Banner
University Health Plans

www.BannerUHP.com
(800) 582-8686, TTY 711
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Provider Update

July 14, 2023

Member Rights

- Rights & Responsibilities are shared with staff, providers and members (pg. 25)

Compliance Corner

- What is “Vishing?” (pg. 25)

2023 VFC Re-Enrollment Required by AHCCCS

If you are a B – UHP contracted provider with members under 19 years of age, it is vital that you complete your 2023 VFC re-enrollment no later than **Aug. 31, 2023**. Only when the Provider Agreement in ASIIS shows an "Approved" status is your facility officially re-enrolled in the program.

There are two steps to re-enrollment.

1. Complete the VFC Provider Agreement for 2023 in the ASIIS portal.
2. Use this website to upload ALL required re-enrollment documents: https://redcap.link/Reenrollment2023

Please check ASIIS to view your expiration date and submit your agreement before your current 2022 agreement expires. If your 2022 agreement expires before your 2023 agreement is approved, your VFC ordering will be interrupted. The VFC re-enrollment process will close on Aug. 31, 2023.

If a location fails to re-enroll by Aug. 31, 2023, that location may be inactivated from the VFC program for non-compliance. Providers who are inactivated by the VFC program WILL have their panel closed to all members under 19 years of age and existing members will be moved to another provider panel.

Link to VFC 2023 re-enrollment instruction guide:
https://asiis.azdhs.gov/AIPO_Announcements/Re-enrollment/Re-enrollment_instructions.html

If you have questions regarding the VFC re-enrollment process or the online forms, please contact the Bureau of Immunization Services, at ArizonaVFC@azdhs.gov or contact your Immunization Program Specialist directly.

Gift Card for Wellness Screenings

AHCCCS or KidsCare members ages 3-19 who complete a well-care visit with their PCP or OB/GYN between June 5 and September 5, 2023, are eligible for a $25 gift card. Well-care visits include screenings, preventive measures, and help doctors track a child’s developmental progress while giving parents a chance to discuss any physical or behavioral health concerns. The gift cards are mailed to the head of household once the claim is submitted. For more information, reach out to your Care Transformation Consultant.

Physical Health Best Practice Guidelines

By Sheena Sharma, MD, Medical Director

B – UHP has devised a set of Physical Health Best Practice Guidelines that are founded in the most current evidenced-based literature; the guidelines are member-centric, population-outcome based, and focused on quality improvement. Primary care physicians, specialists and other health care providers are expected to utilize these Best Practice Guidelines to achieve excellence in patient care and service delivery. These guidelines will be disseminated widely, and their implementation will be monitored on an ongoing basis. We have recently completed a three-part education series on Alzheimer's Disease utilizing our experts within the field at the Banner Alzheimer Institute. The series included the topics of diagnosis and management of Alzheimer's Disease, in addition to support services available for patients and caregivers. Guidelines from the American Academy of Neurology and Alzheimer's Association were utilized.

Additional information and resources on best practice guidelines are available on the Medical Necessity Criteria & Clinical Practice Guidelines webpage: https://www.banneruhp.com/resources/clinical-practice-guidelines.

We welcome any feedback regarding the adoption of the Alzheimer's Disease Best Practice Guidelines for B – UHP. Feel free to contact me via email at sheena.sharma@bannerhealth.com with any questions or concerns.

Update to Colonoscopy Coding

A colonoscopy after a positive result from a non-invasive stool-based CRC screening test is now a screening colonoscopy **NOT** a diagnostic colonoscopy. CRC screening tests now include a follow-on screening colonoscopy after a Medicare-covered, non-invasive, stool-based CRC screening test returns a positive result. Attach the KX modifier to a screening colonoscopy code to indicate such service was performed as a follow-on screening after a positive result from a stool-based test.

To find the information from CMS, use this link: https://www.cms.gov/files/document/mm13017-removal-national-coverage-determination-expansion-coverage-colorectal-cancer-screening.pdf

Treatment Capacity Survey - Q2 Deadline Aug. 1

Under the Arizona Opioid Epidemic Act of 2018, each facility that provides inpatient or outpatient substance use disorder treatment (SUDT) is required to submit a quarterly report to Arizona Department of Health Services (ADHS) that includes information regarding the number of days in the quarter that the facility was at capacity and unable to accept referrals for treatment. The purpose of the reporting is to identify gaps in care and unmet SUDT needs in the state. Annual reports are published on the ADHS website.

To complete your Q2 survey by Aug. 1, visit the link below:
https://adhs.co1.qualtrics.com/jfe/form/SV_6opxx3Wl7BZ9l3g
OR

https://shorturl.at/duyE4

For providers with multiple facilities: If one person is completing the survey for many facilities, they may complete one entry with the total numbers of inpatient/outpatient beds as well as the total numbers of available inpatient/outpatient beds. If the method of distribution is fax, please make sure to enlarge the font of the web address to aid visibility.

Please send any questions or concerns to Mercedeh Reamer at mercedeh.reamer@azdhs.gov.

Behavioral Health Appointment Standards

Banner – University Health Plans (B – UHP) has a process in place to track capacity issues to better serve and coordinate care for our members.

Behavioral Health Provider Appointments:

- Initial assessment within seven calendar days of referral or request for behavioral health service
- Urgent need appointments are to be scheduled no later than 24 hours from identification of need

Inpatient Discharge Appointments:

- Discharge follow up appointments must be scheduled within 7 days to ensure member stabilization, medication adherence and to avoid re-hospitalization

Behavioral Health Providers can utilize telehealth as an option to meet appointment standards. Behavioral Health Providers are required to notify B – UHP when appointments are not within the required AHCCCS timeframes or are at capacity.

Please notify the following when appointment and capacity concerns arise:
Care Transformation: BUHPProviderInquiries@BannerHealth.com
Adult System of Care: ASOC@BannerHealth.com
Children's System of Care: CSOC@BannerHealth.com

Medicaid Reimbursement for Peer and Recovery Support Services

AHCCCS Medical Policy Manual (AMPM) 963-Peer and Recovery Support Service Provision Requirements establishes Medicaid reimbursement requirements for peer support services delivered within the AHCCCS programs. These requirements include the qualifications, supervision, continuing education and training/credentialing processes of Peer and Recovery Support Specialists (PRSS).

AMPM 963 can be found here: https://www.azahcccs.gov/shared/MedicalPolicyManual/

As stated in both B – UHP contract and AHCCCS AMPM Policies 963 and 964, it is the responsibility of B – UHP's Office of Individual and Family Affairs (OIFA) to ensure provider agencies that employ,

train and/or bill for peer support services are following these requirements. A request for your organization's policies, procedures and any documents demonstrating compliance with AMPM 963 can be requested at any time.

Additional information on Peer and Recovery Support Service Provisions, how this is monitored and audited can be found in the current Banner – University Family Care Provider Manual pgs. 39-43.

If you are an agency that delivers peer support services and have questions about the requirements of this policy, you can contact B – UHP's Office of Individual and Family Affairs (OIFA) Team general email box: OIFATeam@bannerhealth.com.

News of Note

- **Updated Pharmacy Prior Authorization Grids** The Pharmacy Prior Authorization (PA) grids for both the Banner Medicare and Banner Medicaid lines of business have been updated. They will be effective starting Aug. 1, 2023. Be sure to refer to the new grid located on the BannerUHP.com and BannerHealth.com/Medicare websites.

Maternal Child Health

Blood Lead Screening, Testing, Reporting for EPSDT-Aged Members

Blood-Lead screening and reporting requirements were revised in 2021 and continue to be covered as part of the Early and Periodic Screening Diagnostic and Treatment (EPSDT). The COVID-19 pandemic caused blood lead testing numbers to drop by 25.7% in 2020.

With this dramatic drop in statewide screening, all PCPs are encouraged to screen members per the following AHCCCS requirements.

- Blood-Lead testing is required for:
  - All members between 12 to 24 months of age
  - Members between 24 and 72 months (6 years) of age:
    - Who have not been previously tested, or
    - Who missed either the 12- or 24-month test.
- Lead levels may be measured at times other than those specified, if thought to be medically indicated by the provider, by responses to a lead poisoning verbal risk assessment, or in response to parental/guardian/Health Care Decision Maker (HCDM) or Designated Representative (DR) concerns.
  - An example of a lead risk assessment is available from ADHS, via the link here: https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/lead-poisoning/parent-lead-questionnaire-eng-spa.pdf

- All providers are required to report blood lead levels equal to or greater than the current CDC Blood Lead Reference Value of [3.5 micrograms of lead per deciliter of whole blood] to ADHS.
  - A capillary blood lead test result equal to or greater than the current CDC Blood Lead Reference Value, obtained by capillary specimen or finger-stick, must be confirmed using a venous blood sample.

- The higher the BLL is on the initial screening capillary test, the more urgent it is to get a venous sample for confirmatory testing.
- CDC Recommended Schedule for Obtaining a Confirmatory Venous Sample

Capillary Blood Lead Level (µg/dL)	Time to Confirmation Testing
≥3.5–9	Within 3 months
10–19	Within 1 month
20–44	Within 2 weeks
≥45	Within 48 hours

- Members who have a blood lead test result equal to or greater than the current CDC Blood Lead Reference Value of [3.5 micrograms of lead per deciliter of whole blood] confirmed by venous sample should have follow up testing completed using CDC guidelines below.

Venous blood lead levels (µg/dL)	Early follow up testing (2–4 tests after initial test above specific venous BLLs)	Later follow up testing after BLL declining
≥3.5–9	3 Months	6 – 9 Months
10–19	1 – 3 Months	3 – 6 Months
20–44	2 weeks – 1 month	1 – 3 Months
≥45	As soon as possible	As soon as possible

- For further information on recommended schedules of blood lead level screening and interventions please visits: https://www.cdc.gov/nceh/lead/advisory/acclpp/actions-blls.htm.

Banner − University Family Care has Pediatric Care Managers available to assist providers and members in managing healthcare needs and overcoming barriers to obtaining care. Please call our Customer Care Department at (800) 582-8686, TTY 711 to submit a referral to the Maternal Child Health department or send an e-mail to BUHPMaternalChildHealth@bannerhealth.com.

Updated Requirements for Anthropometric and Biomedical Data

Why Am I Getting This Notice?

Arizona WIC agencies had previously been permitted to waive collection of anthropometric and biochemical data when enrolling applicants on the WIC program due to the nationally declared Public Health Emergency(PHE). The PHE ended on May 11, 2023. As a result of the nationally declared PHE ending, the Arizona WIC program will require anthropometric and biochemical data starting Oct. 1, 2023.

What Anthropometric and Biochemical Data is Required?

Starting Oct. 1, 2023, height/length and weight values and hemoglobin/hematocrit data will be required.

How Can Applicants and Participants Provide Anthropometric and Biochemical Data?

Anthropometric and biochemical data may be utilized from a medical provider or obtained via a patient portal for Arizona WIC Participants. Acceptable forms of documentation that may be provided include the following:

- Arizona WIC Health Data Form (available at azwic.gov Physicians webpage)
- Arizona WIC Referral and Physical Presence Exemption Form (available at azwic.gov Physicians webpage)
- Doctor's letterhead with anthropometric/biochemical data
- Doctor's prescription form
- Formula and Food Request Form (available at azwic.gov Physician webpage)
- Head Start and WIC Referral Form (available at azwic.gov Information and Forms webpage)
- Printed medical records form a medical provider that includes the date of the measurements and the medical provider's name)
- Verbal medical data provided to WIC staff from a medical provider

What Can Applicants and Participants Do If They Do Not Have Recent Anthropometric and Biochemical Data?

Applicants and participants can call their local WIC clinic to have anthropometric and biochemical data taken at a clinic location. If they don't know how to contact their local WIC office, they can find contact information for their local WIC office on the clinic search website at clinicsearch.azbnp.gov or call 800-252-5942.

If an applicant or participant has a complaint or concern, they can also visit complainttracking.azbnp.gov or call the WIC complaint Hotline at 866-229-6561 (Monday through Friday).

Banner – University Family Care Provider Training Series

Whole Person – Social Determinants of Health (SDoH)

This educational training series is designed to enhance awareness, knowledge and provide tools to identify interventions that address Social Determinates of Health (SDoH) within General Mental Health & Substance Use (GMH|SU) populations.

B – UFC is proud to offer Continuing Education Units (CEU's) for licensed clinical/non-clinical professionals and other direct support staff.

You may register in Relias or Eventbrite. If you have a Relias account, we encourage you to register via Relias for easier access to your CEU transcript and certificate. Search the assigned course code in the Relias Course Library to locate and enroll in each training.

Training Schedule:

- **Quality Healthcare: Veteran PTSD/Moral Injury**

Wednesday, July 26, 2023 | Noon – 1 p.m.

- **Quality Healthcare: Substance Use and Trauma**
  Wednesday, Aug. 9, 2023 | Noon – 1 p.m.
- **Social Support: Loneliness and Isolation**
  Wednesday, Sept. 27, 2023 | 10 – 11 a.m.
- **Food Insecurity: Nutritional Strategies**
  Wednesday, Oct. 11, 2023 | Noon – 1 p.m.
- **Food Insecurity: Impacting Homelessness**
  Wednesday, Nov. 1, 2023 | Noon – 1 p.m.
- **Quality Behavioral Health Care: Professional Wellness**
  Wednesday, Nov. 15, 2023 | Noon – 1 p.m.

Learn more or register for any of the trainings here:
www.eventbrite.com/cc/b-ufc-whole-person-care-sdoh-training-series-2197149

HEDIS Talk: Social Need Screening & Intervention (SNS-E)

Social Factors Significantly Impact Health Outcomes

SNS-E is a first-year measure beginning in 2023. This measure will focus on the social needs of our health plan members.

Here is what you need to know:

- Product lines include **Commercial**, **Medicaid** and **Medicare**
- SNS-E will be reported electronically using the **Electronic Clinical Data Systems (ECDS)** reporting standards (that's the E in SNS-E)
  - ECDS includes electronic enrollment data, claims, encounter EHR's, registries, and case management data.
- Required Exclusions for this measure include members enrolled in Hospice, I-SNP, or LTI during the measurement year.
- Measure identifies both **Screening AND Interventions** (total of six indicators) for **three** social needs:
  - Food
  - Housing
  - Transportation
- Interventions must be addressed on, or up to, 30 days after the date of the first positive screening.
  - Interventions may include *assistance*, *assessment*, *counseling*, *coordination*, *education*, *evaluation of eligibility, provision or referral*.
- SNS-E measure applies to all age ranges. Reporting will be stratified by age.

To find out more about this new measure visit www.NCQA.org\HEDIS.

Look for more helpful HEDIS education and resources to come in this newsletter.

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

Member Engagement & Employment Services

Employment Services for Tribal Members: Cultural Considerations

The Native American population faces health and socioeconomic disparities. Poverty rates are higher in tribal communities, even among the employed, due to geographic isolation and discrimination. Employment can have a positive impact on a member's self-esteem, decrease symptoms, improve feelings of connectedness and improve mood.

ARIZONA @ Work has sites around the state available to help people find work. But there are also 11 sites available to help our tribal members access the same resources. Sites are located in:
Fort Mojave Indian Tribe (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-fort-mojave-indian-tribe)
Gila River Indian Community (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-gila-river-indian-community)
Colorado River Indian Tribes (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-colorado-river-indian-tribes)
Hualapai Tribe (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-hualapai-tribe)
Pascua Yaqui Tribe (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-pascua-yaqui-tribe)
Quechan Indian Tribe (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-quechan-indian-tribe)
Salt River Pima-Maricopa Indian Community (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-salt-river-pima-maricopa)
San Carlos Apache Tribe (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-san-carlos-apache-tribe)
Tohono O'odham Nation (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/nineteen-tribal-nations-tohono-oodham-nation)
White Mountain Apache Tribe (https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/white-mountain-apache-tribe)
Yavapai-Apache Nation https://arizonaatwork.com/locations/nineteen-tribal-nations/local-offices/yavapai-apache-nation)

Many tribes provide workforce and employment preparation and assistance for Tribal members. Services can also be found within our B – UHP Network. These services may include career counseling, skills training, training for youth and job coaching. Members can access these services by visiting their tribe's website or B – UHP's Employment Website located at https://www.banneruhp.com/resources/employment-services

VR is a work program that provides counseling, guidance, services, and supports to help individuals with disabilities prepare for, obtain, maintain, or advance in employment. Some tribes

have their own Vocational Rehabilitation Office, members can check with their individual tribal office or visit https://des.az.gov/rsa-contact-information

Members who have jobs that they enjoy report having higher levels of satisfaction and stay at their jobs longer. This is why providing services to members that are specific to them is very important. All decisions about work should be based on:

- the experience of the member
- their strengths
- preferences
- culture

Tips for Building Rapport

- Humor is sometimes a sign of affection. Be willing to laugh at yourself.
- Ask for permission before touching the member (including hair, traditional regalia, etc.)
- Receptive to casual conversation to develop rapport
- You may be offered beverage/food-- Important to accept as a sign of respect
- Familiarize yourself with how to assist members to get the documents needed for hiring purposes:
  - Social Security Card
  - Proof of Residency
  - Birth Certificate
  - Ask if there are any cultural considerations they'd like to include in your work together
  - A strength and opportunity to create diversity and inclusion

Vocational Rehabilitation Services for Youth

Rehabilitation Services Administration/Vocational Rehabilitation is a program that provides a variety of services to persons with disabilities who require assistance obtaining and retaining employment.

For members 14-22 years of age, VR's Pre-Employment Transition Services (Pre-ETS) are tailored to prepare students for future employment using job exploration, work readiness curriculum, post-secondary education/training counseling, work-based learning and teaching self-advocacy skills.

Eligibility

Youth with disabilities can receive Pre-ETS. Arizona defines a 'student with a disability' as an individual who is between 14-22 years old, that participates in an educational program (e.g. public, private or charter schools, home school, vocational programs, college, GED programs, etc.), and has a documented disability (this includes students who qualify for a 504 plan or who have an Individualized Education Plan or IEP).

Members with disabilities may also be eligible for additional VR services including mobility equipment to aid in the youth's movement, tools to help make learning materials accessible, assistive technology, and more.

For more information on the Pre-ETS program please visit the Pre-Employment Transition Services Website: https://des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation/pre-employment-transition.

Children's System of Care

Child and Family Team (CFT)

Banner – University Family Care (B – UFC) wants to ensure that all members receive care coordination that aligns with the CFT process. Arizona's CFT practice model was created as a guide to ensure the consistent delivery of quality care to children enrolled in behavioral health services. The CFT model utilizes nine guiding principles and is reflective of the Arizona 12 Principles and the Arizona Vision.

The Arizona Vision

The Arizona Vision (as established by the Jason K. Settlement Agreement in 2001) states, "In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's and family's cultural heritage."

The Twelve Principles for Children's Service Delivery (12 Principles):

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting
7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family's unique cultural heritage
11. Independence
12. Connection to natural supports

All children's behavioral health providers are required to deliver care and services by applying these principles and in accordance with the Arizona Vision. Through the CFT process, parents/caregivers and youth are treated as full partners in the planning, delivery and evaluation of services and supports.

For additional information please see:

AHCCCS 12 Guiding Principles in the Children's System of Care: https://www.azahcccs.gov/AHCCCS/Downloads/12GuidingPrinciplesInTheChildrensSystemOfCare20200213.pdf

B – UFC Child and Family Support Page:

https://www.banneruhp.com/resources/child-and-family-support
For additional questions please email the Banner Children's System of Care at: csoc@bannerhealth.com

CALOCUS

The Child and Adolescent Level of Care Utilization System (CALOCUS) is a standardized assessment tool that provides determination of the appropriate intensity of services needed by a child or adolescent and their family and guides the provision of ongoing service planning and treatment outcome monitoring in all clinical and community-based settings.

AHCCCS providers who deliver behavioral health services to children and adolescents are required to conduct the CALOCUS.

All those who administer the CALOCUS are required to take the training provided through Deerfield.

Providers should use the online instrument until the EHR integration can be completed. Assessment information will be automatically compiled through Deerfield, so providers will no longer be required to submit the CALOCUS scores separately through the DUGless portal.

For more information about the AHCCCS requirements for the CALOCUS, refer to the AHCCCS FAQs or contact the Children's System of Care team at CSOC@bannerhealth.com.

FAQ link:
https://www.azahcccs.gov/Resources/Downloads/SystemOversiteStructure/CALOCUS_FAQ.pdf

New High Needs Case Management (HNCM) Exemption Request Process

As outlined in AMPM Policy 570 and AMPM Policy 570 A, high needs members should be assigned to dedicated high needs case managers with a ratio of no more than 25 members to 1 case manager. Additionally, high needs case managers should not have a blended caseload.

Should a provider agency face circumstances that require a blended caseload, the agency should request an exception by completing the exception tab on the quarterly HNCM Inventory.

When requesting an exemption to the requirements outlined in AMPM Policy 570 and AMPM Policy 570 A on the Exemption Request Tab, providers will submit a detailed response to the each of the areas listed below and submit to all contracted health plans along with the completed HNCM Inventory and Supervisor Tab.

- State the exemption being requested (i.e. higher caseload ratios, blended caseloads, etc.). If the agency has multiple sites, please include which sites the exemption will apply to.
- What is the reason for the exemption request?
- Provide a detailed explanation of the high needs case management plan or business model (i.e. staffing model, maximum caseload size, etc.) including any actions taken to address the non-compliance.
- What is the timeframe for exemption being requested?

Requests for exemptions will be reviewed with all Health Plans, if additional information is requested the provider agency will be outreached, and then one of the health plans will forward the request to AHCCCS.

Providers can access the AMPM Policies at: AHCCCS Medical Policy Manual (AMPM) (azahcccs.gov). If you have questions about this process, please contact the Children's System of Care Team at csoc@bannerhealth.com.

NEW SED Determination Process

In January 2023, AHCCCS issued an announcement of the statewide SED and Serious Mental Illness (SMI) Eligibility Determination contract to Solari thus expanding the responsibility of the vendor to include eligibility determinations for individuals who may have an SED effective October 2023. Children who are determined to have a SED are considered to have special health care needs and are eligible to receive additional services not covered through Title XIX funding through Mental Health Block Grant (MHBG) funding.

The formal process for SED determinations will allow clinicians to follow a similar process to what currently exists for SMI eligibility determinations. Final designation will be made by the determining entity Solari. Additional information on SED Determination is included within the SED Determination FAQs on the AHCCCS website.

Solari started offering in-person and virtual training for providers throughout the state in June 2023. Providers are strongly encouraged to attend the SOLARI trainings to ensure they understand the SED and SMI Eligibility Determination process. Solari will also be posting updated training opportunities as they become available. Contact Solari representatives Ashley Gill (Ashley.Gill@solari-inc.org) or Tara Bingdazzo (Tara.Bingdazzo@solari-inc.org) for additional questions.

Integrated System of Care

NEW SUD Provider Network Meeting

The Banner Integrated System of Care team is extending an invitation to participate in a quarterly substance use disorder (SUD) meeting aimed at fostering collaboration and sharing knowledge among SUD service providers.

The purpose of this meeting is to bring together a diverse group of SUD service providers who are actively engaged in providing services to members with a substance use disorder diagnosis.

During the meeting, we plan to cover a wide range of topics, including but not limited to:

1. Current trends and challenges in SUD diagnosis, treatment, and management.
2. Innovative approaches and evidence-based practices in SUD treatment.
3. Collaborative strategies for integrated care and addressing social determinants of health (SDoH).
4. Best practices for supporting members in their recovery journey.
5. Addressing the stigma associated with SUD and promoting public awareness.

We believe that your expertise and insights will contribute to the success of this meeting. We anticipate a collaborative and interactive meeting where participants can share their perspectives, learn from one another, and identify best practices and areas for improvement.

Registration: https://teams.microsoft.com/registration/0tzqra86NUiycx6-incm8Q,K_nDe7g_rEu87Zz3QVMSQw,cgzY8GoulEuBNnu_DcJrGA,lesfcn9zS0aLaolw2bqgdA,xxmTvSjG60G4RBUWufSeaw,jv44ZRRvdUug7Tyakrmsaw?mode=read&tenantId=adeadcd2-3aaf-4835-b273-1ebe8a7726f1&skipauthstrap=1

We look forward to your participation. If you have questions or need additional information, please email the Integrated System of Care team: Alejandro.Flores@bannerhealth.com, Joanne.Kautzman@bannerhealth.com and Hilary.Mahoney@bannerhealth.com.

AHCCCS Updates

Members Who Lose AHCCCS Coverage May Have Continuity of Care Option

AHCCCS members who have recently lost AHCCCS coverage and are now enrolled with another health insurance company may be able to continue seeing a previous health care provider to continue a course of treatment.

Arizona law allows a new member in a health insurance plan with a life-threatening illness or in the last trimester of pregnancy to continue an "active course of treatment" with their previous health care provider when certain requirements are met. This continuity of care lasts only for a limited time. The new member must send a written request to the new health plan in order to ask to continue care with a previous provider.

To get continuity of care with a previous provider, an individual must be a new member of a health insurance plan and:

1. Have a life-threatening disease or condition (continuity of care coverage is limited to not more than 30 days after the effective date of enrollment) **or**
2. Have entered the third trimester of pregnancy on the effective date of enrollment with the new health insurance plan (continuity of care coverage includes delivery and care up to six weeks after delivery when the care is related to the delivery).

The new health insurance plan is required to provide this continuity of care with no ban on any preexisting condition(s) when:

1. The member submits a written request to the new health insurance plan to continue an "active course of treatment" with a previous provider
2. The previous provider agrees in writing to accept payment at the rates of the new health insurance plan **and**
3. The previous provider agrees to the new health insurance plan's other requirements.

Members with questions about getting continuity of care and treatment from a previous health care provider should contact their new health insurance plan as soon as they are no longer eligible for AHCCCS coverage.

AHCCCS Provider Registration Changes

AHCCCS has recently implemented changes to the provider registration process. One change is to not enroll providers on a retrospective basis on a routine basis. For a variety of reasons,

certain providers may still require retrospective enrollment. Providers that require a retroactive enrollment date should reach out to AHCCCS Provider Enrollment Program (APEP) by email to request an exception: APEPTrainingQuestions@azahcccs.gov.

In addition, AHCCCS has announced a moratorium on new providers for certain provider types. (link to original document: https://www.azahcccs.gov/Resources/Downloads/GovernmentalOversight/AHCCCSBehavioralHealthProviderMoratorium.pdf)

Exceptions will be considered on a case-by-case basis by contacting providermoratorium@azahcccs.gov.

SAMHSA's Extended Flexibilities

In March of 2020, SAMHSA issued an extension to Opioid Treatment Programs (OTP) that would allow each state to request "a blanket exception for all stable patients in an OTP to receive up to 28 days of take-home doses of the patient's medicate for opioid use disorder." (1) Arizona requested this flexibility and maintained this flexibility throughout the course of the Public Health Emergency (PHE). On Apr. 19, SAMHSA provided guidance to allow for Methadone take-home flexibility extension for a period of one year from the end of the PHE or until such time that the U.S. Department of Health and Human Services publishes their final rules. Arizona has reviewed this option for the continuation of these flexibilities and has determined that we will be opting out effective June 16, 2023. This will allow providers to coordinate care for their members and begin the process of requesting these exceptions on a case-by-case basis and submission to the State Opioid Treatment Authority (SOTA) for individual approval. Additional information regarding this flexibility from SAMHSA can be found on the SAMHSA Methadone Take-Home Flexibilities Extension web page: https://www.samhsa.gov/medications-substance-use-disorders/statutes-regulations-guidelines/methadone-guidance

Additionally, SAMHSA and the DEA issued an extension to the COVID-19 telemedicine flexibilities for prescribing controlled medications for six months while considering comments from the public, which is a temporary rule that extends flexibilities adopted during the PHE.

This temporary rule took effect on May 11, 2023 and will allow for the continuation of all flexibilities previously set through Nov. 11, 2023. Arizona has evaluated this opportunity and has opted into the continuation of these flexibilities. Further information on this extension, as well as a full text to the temporary rule, can be found on the SAMHSA DEA Telemedicine Flexibilities web page: https://t.ly/ShK7.

Transmucosal Immediate-Release Fentanyl Medicare Compliance Review

Transmucosal Immediate-Release Fentanyl (TIRF) drugs are products which contain fentanyl, which is a high potency opioid, and also has a high potential for abuse. For this reason, these drugs are only FDA approved for the management of breakthrough cancer pain in patients that are already receiving and tolerating around the clock opioid therapy for cancer pain. Due to its

high abuse potential and its detrimental effects, Medicare has determined it should only be dispensed with a prescription along with a medically accepted indication.

The Office of Inspector General (OIG) conducted an audit from July 1, 2015 through December 31, 2019 to see if TIRF drugs were dispensed in compliance with Medicare's requirements. They found that plan sponsors:

- Approved TIRF drugs for those who did not have a cancer diagnosis in their Medicare claims history
- Approved TIRF drugs for those who had Medicare claims that showed recent cancer diagnosis, but drugs were dispensed for more than a year prior
- Continued approval of TIRF drugs after it had been determined to be unallowed during a previous audit
- They identified providers who were prescribing TIRF drugs to those who didn't have a medically accepted indication

In order to decrease the risks of misuse, abuse, overdose, and serious complications that can arise from these drugs, CMS wants to ensure that these drugs are only being prescribed for the management of breakthrough pain in patients with cancer and that these patients are already on and tolerating around the clock opioid therapy for their persistent cancer pain.

AHCCCS Audio Only Telehealth Changes

Effective May 12, 2023, the **audio only modifier FQ** will **no longer be valid** for any Evaluation and Management codes. During the federally declared Public Health Emergency (PHE), AHCCCS sought and received approval for a waiver to allow the use of audio only delivery of the service codes identified below. When the PHE ended on May 11, the 2023 CPT guidelines will go into effect, which state that these services must be delivered face-to-face. Providers will be able to use modifier GT-Via interactive audio and video telecommunication systems for those services performed via synchronous telehealth (remote exchange of patient information through direct, real-time interaction between a physician and a patient).

All evaluation and management codes will be updated to reflect and end date of the FQ modifier effective for dates of service July 1, 2023, and after. This will also be updated on the AHCCCS approved telehealth spreadsheet located on the AHCCCS Medical Coding Resources page.

99202	Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	GT
99203	Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	GT
99204	Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically	GT

	appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	GT
99211	Office or other outpatient visits for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	GT
99212	Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	GT
99213	Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	GT
99214	Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	GT
99215	Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	GT
99288	Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support.	GT
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	GT
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (list separately in addition to code for prolonged service)	GT
99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of	GT

	total time (List separately in addition to the code of the outpatient Evaluation and Management service)	
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate	GT
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	GT

Breast Cancer Screening

Members 40 years or older are encouraged to get a mammogram to screen for cancer. As a health plan, it is encouraged for them to do so on or before Oct. 1. Routine screenings are important to maintain good health.

In addition to routine screenings, knowing the signs and symptoms of breast cancer is also important. Breast tissue, in general, is lumpy which can be misinterpreted as a health concern. However, lumps that feel harder than the rest of the tissue should be examined. Other signs that women should not ignore are:

- Lumps, hard knots or thickening inside the breast or underarms
- Swelling, warmth, redness or darkening of the breast
- Breast size or shape changes
- Dimpling or puckering
- Sores or rashes on the nipple that may be itchy or sore
- Nipple discharge
- Pain in one spot that continues
- Pulling in of the nipple or other parts of the breast

If members have questions or need help scheduling a mammogram, they can call the Customer Care Center at (800) 582-8686, or TTY 711, 8 a.m. -5 p.m., Monday – Friday.

Provider Services & Support

Model of Care Reminder - *IMPORTANT NOTICE*

Model of Care Training and attestation is required annually. We strongly encourage you to complete the training and submit the attestation as soon as possible. By doing so, you will be better equipped to implement the content and incorporate the requirement into the care you provide.

Contracted providers, Subcontractors and Non-participating providers with Banner Medicare Advantage Dual HMO D-SNP are required to complete the Model of Care Annual Training and submit the Attestation.

This training and attestation take a minimal amount of time to complete (approximately 10 minutes).

Instructions:

1. Review the training content located here: https://www.baneruhp.com/resources/provider-trainings > Select Model of Care Training to access the required training and attestation
2. Complete the *Annual Attestation*: https://bannerhealth.formstack.com/forms/moc_attestations
3. When completing your online attestation, please ensure you are documenting each provider's individual NPI on the attestation form.

Vaccines for Children (VFC)

The VFC program relates to AHCCCS ACC and ALTCS members from birth through 18 years of age. AHCCCS requires BUHP contracted providers to remain enrolled in VFC and use VFC vaccines for all members under 19 years old. If a provider is disenrolled, they risk losing AHCCCS pediatric members assigned to them. Providers may visit: ADHS-Arizona Immunization Program – Vaccines for Children (VFC) – Home (azdhs.gov) for details and information on enrollment and operations.

ASIIS Registry

The Arizona State Immunization Information System (ASIIS) is a central registry designed to capture immunization data within the state. Providers are required to report all immunizations administered to children 18 years of age and younger to the state health department (providers are strongly encouraged to also enter adult vaccination data). The registry provides a valuable tool for reporting immunization information to public health professionals, private and public health care providers, parents, guardians and other childcare personnel. A goal of ASIIS is 100% capture of vaccinations provided to children, giving providers a reliable place to check for both current and historic immunization records. Another ASIIS goal is to ensure health care professionals administering immunizations are reporting to the ASIIS registry in a regular and timely manner. Banner – University Health Plans reviews the performance of contracted providers in their reporting of administered vaccinations into the ASIIS Registry, as required by state law and AHCCCS guidelines. The Health Plan's EPSDT team will be reaching out to providers identified to have ASIIS immunization entry gaps to increase awareness and improve ASIIS entry performance. For more information on the ASIIS, please visit the Arizona Department of Health Services – ASIIS webpage at: http://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/asiis/index.php

Additional information can be found in our Provider Manual. You can access our provider manual by visiting our website https://www.banneruhp.com/ then select Provider Manual from the Quick Links section.

Direct Secure Messaging Available

Through Banner Health's Clinical Connectivity portal

Banner Health is excited to provide Direct Secure Messaging (DSM) to save you time and improved coordination of care for patients. A HIPAA compliant alterative to faxing or mailing information, DSM is a secure exchange or electronic health records (EHR to EHR) and enables you to securely:

- Transition care (CCD, CCD-A documents)
- Send referrals to Banner Health physicians
- Exchange consult notes and results
- Receive and distribute finalized reports

Benefits of DSM

- Secure and Trusted – Messages are authenticated and encrypted to ensure Personal Health Information (PHI) is sent securely and received only by authorized parties.
- Timely and Available – DSM provides you the ability to send information about your patient within minutes, allows clinicians timely details, and helps address gaps in information that occur during transitions of care
- Efficient and Adaptable – DSM is an alternative to mailing or faxing your patient's information, which can be time consuming and may not always be secure

Start Using DSM

If your clinic is already set up through Banner Clinical Connectivity: Your group administrator needs to request DSM access be added to your account. Visit access.bannerhealth.com/clinicalconnectivity to submit that request.

To enroll or request DSM access for the first time. Visit bannerhealth.com/clinicalconnectivity

If you have questions or need support:

- Access self-enrollment and training guides at bannerhealth.com/clinicalconnectivity
- Contact the support team at 602-747-4444, option 4
- Email webconnect@bannerhealth.com

Provider Manual

The Banner − University Health Plans Provider Manual is located on our website, www.banneruhp.com under the Quick Links section on the right-hand side of the page. A copy of the Provider Manual is available upon request at no charge. If you need assistance, please contact your Care Transformation Consultant or Specialist.

Provider Manual Updates

Updates to the B − UHP Medicaid Provider Manual have been made and will be effective **Aug. 14, 2023**

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

Key Updates and Changes:

- Tucson Office Address Updated throughout B – UHP Provider Manual
- PCP Policies – Provider Assignment.
    - Updated verbiage to include PCP's participation in Value-Based Purchasing. (Pg.25)
- AzEIP
    - Included information regarding Screening and Identification.
        - "B – UHP strives to remove barriers to developmental screening and evaluation services for our youngest AHCCCS members ages 0-3 years old, to ensure that early developmental opportunities are maximized. During the EPSDT visit the PCP will determine the child's developmental status using appropriate developmental screening tools and discussion with the parent/guardian/designated representative." (Pg. 69)
    - Added verbiage regarding section *Primary Care Providers (PCP) Initiated Service Request* and included (Pg. 69-70)
        - PCP's may submit a referral to the AzEIP central office for evaluation, support and education, via the online AzEIP portal: https://azeip.azdes.gov/AzEIP/AzeipRef/Forms/Categories.aspx or by calling (888) 592-0140.
        - If the PCP identifies potential developmental delays, the PCP can also refer the member to a specialist in the field that the delay was noted.
        - The PCP shall document the referral to AzEIP and/or other specialist provider(s) on the EPSDT form (or provider's EMR equivalent) prior to submission to health plan. Once the EPSDT form is received, the Banner – University Family Care EPSDT coordinator will review the necessary records to determine if an evaluation by the specialist or AzEIP has been completed. If there are no claims to indicate an evaluation has been performed, the Health Plan's AzEIP Coordinator will contact the AzEIP central referrals coordinator, the member and/or the PCP to determine the referral status and facilitate completion.
    - Added information about EPSDT services, resources, and children over the age of 3 as follows: (pg. 72)
        - For members who do not qualify for EPSDT services, support is available through other programs:
            - Raising Special Kids (RSK)
                - RSK, Arizona's Parent and Training Information Center, has identified many different resources for members who don't qualify for AzEIP but may still need additional support. A referral

to this program can be made by visiting https://raisingspecialkids.org/refer-a-family/

- Directory of Resources
  - AzEIP's Central Directory of Resources includes the following for infants and toddlers and their families:
    - Public and private early intervention services, resources, and experts available in the state
    - Professional and other groups including parent support, training, and information centers
    - Research and demonstration projects being conducted in the state
    - More information can be found at https://des.az.gov/services/developmental-disabilities/early-intervention/resources

- For Children Over the Age of 3
  - If the PCP is concerned about the member's development and the member is between the ages of 3 (or within 45 days of their third birthday) and 21 years, the PCP can make a referral to the District of Residence by reviewing the AZ Child Find Requirements and Screen Information and submitting the referral form.
  - More information can be found at https://www.azed.gov/specialeducation/az-find

- Prior Authorization
  - Removed, "Psychological and Neuropsychological Testing", no additional verbiage or terms were added in place of this.
- Arizona State Hospital – Pima County, page
  - Added new information regarding AzSH
    - B – UHP Behavioral Health Department maintains contact with AzSH, to ensure awareness of members admitted to AzSH and of potential discharges, for the purpose of coordination of care. For members with diabetes who are being discharged from AzSH, the B – UHP Behavioral Health Department ensures that the same brand and model of both glucometer and supplies that the member received and were trained to use while admitted to AzSH, are supplied upon discharge. (pg. 126)
  - "Psychiatric Security Review Board" (PSRB) was removed and replaced with "Superior Court" (Pgs. 126-128)

  - Removed “Attendance in a monthly conference call with AHCCCS Medical Management (MM)”, no additional verbiage or terms were added in place of this. (Pg. 127)
  - Added “1320-Z. Forms may be found on the AHCCCS Website under “*Resources, Oversight of Health Plans – System of Care.”* (Pg. 128)
- Prior Authorization Procedures for Behavioral Health Providers
  - Removed “Emergent Admissions to BHRF, BHIF, TFC, and ABHTH will no longer be authorized effective October 1, 2021.” (Pg. 148)
    - Added in its place, “Emergent admission to and continued stay for inpatient medical facility, psychiatric or detoxification acute inpatient facility”

AHCCCS Appointment Availability and NCQA Requirement Regarding Office After-Hours

In compliance with AHCCCS and NCQA after-hours care should be available by either recording or an answering service for the following provider types. The information provided will need to instruct members/patients on the process of the office after hour care or emergency as well as the steps for non-life-threatening Behavioral Health emergency during normal business hours.

Specialists

- A recording or answering service that would either notify the Dr on call, and/or direct the patient to go the nearest emergency room or urgent care

Behavioral Health

- A recording or answering service that would either notify the Dr on call, and/or direct the patient to go the nearest emergency room or behavioral health crisis unit
  - Care for a non-life-threatening emergency during normal business hours: If unable to schedule a non-life-threatening emergency within 6 hours of request
  - Patients should be directed to the nearest emergency room or a behavioral health crisis unit

Member Rights

Banner − University Health Plan is committed to treating members with dignity and respect at all times. Member rights and responsibilities are shared with staff, providers and members and are included in our Member Handbook. A list of member’s rights under 42 CFR 438.100 is included below:

- A member’s right to be treated with dignity and respect
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164 and applicable State law

- Exercise his or her rights and that the exercise of those rights shall not adversely affect service delivery to the member

Compliance Corner

Cybersecurity Information – What is "Vishing?"

The term "vishing" refers to attempts to solicit or gain information or to try and influence actions by using the telephone instead of the email or computer. In this regard, the individuals attempt to act as if they are a legitimate company or source and oftentimes use phone spoofing. Phone spoofing allows the attacker to hide their actual phone numbers and instead display a number that appears to be from a legitimate company or person. The fake number will display on the caller ID making it seem real to the recipient.

With the use of Voice over IP (VOIP) systems, the potential to display a fake number is much easier than it used to be with prior traditional phone services. With traditional phone services the system exchange would connect one circuit directly to another circuit, but when VOIP is used, phones are assigned IP addresses and the phone number can be anything that the attacker chooses to use. Most times the users find legitimate phone numbers from an organization's website or from social media platforms.

Callers attempting to scam frequently use "social engineering" tactics to deceive or mislead the recipient. Some of those include saying something they know is not accurate so that the person they are attempting to scam feels the need to correct the caller and in doing so inadvertently gives information to the scammer. Giving an incorrect email address is one example.

Another method used is to attempt to solicit emotional responses such as asking for help or sympathy. In other situations, the caller has impersonated IT Personnel and offered to help with IT.

In order to not become a victim of vishing, the best protection is awareness. There are actions that can be taken to reduce the risk and include:

- Do not provide usernames or passwords to a caller for granting access to their systems. Most companies customer service reps would not be able to see this information.
- Be wary of any caller asking for your credit card, banking information, or personal information.
- Pretending to be a licensing/certification agency and claiming that the license or certification will be revoked unless their instructions are followed.
- Don't trust caller ID. The scammer could call you from any number and it appears as a different caller.
- If you are not sure, you can always hang up and call the company back on the official number on their website or on the back of your card and confirm the situation.

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
5255 E Williams Circle, Ste 2050
Tucson, AZ 85711

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** Raquel Chapman via phone 602-747-1194 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, TTY 711
Banner - University Family Care/ALTCS: (833) 318-4146, TTY 711

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

- 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