.gov.

HEDIS Talk! – Transitions of Care (TRC)

Our goal is to improve the quality of care your patients receive when transitioning from an inpatient setting to home. The HEDIS Transitions of Care (TRC) measure helps to improve the transition process by incorporating time-sensitive elements known to reduce hospital readmission, costs and adverse events.

Too often patient transitions from inpatient settings (hospitals, SNFs, etc.) to home can result in poor outcomes, including communication lapses, intentional and unintentional medication changes, incomplete diagnostic workups, and possible misunderstanding of diagnosis by patient or caregiver.

Currently, the HEDIS Transitions of Care measure requires four steps:

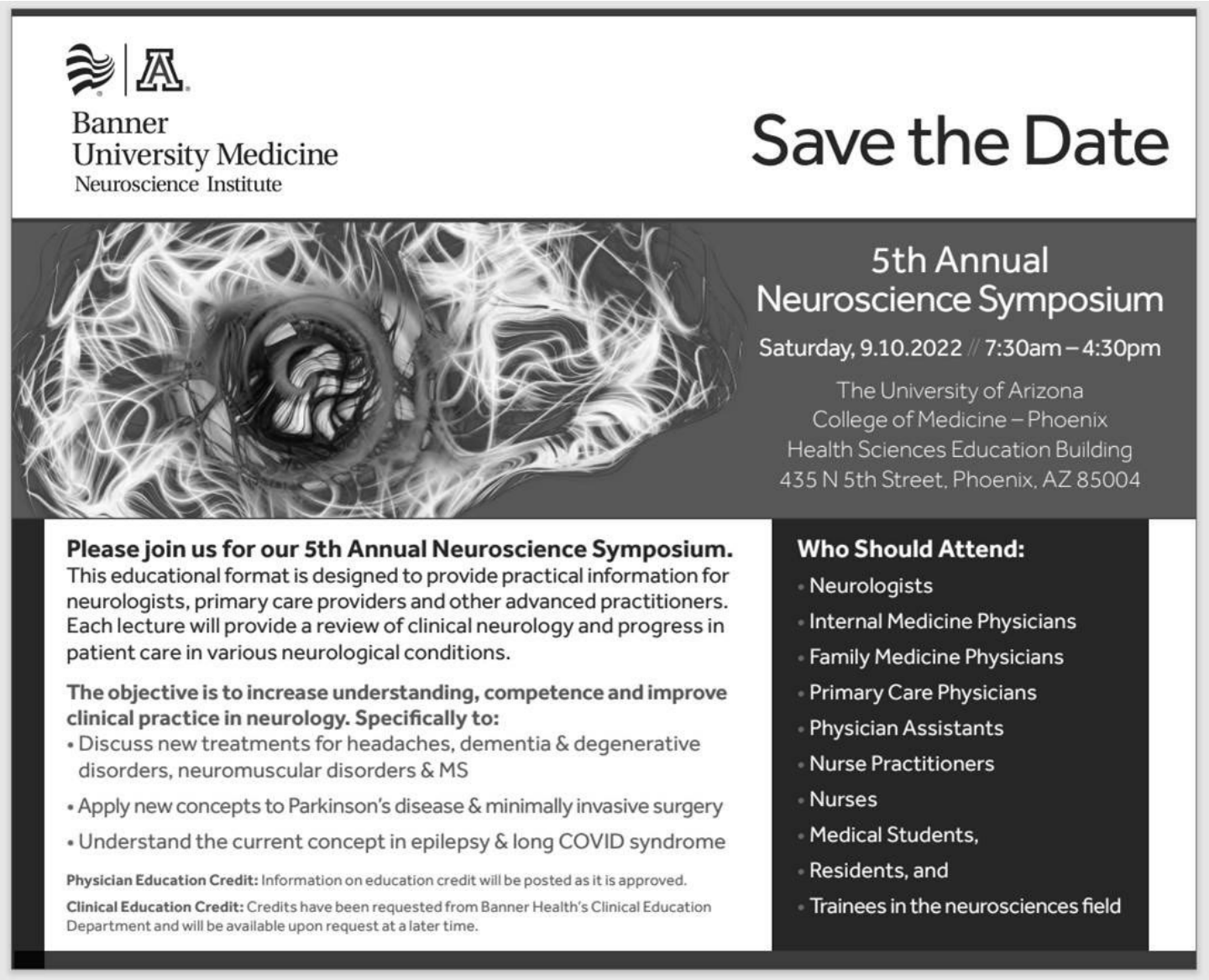
- *Notification of Inpatient Admission*.
    - Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- *Receipt of Discharge Information.*
    - Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- *Patient Engagement After Inpatient Discharge*.
    - Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- *Medication Reconciliation Post-Discharge*.
    - Documentation of medication reconciliation on the date of discharge, through 30 days after discharge (31 total days).

It's important to start thinking about how to implement tools and programs to help improve care coordination for your patients post discharge now.

We are here to help! Reach out to your Care Transformation Consultant if you have any questions. If you are unsure of who your representative is, you may send an inquiry to BUHPProviderNotifications@bannerhealth.com.

Look for more helpful HEDIS education and resources in future newsletters.

Together we can make a difference in our members' lives through excellent patient care.



Summer Heat Awareness for Heart and Lung Patients

The summer months can be exceptionally difficult for patients living with heart and lung disease. Banner Home Care provides therapy options that can help these patients reduce emergency room visits and hospitalizations during the heat of the summer.

- Home Infusion Therapy
  - Antibiotics – for infections (Bacterial PNS)
  - Antiemetics – for nausea and vomiting
  - Diuretics – for fluid overload
  - Hydration therapy – to rehydrate and boost immunity
  - Inotropic therapy – to manage heart failure
  - Steroids – to reduce inflammation

- Home Medical Equipment
    - Airway clearance vests – to help mobilize and clear secretions
        - Prevent and reduce reoccurring lung infections (PNA)
        - Prevent and reduce exacerbations
    - Non-invasive ventilation (Trilogy/Astral Bi-pap)
    - Long term NIV therapy at home for stable hypercapnic COPD patients reduces:
        - Exacerbations
        - Risk of mortality
        - Frequent emergency room visits and hospitalizations

Service:	**Phoenix**	**Tucson**
Home Infusion contact	P: 480-657-1000 F: 480-657-1782	P: 520-694-2491 F: 480-657-1782
Home Medical Equipment contact	P: 480-657-1600 F: 1-888-403-4114	P: 520-694-0118 F: 1-888-403-4114

Office of Individuals and Family Affairs (OIFA)

Peer Recovery Support Specialist Continuing Education and Ongoing Learning Requirements

AHCCCS Medical Policy Manual (AMPM) 963-Peer and Recovery Support Service Provision Requirements speaks to ensuring providers that employee and individuals employed as Certified Peer Recovery Support Specialists (PRSS) have access to a minimum of four hours of continuing education and/or ongoing learning per year. These must be relevant to peer support and at least one hour covering ethics and boundaries related to the practice of peer support.

Banner – University Health Plans (B – UHP) Office of Individual and Family Affairs (OIFA) wants to assure these continuing education and ongoing learning requirements are met. You can find resources on pg. 46 of the Banner – University Family Care ACC and ALTCS Provider Manual (B – UFC) https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories#Provider-Manuals.

In addition, these can also be found on our B – UHP Health Care Provider website in two places https://www.banneruhp.com/resources/mental-health-substance-use and https://www.banneruhp.com/resources/child-and-family-support under Peer and Family Workforce.

For additional PRSS continuing education and ongoing learning resources or question about this requirement outreach B – UHP OIFA through our general mailbox OIFATeam@bannerhealth.com.

Behavioral Health Clinical Chart Audits Resuming

Health plans are required to conduct medical record compliance audits of behavioral health outpatient clinics, behavioral health outpatient integrated clinics and behavioral health residential facilities. This process was paused during the pandemic, but it has recently resumed. (The requirements can be found in the AHCCCS Medical Policy Manual Chapter 900, Policy 910, Attachment 910A and Policy 940). In addition, B – UFC will conduct concurrent treatment modality fidelity audits for applicable providers.

The Audit Process: What to Expect and How to Prepare

Medical record reviews will be conducted remotely utilizing a provider's electronic medical record (EMR) where applicable to lessen provider burden. Please be sure to designate a staff member to assist with EMR setup one week prior to the audit to work out any issues that might cause any delays.

A B – UFC quality management representative will notify a provider of their scheduled audit at least 2 weeks prior to the start date either by secure encrypted email or letter. Audit notification, at a minimum, will include the following information:

- Start and End Date of the Audit
- Sample and Over Sample List if applicable
- AHCCCS Audit Tools & Operational Definitions applicable to the Audit Sample
- Audit Review Period

Medical record audit data will be recorded daily by the assigned B – UFC quality management representative. The audit will take approximately 1-2 weeks to complete. Please also designate a point of contact to answer the QM representative's questions or requests during the audit.

An exit interview will be conducted by the assigned QM representative at the end of the scheduled provider audit in which areas of strength and areas of refinement will be discussed. Technical assistance will be provided in reference to any of the individual standards of the audit tool(s) that did not meet the minimum performance standard (MPS) of 85 percent.

A summary of the technical assistance provided will be sent by secure encrypted email to the provider staff at the end of the provider's exit interview. Final audit results will be sent within 30 days of the provider's exit interview to ensure all data entered is accurate.

We appreciate your collaboration with the audits in advance. If you have any questions regarding the audit, please contact Jennifer.Lewusz@bannerhealth.com

Provider Manual Updates

Updates to the B – UHP Medicaid Provider Manual have been made and will be effective **Aug. 8, 2022.**

Reminder: These updates can be found on BannerUHP.com under the Banner – University Family Care (ACC and ALTCS) Provider Manual.

Key updates and changes:

- Revised the following sections:
  - Added language for DME Delivery to align with AHCCCS Policy AMPM 310-P. Pg. 3.
  - Added language to ensure that the provider sites where provider care management services are delivered have regular and ongoing member and/or family member participation in decision making, quality improvement, and enhancement of customer service. Starting on Pg. 40
  - Added new section for Peer Support Employment Training Programs Curriculum Monitoring, Development, and Enhancement. Pg. 50
  - Added additional advance directive language to existing section. Pg. 131 and 132

Adult System of Care

Crisis and Safety Plan

A Crisis and Safety Plan provides a written method for potential crisis support or intervention that identifies needs and preferences that are most helpful in the event of a crisis.

A Crisis and Safety Plan shall establish goals to prevent or better the effects of a crisis using techniques for establishing safety, as identified by the member and/or healthcare decision maker, as well as members of the Child and Family Team (CFT) or Adult Recovery Team (ART).

Key to members' behavioral health treatment and recovery is developing crisis and safety plan at intake/assessment, discharge coordination when the member is impatient and/or BHRF services.

For additional information refer to the B – UHP Provider Manual and AMPM 320-0 https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories#Provider-Manuals

Resources: https://www.banneruhp.com/materials-and-services/behavioral-health

Provider Services & Support

Provider Data Updates Notification Process Change

B – UHP strives to maintain an accurate and current Provider Directory. This allows our members to be able to select and contact you. Please notify us immediately of changes within your practice, including:

- Address changes
- Open or close panels
- Adding or removing a practitioner
- Key contacts, phone, fax numbers
- TIN changes or corporate structure changes
- Other demographic changes

All AHCCCS plans will implement the use of the AzAHP forms for notification of provider and organization updates. We hope this standardization will remove the duplicative work on you and your team. The standardized form with make it easier for you to complete one form and submit to all AHCCCS plans you work with.

Our current Provider Data Update form which is located on our website www.banneruhp.com/materials-and-services will be discontinued on Sept. 30, 2022.

Beginning Oct. 1, 2022, you will be required to submit the most current AzAHP form(s) for any new additions, updates, terms and changes.

The AzAHP forms are located on the website https://www.banneruhp.com/join-us/join-our-network. You will find the AzAHP Practitioner Data Form, Practitioner Practice Form, and the Organization Facility Form. When submitting a request, please complete the appropriate form and email the completed form and supporting documents directly to the data department at BUHPDataTeam@bannerhealth.com.

Employment Competencies

As you may know, several requirements have been updated relating to staff who direct behavioral health services to members. Rather than focusing solely on training, there has been a shift to focusing on staff competency in specific areas.

The Competency Skills checklist was created to ensure that staff has the skills needed to assist members and is adept in delivering employment services and supports. A copy of this Competency Skills Checklist can be found in Relias and for more information on using the tool, please visit https://azahp.org/wp-content/uploads/2022/03/Competency-Skills-Checklist-ACOM-447_FINAL_2021.pdf
There are Four Employment Competencies:

- Member engagement
- AMPM Policy 310-B and AHCCCS Behavioral Health Services Matrix
- Disability Benefits 101 (DB101)
- RSA/Vocational Rehabilitation

Within each of those competencies, staff must meet a certain level (Employment staff level 3 or greater, non-employment staff level 1 or greater). The Competency Skills checklists shall be completed within 90 days of hire for new employees, and existing employees shall have it completed as soon as possible. The Competency Skills Checklists shall be completed on an annual basis for each staff.

AHCCCS recognizes that some supervisors may be unfamiliar with the topics related to employment service delivery and therefore have created the Job Aid for Supervisors which can be located here: https://azahp.org/wp-content/uploads/2022/03/Competency-Job-Aid-for-ACOM-447_FINAL.pdf

For more information on Employment Competencies, you can reference the new FAQ located at https://azahp.org/wp-content/uploads/2022/04/CSC-for-Employment-FAQ_FINAL.pdf

ADA Compliance and Healthcare Requirements: Effective Communication with Patients

Title III of the Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability in places of public accommodation. The law requires that covered entities such as hospitals and health care providers ensure effective communications with people who have communication disabilities. The goal is to ensure equal and effective communication for people with and without disabilities. According to the ADA, the term "auxiliary aids and services" are the ways to communicate with people who have communication disabilities. The ADA requires covered entities to provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities.

One type of auxiliary aid and service is Augmentative Alternative Communication (AAC) devices. There are many types of AACs ranging from high-tech devices to simple dry erase boards. Recent complaints from advocacy groups report issues with behavioral health residential facilities and the use of AAC for patients. Providers are reminded about the requirement to comply with the terms of the ADA, including offering reasonable accommodations to individuals with disabilities. A provider may only replace an AAC device with an alternate communication device if an individual presents an immediate risk of harm to self or others, other interventions have failed, and the alternate communication device is an effective means of communication. For more information on ADA compliance, please see these resources:

Pacific ADA Center: https://adapacific.org

Reference Guide: https://adata.org/factsheet/health-care-and-ada

Compliance Corner

Provider Audits to Resume

All Medicaid Health Plans are required to conduct provider audits to compare claims to medical record documentation to determine if the documentation supports the billing. These audits were suspended by AHCCCS in the spring of 2020 due to the Public Health Emergency (PHE).

On June 15, 2022, AHCCCS announced that the audits could resume effective immediately. These audits are required by AHCCCS, but Banner Medicaid and Medicare Health Plans include all lines of business. Providers are randomly selected for these audits and will be provided ample notice of the intent to audit. Sixty days prior to the audit dates, the provider will be sent a letter requesting medical records for approximately fifteen members and thirty claims. Even though the request allows for ample time to send the medical records, as a reminder, providers are obligated per their contracts to furnish at no charge copies of all medical records, x-rays, laboratory reports, or any other patient information within ten working days of the receipt of the request.

In addition, some audits may be conducted on site at the provider's office. If this is the case, the letter will provide information related to this type of audit and the auditor will contact the provider's office to make arrangements for the audit.

Medical records are generally provided through fax. The Compliance Department has a dedicated fax number of (520)874-7072. There is also a Department Email that could be utilized to send records if they are sent securely (encrypted). That email is BHPCompliance@bannerhealth.com. If these methods are not available, they can be mailed to the Banner Health Office at the following address:

Banner – University Health Plans
Compliance Department
2701 E. Elvira Road
Tucson, AZ 85756

Once the audit has been completed, the auditor will supply a findings letter and information on next steps. Next steps could be recoupment of claims billed incorrectly, requests for additional documentation, education for the provider, and information on how to resubmit a corrected claim. If during the audit, fraud, waste, or abuse is suspected, a referral will be made to the applicable regulatory agency.

Common errors the auditors have identified during previous audits include the following types of errors:

1. Progress notes not signed appropriately – Progress notes are required to be signed and dated by the rendering/treating provider after each appointment and/or procedure prior to being billed. What we see are notes that say pending; notes that are signed up to a year later; notes that are signed by someone on behalf of the provider or notes with no signature or date. These examples make the note invalid.

2. Services billed under the NPI of a provider who did not render the service for an AHCCCS service - For AHCCCS, providers are required to bill the claim under the NPI of the provider who rendered the service. Incident-to-services that are allowed under Medicare for Mid-levels to bill under a supervising physician is not allowed under AHCCCS. The PA and NP must be registered with AHCCCS and credentialed. If it is not billed under the rendering provider, the claim is null and void.

3. Upcoding of Evaluation and Management Services – Coding Guidelines require medical documentation to support the proper evaluation and management code billed. What we see in practice is that the provider's progress note does not support the level of service billed. Frequently, we are hearing some providers are using autofill and auto-prompts to facilitate and improve documentation, coding, and billing. If used inappropriately, these tools can suggest a higher billing code than the actual services furnished warrant.

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 Road
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 Adam Barker via phone (602) 747-8452 or email Adam.Barker@bannerhealth.com

Banner Medicaid and Medicare Health Plans Customer Care Contact Information
B – UHP Customer Care
Banner – University Family Care/ACC: (800) 582-8686, TTY 711
Banner – University Family Care/ALTCS: (833) 318-4146, TTY 711

Banner Medicare Customer Care
Banner Medicare Advantage Dual HMO D-SNP: (877) 874-3930, TTY 711
Banner Medicare Advantage Prime HMO: (844) 549-1857, TTY 711
Banner Medicare Advantage Plus PPO: (844) 549-1859, TTY 711
Banner Medicare RX PDP:(844) 549-1859, TTY 711

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
801 E Jefferson Street
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