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University Health Plans

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Provider Update

Jan. 13, 2023

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Post-Flu Recovery Tips and Questions Answered

Kick off the new year right! Talk to your patients about some post-flu recovery tips and help answer their questions. Share our Banner Health blog article *Post-Flu Recovery Tips and Questions Answered* - https://www.bannerhealth.com/healthcareblog/teach-me/post-flu-recovery-tips-and-questions-answered

BUHP PA Grid changes for 2023

Prior authorization is NOT required for members <21 years of age for PT/OT/Speech services. We ask that you not submit a request to eviCore. Please note: Limits may be in place for the number of units allowed per month and/or maximum amounts for the plan. (Please refer to the AHCCCS Medical Policy Manual for limitations related to any coverage limitation for therapy services.)

Also, CPT code 77427 (radiation) no longer requires prior authorization (we ask that you do not submit a request to eviCore).

The Prior Authorization Grid for 2023 will be available on the online provider portal no later than Jan. 15, 2023.

ATTENTION: Home Health Agencies
REGARDING: HCPCS Codes G0299 and G0300 Billing

To relieve provider administrative burden and related costs, providers will be permitted to zero (0) fill the Medicare payment information (indicating no payment by Medicare). This will indicate that the services billed on the claim using HCPCS Code G0299 or G0300 do not meet Medicare guidelines for coverage as Home Health. Following these guidelines will greatly improve the timeliness and accurate processing of your ALTCS claims for these services when Medicare coverage guidelines are not met. If you have any questions about this guidance, please contact your Care Transformation Specialist or the Provider Experience Center.

2023 Pharmacy Network Update

You may have heard about ongoing negotiations between Express Scripts and Kroger (Fry's Food & Drug locally). We have secured a direct network agreement with Kroger to remain in our B – UHP pharmacy network. Due to this direct agreement, there will be no impact to our Banner members who utilize Kroger/Fry's.

EPCS Requirements enforcement effective Jan. 1, 2023

Effective Jan. 1, 2023, CMS will be enforcing the EPCS requirements and will be sending non-compliance notices via either physical letter or email to all prescribers in violation of the EPCS requirement. EPCS requirement is prescribers must electronically prescribe at least 70% of their schedule II, III, IV and V controlled substances that are Part d drugs. CMS will identify compliance using PDE data from the evaluated year as soon as it becomes available. Beginning in 2024, CMS will be issuing compliance actions (punitive measures) if EPCS requirement is not met.

Exempt prescribers are those who:

- prescribe fewer than 100 Part D controlled substance prescriptions. However, important to note that once the prescriber reaches more than 100 Part D controlled substance prescriptions the EPCS requirement (70%) would be applicable.
- prescribe during a recognized emergency, such as a natural disaster, a pandemic or a similar situation, where there is an environmental hazard. CMS will identify prescribers who meet this exception by the address listed in the either PECOS or NPPES systems. If provider's address within these systems is not within the emergency/disaster area as declared by Federal, State or local government the prescriber will not be exempt from the EPCS requirement.

Banner Children's

Banner Children's FREE Virtual Lunch Lecture Series

Join us monthly for a free virtual lecture series happening the first Wednesday of each month. This educational lunchtime lecture hosts a different pediatric specialist to share informational content to providers. Each lecture offers 1 CME credit.

When: Wednesday, Feb. 1, 2023

Time: Noon – 1: 00 p.m.

Speakers: Pediatric Sleep Medicine specialists, Dayana Dominguez Batista, MD and Andrew R. Valenzuela, MD

Topic: Sleep 101: Common Sleep Disorders in Children

At this lecture, speakers will share:

- Overview of sleep disorders by age group
- Identifying sleep disordered breathing and high-risk populations
- Introduction to insomnia and treatment approaches
- When to refer to sleep medicine

Add event to calendar: https://bit.ly/3GJLp4d

Join via Microsoft Teams: https://bit.ly/33ej6gq

*Banner Health is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Banner Health designates this virtual activity for a maximum of **1 AMA PRA Category 1 Credit™**. Physician should claim only the credit commensurate with the extent of their participation in the activity.*

Dayana Dominguez Batista, MD, Andrew R. Valenzuela, MD and the series planners have reported no financial relationships.

CME credit is available to Banner Health staff, Banner Health Network and affiliated providers only.

An Important Message from AHCCCS: EVV (Electronic Visit Verification) edits implemented Jan. 1

The implementation for the EVV (Electronic Visit Verification) hard claim edits was effective Jan. 1, 2023; thank you for working hard to comply with EVV. We understand it has been a learning curve and an adjustment for everyone: members, families, direct care workers, provider agencies and health plans.

The AHCCCS Team is available to support you, to answer questions, to provide technical assistance, and ensure your seamless transition to full EVV compliance. You may reach the AHCCCS team using the EVV@azahcccs.gov inbox, which is closely monitored to ensure our responsiveness to your needs.

Key EVV Topics for Providers

During the next few months, AHCCCS will share information about the most pressing topics of the day based on our day-to-day interactions with you.

The first two topics are **hard claim edits** and **scheduling**.

Hard Claim Edits

Hard claim edits DO mean that:
Providers need to comply with EVV in order to get paid.

Beginning Jan. 1, 2023, EVV compliance is being enforced to make sure claims don't get paid unless all the required data in the federal regulation is present. AHCCCS is required to enforce EVV compliance for providers in order to maintain compliance status with the Centers for Medicare and Medicaid Services (CMS).

Hard claim edits DO NOT mean that:
Providers won't ever get paid if something goes wrong.

It is understood that sometimes things go wrong, and some required data may not be captured when care is provided. Despite this, providers and direct care workers can still get paid as long as the missing data is entered into the system or reconciled by the agency administrator through the visit maintenance process. Providers can use a checklist to help assess whether or not a visit is ready to be billed and what they need to do in order to get it to a billable state. You can find the checklist here:
https://www.azahcccs.gov/AHCCCS/Downloads/EVV/EVVBillingChecklist.pdf

See these FAQs (Visit Maintenance and Audit Documentation FAQ (azahcccs.gov) that explain how to document the missing information, including roughly 30 different examples of real-life events that might result in missing information and how to get those visits to a billable state.

Scheduling

Scheduling Requirements DO mean that:
AHCCCS requires a schedule for pre-planned visits.

The schedule will help to track and monitor access to care by helping to tell the story of service delivery. It is simply a plan for service delivery that is informed by the member and their families' needs and preferences. With a schedule, we can see if a planned visit was late or missed altogether. After talking with the caregiver and member/family, the agency administrator can document the reasons why a visit was late or missed. Was the missed visit due to the member's preference? Was it simply a caregiver error where they may have forgotten to log in? Was there an issue with the device? It will help to understand the reason(s) why the visit didn't occur as originally planned and if there are reasons that are not concerning (i.e., the member didn't want service at that time) or if there are concerning reasons (i.e., caregiver did not show up).

Scheduling Requirements DO NOT mean that:
Care must be provided within the exact scheduled window of time or care can't happen on demand.

Schedules are not meant to be inflexible, nor do they dictate the member/family's day-to-day living choices. AHCCCS has provided many flexibilities, including the allowance of unscheduled visits (to account for everyday life events) as long as there is an explanation and resolution when a caregiver does not show up as planned. Scheduling does not require the caregiver to wait to log in in order to provide services. It is important to be aware that visits are not considered late until an hour after the scheduled start time.

For more information on scheduling, please visit our Scheduling FAQ (www.azahcccs.gov/AHCCCS/Downloads/EVV/ScheduliingFAQ.pdf) on the EVV (www.azahcccs.gov/AHCCCS/Initiatives/EVV/

Banner's Got Your 6! Campaign

Banner recognizes the struggle veterans, and their families face when trying to access services and resources. This incredible group is comprised of our friends, neighbors, co-workers, and family members. That is why Banner cares and why **Banner's Got Your 6!**

To better meet the needs of veterans and their families in Central and Southern Arizona, **Banner's Got Your 6** will help provide service delivery and access to necessary resources, which are often separated and difficult to find and navigate. We are developing a comprehensive list of resources and providers who serve veterans. The information about services and supports available in Central and Southern Arizona will be housed on our Health Plan sites. The list will include behavioral health providers, community agencies, the US Dept. of Veteran Affairs (VA), the Arizona Department of Veterans, BeConnected, the Arizona Coalition for the Military Family, and more.

Special Considerations for Veterans

There are many myths regarding medical care of the veteran population. Here are three helpful facts concerning the care and insurance coverage of veterans.

1. **Service-connected disabilities.** A service-connected disability means a disability or injury suffered during the execution of their duties while serving in the military. If an individual has a service-connected disability, that has been identified by the US Dept. of Veteran Affairs (VA) and they have been given a disability rating, the VA will cover the cost of this care for the disability. A veteran may have a disability rating between 0%-100%. A 0% disability rating for a service-connected disability or injury is still a rating.
2. **Dishonorable Discharge.** Members who received a Dishonorable Discharge are most likely not eligible for benefits from the VA. This information can be found on the members DD Form 214 and confirmed with the VA.
3. **Military Service.** Even if an individual served in the military, they may have never received any VA disability benefits. This phenomenon is more prevalent among those who served during the Vietnam conflict. Some of these individuals may still be eligible for VA benefits. To confirm benefits, the veteran should contact the Arizona Department of Veterans and speak with a Veteran Benefits Counselor.

Impact of SUD on oral, physical, mental health

There is a strong correlation between oral health, physical health, mental health and substance use. Much of the research seems to focus on the direct consequences that Substance Use Disorder (SUD) can have on an individual's oral health and are the result of neglected self-care. Oral health complications are associated with a spectrum of addictive behaviors such as poor hygiene, aggression or directly exposing oral tissues to drugs. This can often lead to broken, infected or extracted teeth. While it is common that people in active addiction ignore health problems and tend to seek care only in advanced stages or with severe symptoms, it is also important to keep in mind the effect oral complications can have on mental health and SUD recovery process.

Pre-existing oral health issues can impact SUD treatment and recovery. It is a common perspective that a recovering addict may feel inferior regarding oral health issues and it may have a profound effect on a member's anxiety level or self-esteem. It is equally significant that we consider the physical and mental health comorbidities that contribute to overall health due to the inability to chew healthy food properly. The association between oral health and quality of life could indicate the presence of severe oral discomfort and the impact it has on a member's quality of life. Dental complications could present as, or exacerbate, the compulsive symptoms of addictive behaviors. The result of the increased risk behaviors could then manifest as a cycle of disparity in a member's Social Determinants of Health (SDoH). Some examples include: relapse, loss of employment, dropping out of school, isolation, justice involvement or homelessness.

Presently, there are several ways in which the Banner provider network can support whole person care within the adult General Mental Health Substance Use (GMHSU) population. One productive approach could be to include the member's oral health when assessing and providing resources. Secondly, providers should understand that some "behavioral" symptoms may stem from physical issues relative to oral health and poor quality of life. The goal is to support the member and help shift the focus to ***restorative/preventative dental care.*** This will help reduce the number of dental emergencies, prevent the persistent cycle of disparity and empower the member to improve their overall quality of life.

If you have any questions about the emergency dental benefits in Arizona, please refer to AMPM 310-D1 – www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310-D1.pdf

Biosimilars: Are They the Same Quality?

What are biologics?

Biologics (also called biological products) include a wide range of products such as vaccines, monoclonal antibodies, blood components, allergenics, gene therapy, tissues, and proteins.

- Biologics are medicines that generally come from living organisms, which can include animal cells and microorganisms, such as yeast and bacteria.
- They are used to treat a variety of diseases and conditions, such as cancer, kidney diseases and autoimmune diseases.

What are biosimilars?

A biosimilar is a biologic that is highly similar to another biologic that's already FDA-approved, called a reference product. Biosimilar have no clinically meaningful differences from their reference product in terms of safety, purity and potency.

Biosimilars have the same:

- Route of administration to patients
- Potential side effects
- Strength and dosage form

Biosimilars are approved for many biologic reference products, including: Avastin, Epogen/Procrit, Enbrel, Humira, Herceptin, Lantus, Lucentis, Neulasta, Neupogen, Remicade and Rituxan.

Note: Biosimilars can improve patient access to quality medicines – Biosimilars are versions of brand name biologics that may offer more affordable treatments options to patients, like generic drugs.

Understanding the quality of biosimilar products
Biosimilars are rigorously tested by their manufacturers following the same robust quality assessments as their reference products. These assessments are performed in accordance with the Current Good Manufacturing Practice regulations enforced by FDA.

What steps are involved to help ensure quality biosimilars?

- Extensive research and comparative studies are conducted by the manufacturers to demonstrate high similarity to the reference product.
- Studies directly comparing the biosimilar to the reference product to demonstrate no clinically meaningful differences in safety, purity and potency.
- FDA review of data required for approval of a biosimilar.
- FDA inspections of the biosimilar manufacturing facilities.
- Post-market drug safety surveillance by FDA and biosimilar manufacturers.

Visit www.usp.org/about/convention-membership and www.fda.gov/drugs/biosimilars/patient-materials to learn more.

Providers may also access free accredited continuing education courses (Biosimilars & Interchangeable Products) for health care providers if they have a Medscape account.

Maternal and Child Health

Maternal & Child Health – OB, Pediatric and CRS Care Coordination

The B – UHP 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 health throughout the member's pregnancy and postpartum periods. Care Managers help link mothers to medical, behavioral and community-based resources. We provide direct member support and promote compliance with prenatal care appointments, prescribed medical care regimens and postpartum follow-up. B – UHP places a critical importance on early and regular maternity health care. A provider's early submission of the **Notice of Pregnancy**

(NOP) form to the Health Plan is a 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 is available to support 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. They work 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 health care needs.
- **Children's Rehabilitative Services (CRS)** – The health plan's MCH department has a special team of CRS coordinators who focus on supporting our current and former CRS-enrolled members, their families and their providers. Our CRS team is also available to help manage the complex application process for members who may have CRS eligible conditions, including eligibility review and facilitating any required follow-ups necessary to prepare comprehensive application packets and facilitate successful outcomes.

REFERRALS or requests for assistance with any OB (prenatal or 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.

Tdap Vaccine Recommended in Pregnancy

The American College of Obstetricians and Gynecologists (ACOG) recommends that all pregnant women receive a Tdap shot between 27 and 36 weeks of each pregnancy. The Tdap shot is a safe and effective way to protect women and their babies from serious illness and complications of pertussis (whooping cough). Additionally, it is safe to get the Tdap vaccination at the same time as the influenza and COVID-19 vaccinations. If a mother does not get her Tdap vaccination during pregnancy, she can get it immediately postpartum. If she is breastfeeding her baby, there may be some protection passed on to the newborn through her breastmilk. ACOG also recommends that any adults who have not had a Tdap vaccination get one at least two weeks before interacting with a newborn. Please talk to your patients and their families about the importance of getting the Tdap vaccine during pregnancy. If your patient is covered by a Banner – University Health Plan, and she is having difficulty getting her vaccination, please have her call Banner − University Family Care Customer Care Department at 1-800-582-8686 and ask to speak to an OB Care Manager.

Postpartum Depression and Perinatal Anxiety Screenings

Regular screening for depression and anxiety is very important both during and after a woman's pregnancy to help ensure the best outcomes for both mother and newborn. AHCCCS requires all maternity care providers to complete Perinatal and Postpartum Depression (PPD) screenings at least once during the pregnancy and then repeated at the postpartum visit. Appropriate counseling and referrals must be provided to any member who has a positive screening for depression or anxiety.

Providers may refer to any norm-referenced validated screening tool to assist the provider in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referrals for Behavioral Health services if clinically indicated.

PPD Screening during EPSDT / Well-Baby Visits:
To improve PPD identification and improve health outcomes of both mother and newborn, providers are required to screen the birthing parent for signs and symptoms of PPD as a required element of EPSDT/Well-Baby visits during the one-, two-, four- and six-month EPSDT visits. Providers are to use a standard norm-criterion referenced screening tool and keep a copy of this screening in the newborn member's record. Positive screening results require referral to appropriate case managers and services at the respective maternal health plan.

CSPMP Screening Requirements for Pregnant Members

Per AMPM (AHCCCS Medical Policy Manual) Policy 410 *Maternity Care Services,* page 7 (item 3.b.) states that Maternity care provider shall ensure that:

- All pregnant members must be screened through the Controlled Substances Prescription Monitoring Program (CSPMP) once during each trimester, throughout their pregnancy.
- Pregnant members receiving opioids must be provided appropriate intervention and counseling, including referrals for behavioral health services as indicated for substance use disorder (SUD) assessment and treatment.

Resources: The CSPMP tracks prescribing, dispensing & consumption of Schedule II, III and IV controlled substances in Arizona, to help mitigate inappropriate use.

- For more information on CSPMP, please visit: https://pharmacypmp.az.gov/about-us/about-cspmp
- General CSPMP Contact Information: 602-771-2732 or pmp@azpharmacy.gov

Consents for Coordination of Care with SUD Treatment Providers

OB providers shall obtain member consent for coordination of care and information sharing with SUD treatment providers. AHCCCS requires all maternity care be provided in compliance with current ACOG (American College of Obstetricians and Gynecologists) standards.

Per the ACOG Clinical Guidance Cmte. opinion #711 (reaffirmed 2021), opioid use disorder in pregnancy should be co-managed by the OB provider and a provider with addiction medicine expertise AND *an appropriate 42 CFR Part 2-compliant consent for release of information should be obtained.*

Maternal MAT Resources

Banner – University Health Plans has a Maternal MAT (Medication Assisted Treatment) services directory available online. The Maternal MAT directory is organized by county and provides a break-down of agencies, services, locations and referral info for each provider's site, at: BUHP Maternal MAT Directory www.banneruhp.com/-/media/files/project/uahp/maternity-care/buhp_material-mat-directory_dec2021.ashx?la=en Or go to BannerUHP.com/materials-

and-services/maternity-care. Scroll to ***Maternal Medication Assisted Treatment (MAT) Services & Resources*** and select the ***Maternal MAT Directory*** **link**.

Agencies listed in this directory are contracted with B – UFC and may not reflect all behavioral health providers.
For additional General Mental Health / Substance Use providers, please refer to the B – UHP Provider Look-Up site at https://www.banneruhp.com/find-a-provider

EPSDT/Well-Child Visit Requirements for Behavioral Health Screenings, Developmental Screenings and Developmental Surveillance

Updates have been posted to the **Children's Services – EPSDT** section of the Banner – University Family Care (ACC and ALTCS) Provider Manual. These updates provide greater depth and detail regarding the requirements for Behavioral Health Screenings, Developmental Screenings and Developmental Surveillance during completion of EPSDT/Well-Child visits.
To see the full text of these changes, click the link to the Provider Manual provided below and navigate to Section 4 – Clinical Services; Children's Services – EPSDT.
https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories#Provider-Manuals

AHCCCS – Division of Health Care Management

Case Management for ALTCS Members

AMPM 520 outlines that Case Management for Arizona Long Term Care System (ALTCS) members is a service rendered by the assigned ALTCS health plan. Consequently, Behavioral Health Providers cannot bill for Case Management T1016 when the member is on an ALTCS health plan

To ensure the physical and behavioral health needs of ALTCS members are addressed, Banner – University Family Care/ALTCS (B – UFC/ALTCS) has a team of Behavioral Health Professionals (BHP) to provide clinical support when ALTCS Case Managers are working with members who have behavioral health needs. The assigned BHP coordinates behavioral health related services and supports. The ALTCS Case Manager coordinates services related to long-term and medical needs. The two roles work in partnership with behavioral health providers to ensure access to services and continuity of care for the member. AHCCCS AMPM 1620-G describes behavioral health standards that apply to ALTCS Case Management.

AHCCCS AMPM 1610 outlines the components related to ALTCS Case Management:

- Person centered service planning and coordination
- Brokering of services
- Facilitation and advocacy
- Review and re-assessment
- Monitor and assess

B – UFC contracted behavioral health providers are an instrumental part of the team and tasked with providing clinical services to the member, such as psychiatric services, individual therapy, family supports and specialized behavioral health placements. Navigating the transition between

health plans and the coordination of clinical care can be complex. Behavioral health providers and PCPs are encouraged to reach out to the ALTCS health plan if they have questions or would like more information about the services.

Transition to the ALTCS Health Plan

Members with special health care needs or circumstances may require additional or distinctive assistance during periods of transition to ensure they do not experience a gap in services. AHCCCS identifies ALTCS members as those who are elderly, physically disabled, designated as Seriously Mentally Ill (SMI) or have a developmental disability that warrants additional assistance during transitions. B − UFC/ALTCS has specific protocols in place to ensure seamless transition between Regional Behavioral Health Authority (RBHA) to ALTCS health plan.

If a member is referred to and approved by ALTCS, the relinquishing health plan is responsible for the coordination of the transition to ALTCS or Tribal ALTCS health plan. The ALTCS health plan is responsible for identifying and addressing any special circumstances of the member and ensuring the continuity of care during the transition.

If a provider has member specific questions about the transition to the ALTCS health plan, they are encouraged to call B − UFC ALTCS Customer Service at 833-318-4146 or email at MemberServicesInquiries@bannerhealth.com

Children's System of Care

Building LGBTQ+ Inclusive Spaces: Enhance Service Delivery and Create a More Inclusive Environment

Youth who identify as part of the lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ+) community are at higher risk for suicide, depression and substance use. LGBTQ+ youth may face additional challenges when accessing physical and behavioral health services such as stigma, lack of family support and non-affirming providers. Behavioral health and physical health providers can support LGBTQ+ youth in variety of ways, including ensuring the environment is safe and welcoming.

Creating an Inclusive and Welcoming Environment:

- Stay informed and up to date on the issues impacting the LGBTQ+ community
- Provide routine and ongoing education to staff and discuss the ways implicit bias might impact service delivery
- Get familiar with and comfortable using the terminology
- Utilize posters and educational materials that show racially and ethnically diverse same sex couples, transgender people, etc.
- Update forms and database information to include inclusive terminology, for examples:
    - Use relationship status vs. marital status
    - Include a variety of options including partnered, spouse, and/or husband/wife.
    - Add transgender as on option in addition to male and female
    - Include a question about preferred pronouns – he/him, she/her, and they/them

    - Use open ended questions. For example, is there anything about your gender identity/expression that we should know? Or do you have any concerns related to your gender identity/expression or your sex of assignment?
- Interact with awareness, respect and understanding

Services for LGBTQ+ youth and adults should be individualized, client centered and multi-culturally competent. Supports and services tailored to help the LGBTQ+ population are critical to promote safety, increase access to care, and improve health outcomes. Providers can access a list of resources to meet the unique needs of LGBTQ+ youth on the B-UFC website. https://www.banneruhp.com/resources/child-and-family-support

Oral Health for Children with Special Health Care Needs

Oral health is an inseparable part of health and well-being. Children with Special Health Care Needs (SHCN) are at an increased risk of significant oral health concerns. The Academy of Pediatric Dentistry defines special needs as those with chronic physical, developmental, behavioral or emotional conditions. Children with SHCN may have limitations on daily activities and require more extensive dental and medical services. In addition to SHCN, the American Academy of Pediatric Dentistry clarifies that Social Determinants of Health (SDOH) such as language, transportation, education level and other considerations may have an impact on access to preventative care and treatment, which negatively impact oral health.

Children with SHCN may have a limited ability to understand, assume responsibility for, or cooperate with preventive oral hygiene and health practices. Children with SHCN may express a greater level of anxiety about dental care than those without a disability, which may adversely impact the frequency of dental visits and, subsequently, oral health.

Children with SHCN are at an increased risk of build-up of calculus resulting in increased gingivitis and periodontal disease, enamel hypoplasia, dental cavities, dental crowding, anomalies in tooth development, size, shape, eruption and arch formation, fracture of teeth or trauma.

The Child and Family Team can support the family and dental provider with the following strategies:

- Establish a dental home at an early age, preferably before the child's first birthday
- Develop and adhere to schedules and routines
- Obtain thorough medical, dental, and social patient histories
- Create an environment conducive for the child to receive care, address previous trauma and potential triggers
- Provide oral health education and preparatory guidance to the child and caregiver
- Provide therapeutic services, focus on soothing techniques, skills training and behavior support with a multidisciplinary approach when needed
- Support transitions to new providers and/or adult dental providers

Oral diseases can have a direct and devastating impact on the general health and quality of life for children with complex health care needs. By taking an integrated approach the team and family can decrease the impact of significant oral health concerns and in turn improve overall health.

American Academy of Pediatric Dentistry. Management of dental patients with special health care needs. The Reference Manual of Pediatric Dentistry. Chicago, Ill.: American Academy of Pediatric Dentistry; 2022:302-9.

Child and Family Team (CFT) Practice and CALOCUS

The Child and Family Team (CFT) Practice is a process that is nationally recognized by the Substance Abuse Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health (NIMH) as an evidence-based approach that ensures efficient service delivery for children receiving behavioral health services. CFT Practice is the foundation for CFT facilitation in Arizona and is comprised of Nine Essential Elements that align with the Arizona Vision and 12 Principals. The Nine Elements of CFT Practice include:

1) Engagement
2) Crisis Stabilization
3) Strengths, Needs and Cultural Discovery (SNCD)
4) CFT Formation
5) Service Planning
6) Ongoing Crisis and Safety Planning
7) Service Plan Implementation
8) Tracking and Adapting
9) Transition

AHCCCS has identified processes for how each of the Nine Essential Elements are implemented in CFT Practice, including:

- Implementing CFT Practice on a continuum based on individualized needs,
- Identifying the complexity indicators contributing to the needs of the child and family,
- Utilizing the Child and Adolescent Level of Care Utilization System (CALOCUS) in the Children's System of Care.

To ensure compliance with AHCCCS requirements and timely implementation of CFT required practices, as well as the utilization of CALOCUS within each of the Nine Essential Elements, reference AHCCCS AMPM 220, AMPM 320-O and AMPM 570.

For additional information about CFT Practice training requirements or CALOCUS training requirements refer to the Provider Resources section on the AZAHP Workforce Alliance website at https://azahp.org/azahp/azahp-accrhba-awfda/.

If you have any additional questions about CFT Practice or the utilization of the CALOCUS within CFT Practice, please email the Banner Children's System of Care team at csoc@bannerhealth.com.

Provider Services & Support

Join our Network or Update Your Information

Please visit the B – UHP website where you will find guidance on adding a new provider, location, Tax ID, term requests, or submit an update or change request. You will also find the AzAHP forms which may be required for your requests. Please note, if you are submitting an update or change for an existing provider, who is already credentialed, please submit the AzAHP Practitioner/Practice Change Form.

Now on LinkedIn

Connection – a great New Year's resolution – and one of our goals in launching our new LinkedIn page!

The focus of this platform will be to connect with Health Plan Employees, Providers, Vendors, and Community Partners.

We look forward to sharing Staff Spotlights, Organization Updates, Community Events & Involvement, and Health News with you!

Follow our page: www.LinkedIn.com/company/Banner-Health-Plans

Lunch and Learns

In response to provider requests for more accessible trainings B – UHP's Complete Care Team launched a series of free virtual Lunch and Learns. Topics presented already in 2022 include Understanding Vocational Rehabilitation and Cultural Considerations when working with Tribal Members. All lunch and learns will be recorded and available on Banner's Provider Training website https://www.banneruhp.com/resources/provider-trainings

Lunch and Learn topics scheduled for early 2023 include:

Topic:	**Date**:
Understanding ALTCS	Date TBD
Working with members on the Autism Spectrum	February 1
Providing Services to members with visual impairments	February 23
Peer & Family Support Training and CEU's	March 23
Compassion Fatigue	Date TBD
Accessing Community Resources	Date TBD

All providers and Community Partners are welcome to attend. For more information on these events, please sign up for our mailing list by visiting https://forms.office.com/r/uBWZ9KaZ1z

Behavioral Health Residential Facility (BHRF) Audit Announcement

Banner – University Health Plans (B – UHP) is working with other health plans to visit behavioral health residential facilities. This is to ensure that our members continue to receive the quality care they need in a safe environment. The BHRF audit will occur from Feb. 1, 2023 - Apr. 30, 2023. The onsite visit will include a medical record review and a facility inspection. The medical record review will evaluate documentation pertaining to assessment and treatment planning, admission documentation, and discharge planning. The facility inspection will focus on health and safety areas.

BHRF directors will start receiving notices in January; notices will arrive at least two weeks prior to the scheduled audit. Please respond to audit notices in a timely manner due to the audit timeframe noted above. It is helpful to have staff available to set up the audit, provide access to medical records, and answer questions.

Thank you for helping our members get the quality care they deserve.

Behavioral Health Residential Facility (BHRF) and Medication Assisted Treatment (MAT)

- BHRF providers are not to exclude members on MAT from admission. If BHRF provider does not provide MAT, then the BHRF is required to coordinate care with the member's MAT provider.
- BHRF providers must have policies that specifically ensure that members have access to their MAT services and must train all staff on this requirement.
- If a BHRF program offers access to a provider that prescribes Buprenorphine or an OTP/OBOT provider, the MAT treatment may be transitioned to that provider.
- If the BHRF provider does not offer access to a Buprenorphine prescriber or OTP/OBOT provider, the BHRF is required to coordinate with the external MAT provider to ensure the member has access to the prescribed dosage and treatment.
- If BHRF program offers access to waivered provider or an Opioid Treatment Program (OTP) provider, then MAT may be transitioned to that provider.
- If BHRF provides MAT for a member, then BHRF provider and Health Home must ensure member is enrolled with a MAT provider and coordinate upon discharge.
- If the BHRF cannot accommodate specific MAT treatments due to licensure or coordination constraints, then BHRF providers can present options to transition from MAT or MAT alternatives but must not require their alternative treatment for admission and must coordinate with member, MAT provider, and Health Home. The decision to accept the BHRF's alternative treatment regimen is made by the member, not the BHRF.
- In all cases and situations, best practice includes coordination between the member, the BHRF, MAT Provider, Health Home and prescribing doctors before adjusting prescribed treatment regimens.

*You can find this information in the provider manual at www.BannerUHP.com pages 159-160.

Seclusion and Restraint (SR) Reporting Requirements

It is the policy of B – UHP to ensure that the organization and its providers have the necessary information to ensure that **Behavioral Health Inpatient Facilities (BHIFs) and Mental Health Agencies (MHAs) authorized to conduct Seclusion and Restraint report to the proper authorities as well as the Plan** all Seclusion and Restraints of plan members. The use of seclusion and restraint can be high-risk behavioral health interventions; facilities should only implement these interventions when less restrictive and less intrusive approaches have failed. **The Health Plan requires BHIFs and MHAs to submit each individual report of incidents of seclusion and restraint to the Plan within (5) five business days of the incident utilizing AHCCCS Seclusion and Restraint Individual Reporting Form (Attachment A)** https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/962AttachmentA.docx
Please submit the completed form to B – UHP: Email: BUHPRequests@bannerhealth.com. or Fax: 520-874-3567
Providers are required to submit a separate **Incident/Accident/Death (IAD) report for Seclusion and/or Restraints resulting in an injury to the member**, to the Health Plan and to the AHCCCS Quality Management (QM) Team. Contracted BHIFs and MHAs licensed to conduct Seclusion and Restraints must submit these IADs to the AHCCCS QM Portal **within 24 hours** of becoming aware of the incident.

All Reporting requirements are specified in the B – UHP Behavior Health Provider Manual at:

https://www.banneruhp.com/materials-and-services/provider-manuals-and-directories, based upon **AHCCCS MEDICAL POLICY MANUAL (AMPM) 962**

Incident, Accident, and Death (IAD) Reporting Update

B – UHP Contacted Providers shall ensure that reportable IADs are submitted via the AHCCCS QM Portal **within 48 hours** of the occurrence or notification to the provider of the occurrence. Sentinel IADs shall be submitted by the Provider through the AHCCCS QM Portal **within 24 hours** of the occurrence or becoming aware of the occurrence. Please refer to the *AHCCCS MEDICAL POLICY MANUAL (AMPM) 961* for specific reportable incidents and timeframes.

We encourage our providers of care to reach out with any questions or issues regarding submission of SR and/or IAD reports by **Email to:** BUHPRequests@bannerhealth.com

Conflicts of Interest in Supported Employment

AHCCCS maintains very specific policies related to members becoming employees of a provider. According to ACOM 447 *"Once a member begins employment/becomes an employee with a provider, any employment supports and services provided to that member by the provider shall cease"* Members may then begin to receive employment services from a different provider, should they still desire those supports. Providers contracted with B – UFC are required to meet this requirement.

For example, "Joe" is receiving employment supports from Provider X and becomes a certified Peer Support Specialist. Upon getting certified, Provider X hires Joe to work there. At this point, services must be transferred to another provider.

Please visit https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/447.pdf for more information.

Compliance Corner

Fraud, Waste, and Abuse

What is fraud, waste and abuse for providers?

Fraud is when someone intentionally lies to a health insurance company, Medicaid or Medicare, to get money that they do not deserve. **Waste** is when someone overuses health care services carelessly. **Abuse** occurs when the best medical practices are not followed which leads to expenses and treatments that are not needed.

Even though there is no precise measure of health fraud, those who exploit and take advantage of Federal Health Care Programs (including Medicare and Medicaid), can cost taxpayers billions of dollars and impact members' health and welfare potentially putting them at risk of harm.

Anyone can commit health care fraud. The level of fraud can include an individual who is independently committing fraud to a calculated scheme by an institution or a group.

Some examples of fraud include, but are not limited to:

- Knowingly billing for services at a higher level than the services actually provided or documented in the medical records.
- Knowingly billing for services that were not provided, supplies not given, or both and then falsifying records to show delivery of such items
- Billing the Health Plan for appointments when the member was a no show.
- Billing services performed by an employee unqualified to provide the services.
- Billing separately for services already included in a global fee, such as billing for an evaluation and management service the day after surgery.
- Incomplete progress notes (for example, unsigned, undated, insufficient detail)
- Cloning or copying and pasting of clinical data from one date of service to the next or from one member to another member.

Some examples of Waste and Abuse include, but are not limited to:

- Billing for services or items in excess of those needed by the member.
- Unbundling services that are to be bundled or double billing in order to receive increased payment.
- Requiring a deposit or other payment from members as a condition for admission, continued care, or other provision of service.
- Adding inappropriate or incorrect information to cost reports.

Fraud and Abuse Laws: Federal Laws governing fraud and abuse include:

- False Claims Act (FCA)
- Anti-Kickback Statute (AKS)
- Physician Self-Referral Law (Stark Law)
- Social Security Act, which includes the Exclusion Statute and the Civil Monetary Penalties Law (CMPL)
- United States Criminal Code

These laws specify the criminal, civil and administrative penalties and remedies the government may impose on either individuals or entities committing fraud and abuse in the Medicare and Medicaid Programs.

Enforcement of these laws are managed by several Government Agencies including the U.S. Department of Justice (DOJ), the U.S. Department of Health and Human Services (HHS), the HHS Office of Inspector General (OIG) and the Centers for Medicare and Medicaid Services (CMS).

In addition, Arizona Revised Statute § 36-2918 makes it unlawful for a person or cause to be presented to the State of Arizona or to a contractor (Health Plan):

- A claim for a medical or other item or service that the person knows or has reason to know was not provided as claimed.
- A claim for a medical or other item or service that the person knows or has reason to know is false or fraudulent.
- A claim for payment that should not have been paid due to services by suspended or terminated providers, the item or service claimed is in excess of the needs of the individual or the quality of the service was substandard

and would not meet acceptable quality standards, or the member was not eligible for services on the date received.
- A claim for services furnished by an unlicensed individual or licensed through a misrepresentation or presentation of a falsity to the member of medical board specialty.

Other Arizona statutes prohibit activities such as theft, forgery and fraudulent schemes.

The Arizona Attorney General, AHCCCS Office of Inspector General, Medicaid Control Fraud Unit are investigating and prosecuting these cases.

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

24-hour hotline (confidential and 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 Interim Medicare Compliance Officer Kristina Corlette via phone 602-747-3387 or email BMAComplianceOfficer@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 HMO D-SNP 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
- In Arizona: 602-417-4045
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686

Website -www.azahcccs.gov (select Fraud Prevention)
Mail:
Inspector General
801 E Jefferson St.
MD 4500

Phoenix, AZ 85034

Member Fraud

- In Arizona: 602-417-4193
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686

Medicare

Providers are required to report all suspected fraud, waste, and abuse to the Banner Medicare Health Plans Compliance Department 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