Banner
University Health Plans

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Provider Update

July 2024

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Covered Behavioral Health Services Guide (CBHSG)

A memo from AHCCCS with an effective date of 10/1/2024

The CBHSG is not subject to public comment; however, AHCCCS will be collecting questions on the guide between 7/15/2024 and 9/15/2024. Questions will be used to inform a frequently asked questions (FAQ) document as well as develop training materials for providers and stakeholders. Please submit all questions via email to CBHSGCodingQuestions@azahcccs.gov.

The guide has been published to the Medical Coding Resources page and can be found under the Behavioral Health Services Matrix and Guide drop down: https://www.azahcccs.gov/PlansProviders/MedicalCodingResources.html.

Complete Care

New Health Equity Content on Website

In our on-going efforts to provide resources and information regarding Health Equity, we have added information to our website. The new content contains information and resources about the following topics:

- Collection of Race/Ethnicity and Language, and Sexual Orientation and Gender Identity data.
- Support of Language Needs including how to access and work with interpreters.
- Addressing Health Disparities including information on how our internal committees and our provider and community committees work collaboratively to advance health equity.
- Addressing Health-Related Social Needs including training aid for ICD-10 Z-Codes for Health-Related Social Needs.
- Education and Resources including training and resources from nationally recognized leaders in Health Equity.
- Guiding Documents including guidance from CMS, NCQA and AHCCCS.

Medicaid Websites

- Medicaid 101: https://www.bannerhealth.com/medicaid/health-wellness/topics/health-equity
- Medicaid Providers: https://www.banneruhp.com/about-us/health-equity

Medicare Websites

- Medicare 101: https://www.bannerhealth.com/medicare/health-wellness/topics/health-equity
- Banner Medicare Advantage: https://www.bannerhealth.com/medicare/advantage/members/health-equity
- Banner Medicare Providers: https://www.bannerhealth.com/medicare/providers/health-equity

Children's System of Care

LGBTQ Centers of Excellence

BUFC is establishing LGBTQ Centers of Excellence for Children and Adults. LGBTQ Centers of Excellence incorporate Evidence Based Practices, industry best practices and AHCCCS requirements for screening, assessment, and treatment. BUFC uses the Centers of Excellence designation to highlight providers and programs with exceptional quality and outcomes for our members. For additional information about LGBTQ Centers of Excellence including criteria, timelines and the recognition process, email Alice.Streight@BannerHealth.com.

Implementation and Rollout of Wraparound, FOCUS and MRSS

On 10/1/23 AHCCCS contracted with National Wraparound Implementation Center to implement three models of care into the Children's System of Care; Wraparound, FOCUS and MRSS. The goal of these programs is to provide intensive coordination of care for complex members and members involved with the crisis system.
Over the last several months AHCCCS and NWIC gathered information about the Children's System of Care through audits, listening sessions and systemwide reviews.

In July, 2024 BUFC is meeting with the other MCOs, AHCCCS and NWIC to discuss logistics and implementation of these programs. It is expected that Wraparound will be rolled out first and the other two programs will have a staggered implementation. For information about Wraparound, FOCUS and MRSS access the NWIC website at www.nwic.org or email Hilary.Mahoney@BannerHealth.com.

New Diagnosis List for SED

Effective 10/1/23 AHCCCS implemented a formal process for the determination of Seriously Emotional Disturbed (SED) individuals. Individuals under the age of 18 with a qualifying diagnosis and functional impairment may meet criteria for SED determination.

Based on stakeholder feedback, AHCCCS conducted a thorough analysis of the SED Qualifying Diagnosis List. In June 2024, AHCCCS revised the SED Qualifying Diagnosis List to include diagnoses not previously recognized.

This revised list can be found on the AHCCCS website:
https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AMPM320PSEDDiagnosis.pdf

Solari updated and posted the revised SED Determination form on their website to correspond with the AHCCCS updates.

If you have questions about the SED Determination Process review the SED Frequently Asked Questions on the AHCCCS website, AHCCCS Policy AMPM 320-P and the Solari website. For additional information email Jennifer.Blau@BannerHealth.com.

Adult System of Care

Behavioral Health Residential Facility (BHRF) and Medication Opioid Use Disorder (MOUD)

- BHRF providers are not to exclude members on MOUD from admission. If BHRF provider does not provide MOUD, then the BHRF is required to coordinate care with the member's MOUD provider.
- BHRF providers must have policies that specifically ensure that members have access to their MOUD services and must train all staff on this requirement.
- If BHRF program offers an Opioid Treatment Program (OTP) or Office Based Opioid Treatment (OBOT) provider, then MOUD may be transitioned to that provider if member is agreeable.
- If BHRF program offers MOUD, then BHRF provider and Health Home must ensure member is enrolled with a MOUD provider upon discharge and coordinate.
- If BHRF cannot accommodate specific MOUD treatments due to licensure or coordination constraints, then BHRF providers can present options to transition from MOUD or MOUD alternatives but must not require their alternative treatment for admission and must coordinate with member, MOUD 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, MOUD Provider, Health Home, and prescribing doctors before adjusting prescribed treatment regimens.

In case of an emergency, there are 24/7 Access Point locations providing opioid treatment services 24 hours a day, 7 days a week to serve individuals seeking treatment. MOUD is offered in various settings in the community that are commonly described as Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatment (OBOTs).

CODAC Health, Recovery and Wellness	380 E. Ft. Lowell Rd Tucson, AZ 85705	Phone# 520-202-1786
Community Bridges, East Valley Addiction Recovery Center	560 S. Bellview Mesa, AZ 85204	Phone# 480-461-1711
Community Medical Services	2806 W. Cactus Rd Phoenix, AZ 85029	Phone# 602-607-7000
Intensive Treatment Systems, West Clinic	4136 N. 75th Ave #116 Phoenix, AZ 85033	Phone# 623-247-1234

Please refer to AMPM
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-V.pdf

For assistance in locating a MOUD provider, please visit AHCCCS to find an OTP or OBOT provider https://opioidservicelocator.azahcccs.gov

Integrated System of Care

Banner has partnered with Arizona Coalition for Military Families: BeConnected
Banner Plans & Networks is committed to supporting Veterans, Military Service members, their families, and caregivers. As part of our ongoing commitment, we aim to empower you with resources that will ensure our provider network and community partners are equipped with tools to support bridging and connecting our Veterans, Military Service members, their families, and caregivers to supports and services to best meet their needs.

BeConnected is the Arizona state approved Veteran resource provider. The BeConnected team provides quality resources for Veterans, Military Service members, family members and caregivers. BeConnected also provides trainings to and for providers and community partners. BeConnected offers resources and supports that cover the entire spectrum of the Social Determinates of Health (SDoH) | Health Related Social Needs (HRSN).

Help us continue to ensure our Banner Plans & Network Veterans, Military Service members, their family members and caregivers are getting connected to the right resources at the right time by using the Banner specific referral link below when referring our members to BeConnected.

https://tinyurl.com/2xbsw546

Whole Person–SDoH/HRSN Banner – University Family Care Provider Training Series

This virtual educational training series and our amazing line-up of presenters is designed to enhance awareness, knowledge, and provide tools to identify interventions that address Health Related Social Needs within General Mental Health & Substance Use (GMH|SU) populations.

B–UFC is proud to offer behavioral health CEUs for clinical professionals and support staff including specialized CEUs for Community Health Workers/ Representatives (CHW/CHR) within Arizona!

You may register in Teams or Relias. If you have a Relias account, we encourage you to register via Relias for easier access to your CEU transcript and certificate. Go to your Relias course library and search "Banner" to locate these trainings.

Online Training Schedule:

Harm Reduction: A Scientific Perspective
Dr. Robert Sherrick, MD, FASAM, CSO
July 17, 2024 | 12 – 1 p.m.
Register Here: https://tinyurl.com/25yy98zv

OUD Treatment: Families at the Center of Care
Kate Dobler, AHCCCS (SOTA)(WSC)
July 31, 2024 | 12 – 1:30 p.m.
Register Here: https://tinyurl.com/yafzfaec

Harm Reduction as Trauma: Responsive
Kara Jean Brei, MC, LAC
August 7, 2024 | 12 – 1:30 p.m.
Register Here: https://tinyurl.com/2yuvty2f

Harm Reduction in Action: Sonoran Prevention Works
Kayla Kurti, B.S
August 20, 2024 | 12 – 1:30 p.m.
Register Here: https://tinyurl.com/y9bvdwbf

Overdose Trends and Harm Reduction
Mark Person & Melissa Miller
Pima County Health Department
September 4, 2024 | 12 – 2 p.m.
Register Here: https://tinyurl.com/4mb54bb7

Maternal Child Health

Office of Individual and Family Affairs (OIFA)

Developmental Surveillance, Developmental Screening and AzEIP Referrals

Developmental Surveillance

Developmental surveillance shall be performed by the PCP (with appropriate anticipatory guidance provided) at each EPSDT / Well-Child visit. Provider are encouraged to use the most recent developmental milestones through the "Learn the Signs. Act Early" program, which is regularly updated by the AAP (American Academy of Pediatrics) and the CDC (Centers for Disease Control and Prevention).

Developmental Screening

PCPs shall utilize AHCCCS accepted screening tools to complete general developmental screening at the 9-, 18- and 30-month EPSDT / Well-Child visits. Autism Spectrum Disorder (ASD) specific screening is also required at the 18- and 24-month EPSDT visits. AHCCCS accepted tools are described in the CMS core measure Developmental Screening in the First Three Years of Life, measure specifications.

AzEIP Referrals and Service Requests

The Arizona Early Intervention Program is a statewide interagency system of services and supports for families of infants and toddlers (from birth until 3 years of age) with disabilities or delays. Established by Part C of the Individuals with Disabilities Education Act (IDEA), AzEIP provides eligible children and their families access to services to enhance their capacity to support the child's development.

Anyone can submit an AzEIP referral. This includes PCPs, other providers, parents, caregivers and others. When concerns about a child's development are identified, a referral for evaluation should be submitted directly to the AzEIP central office, via the online AzEIP portal:

https://azeip.azdes.gov/AzEIP/AzeipRef/Forms/Categories.aspx or by calling (888) 592-0140.

The PCP shall provide the member's parents/guardian/designated representative, with appropriate anticipatory guidance. A prior authorization is not required for AzEIP evaluation facilitated through the AzEIP central office. The PCP can also refer the member to a specialist in the field that the delay was noted. Referrals to AzEIP or other specialist shall be documented on the EPSDT form (or provider's EMR equivalent) and submitted to the health plan. A health plan AzEIP Coordinator will follow-up with the AzEIP central office, the member/family and PCP to facilitate completion of the process.

AzEIP Services Determinations

If the AzEIP evaluator determines a child to be AzEIP eligible, an Individual Family Service Plan (IFSP) will be developed and sent with evaluation/developmental summaries to the health plan. The health plan will enter the request into the prior authorization system within one business day and forward the AzEIP Member Service Request (MSR) form and copies of the evaluation/developmental summaries to the PCP within two business days.

- The PCP must determine which AzEIP recommended services are medically necessary, based on a review of the AzEIP MSR form and summaries. The PCP shall return the signed AzEIP MSR form with documented determination of medically necessary services, within ten (10) business days.
- For medically necessary services, the health plan will send notice to the PCP and the authorized AzEIP service provider, indicating services approval, authorized AzEIP services provider(s), approved service frequency and duration, and approved service start and end dates.
- If the PCP deems AzEIP recommended services are Not Medically Necessary, the health plan will send a Notice of Adverse Benefit Determination to the PCP and parent/guardian/designated representative, notifying them of denied services within two business days. The health plan will also return the AzEIP MSR form to the AzEIP services provider and central office, indicating services were deemed not medically necessary by the child's PCP.

Members Not AzEIP-Eligible

For members who do not qualify for AzEIP program enrollment (i.e. the AzEIP evaluation report indicates a child does not have a 50% developmental delay), the health plan's Maternal Child Health department will initiate outreach to review member/family needs, coordinate care and services, evaluate for barriers to care and provide assistance as appropriate.

For any AzEIP questions, please contact the Maternal Child Health department's AzEIP Coordination team by email at BUHPAzEIP@BannerHealth.com or by calling our Customer Care Center at (800) 582-8686.

ASIIS Registry Requirement

The Arizona State Immunization Information System (ASIIS) is a central registry designed to capture immunization data on individuals across the state. This registry serves as a valuable immunization information tool for public health professionals, private and public healthcare providers, parents, guardians and other childcare personnel.

Arizona Revised Statute (ARS) §36-135 requires providers to report all immunizations administered to children aged 0 through 18 years, to the state's health department using the ASIIS registry. ASIIS administrators strive to capture 100% of vaccinations provided to Arizona children, while ensuring secure access to registry data to all ASIIS registered providers.

Banner University Health Plans does review the performance of contracted providers in their reporting of administered vaccinations to the ASIIS registry and sends written notices to providers when administered vaccines are missing from the ASIIS database. If providers have questions about results of the health plan's ASIIS records audits, please email us at BUHPMaternalChildHealth@bannerhealth.com.

For more information on the Arizona State Immunization System (ASIIS), please visit the Arizona Department of Health Services – ASIIS webpage at: http://www.azdhs.gov/preparedness/epidemiology-disease-control/immunization/asiis/index.php

ASHLine

The ASHLine referral program is a resource for healthcare providers and physicians to connect patients with a quit-tobacco program.

As a health professional, you can submit online or fax referrals to the ASHLine and the patient will be contacted within two business days to enroll in Quit Coaching smoking cessation program.

Referring a patient to the ASHLine increases their likelihood of quitting and staying quit. ASHLine coaches support individuals throughout the quitting process—helping them develop a tobacco-free lifestyle and get free medication if they qualify. Recent research shows that up to 70% of smokers think about quitting each year. Advice to quit from a health professional is cited by tobacco users as the number one motivator to quit.

ASHLine Quit Coaches help pregnant women to stop smoking tobacco. Their coaches have special training to provide support before and after pregnancy. Through nine coaching sessions, the Quit Coach will provide telephonic support in addition to Nicotine Replacement Therapy Nicotine replacement therapy, or NRT (Doctor approval is required if pregnant, postpartum, or breastfeeding).

How to make a referral:

Complete an online referral:

https://ashline.quitlogix.org/en-US/Health-Professionals/Make-a-Referral

By Fax – get the fax referral form at the following web address:

https://tinyurl.com/2zxtbmyr

ALTCS

Joining the Assisted Living Facility Network – Contracting Instructions and Tips

Thank you for your interest in joining the Banner University Health Plan (B-UHP) provider network. We are committed to expanding our service array for our members and to making the provider experience meaningful. Please follow the steps below to assist you with becoming a participating provider.

Provider Interest Form and Required Attachments

Please complete a provider interest form at our website at https://www.banneruhp.com/join-us/join-our-network. Make sure the application is complete, signed, dated, and has the following attachments:

- A completed and signed Arizona Alliance of Health Plans (AzAHP) Organizational/Facility application
- A W-9 with a current signature and date
- A copy of a current certificate of insurance
- A copy of the Arizona Department of Health Services (ADHS) license of the home

AzAHP Application

Please fill out the AzAHP Organizational/Facility Application completely and sign page 9. The application can be downloaded at AzAHP-Organization_Facility-Application-FINAL-v1-2021.pdf. Only attach the application to the provider interest form after AHCCCS Registration is completed. If you are reusing an AzAHP Organizational/Facility application submitted to another health plan, make that you are using the 2023 version or newer and that the signature date is current.

W-9

Be sure to fill out the W-9 completely with the legal name on the first row and doing business as name (dba) on the second row. Please ensure that the tax ID is correct, and the W-9 is signed with a current date. The W-9 Form can be obtained from the Internal Revenue Service (IRS) website at https://www.irs.gov/pub/irs-pdf/fw9.pdf

Certificate of Insurance

Every provider needs to show proof of liability insurance prior to contracting with any health plan and throughout the contractual term. Please do not send your homeowner's policy. Instead, provide a copy of the Certificate of Liability Insurance for your business. Please refer to pages 10 and 11 on the AzAHP Organizational/Facility Application for required coverage. Also, make sure your insurance broker follows the instructions carefully.

ADHS License

Submit a digital copy or a photo of your ADHS license. The license must be posted in or near the entrance to your home or center.

Change of Ownership

If you purchase an Assisted Living Facility, license and AHCCCS number, do not transfer from the previous owner to the new owner. The new owner must obtain a new ADHS license and contact AHCCCS to obtain a new 6-digit AHCCCS ID number.

Once the new ADHS license and AHCCCS ID number are obtained, the new owner must complete the provider interest form and attach all four documents from the list above.

Please note: No services can be provided to Banner members and no authorizations will be issued until the new owner completes the process above and obtains a Letter of Agreement (LOA) from Banner.

When a complete AzAHP form is received and your application is approved, the new owner will be issued an LOA until credentialing is complete. After credentialing is completed, a Banner Ancillary Services Agreement will be sent to the new owner to replace the LOA. Please note that the credentialing process and loading into systems can take up to 60 days.

If you have any questions, please contact:
Chris Masiello
Contracts Management Specialist
Banner University Health Plans
480-684-8964 office
Christopher.Masiello@bannerhealth.com

AHCCCS Updates

Intensive Outpatient Program (IOP) Coding Clarification – A Memo Shared by the Office of the Governor on June 4th, 2024.

This memo is being sent to all contracted health plans to provide clarification on psychiatric IOP services based on feedback AHCCCS received from both MCOs and providers related to the March 25, 2024, AHCCCS Memo on IOP.

Specifically, MCOs and providers raised concerns that the AHCCCS standards for S9480

intensive outpatient psychiatric services are above the current Medicare standards and that programs would need to adjust their programming to align to the AHCCCS standards. While AHCCCS, as Arizona Medicaid, is not required to adopt Medicare requirements, we understand that alignment is important given psychiatric IOPs serving multiple payers, including Medicaid only, Medicare only, Dual Medicaid-Medicare, and Commercial plans.

Based on these concerns, AHCCCS will be creating a tiered psychiatric IOP model that will be incorporated into the Covered Behavioral Health Services Guide (CBHSG) which is due to be released Summer 2024 and effective as of October 1, 2024. We expect that our MCOs will be evaluating and monitoring their network based on these updated standards for tiered psychiatric IOP beginning 10/1/24.

Please contact systemofcare@azahcccs.gov with any questions regarding this memo.

Provider Services & Support

Model of Care

Model of Care Training and attestation is required annually every calendar year. 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.

Any and all new providers joining your group should attest within **60 days of hire**.

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

This training and attestation take a minimal amount of time to complete (approximately 20 minutes).

Instructions:

1. Review the training content located here: https://www.banneruhp.com/-/media/files/project/uahp/provider-trainings/moc/prov-bma_model-of-care-education_v2_cy24_en.ashx?la=en
2. Complete the Annual Attestation: https://bannerhealth.formstack.com/forms/moc_attestations
3. When completing your online attestation, please ensure you are documenting each practitioner's individual NPI on the attestation form.

NCQA Member Language Preference added to eServices Patient Roster

Did you know that the Member Language Preference is now available on the patient roster?

When using the self-service portal, eServices, to review the patient roster for your group you will now see a column named "Language Preference". This field contains the patient's preferred language. If you need assistance with accessing this information from eServices please reach out to your Care Transformation Specialist or Consultant.

Language Interpretation and Language Services

B–UHP provides interpretive and translation services for its members. If you have a member who needs these services, please contact the Customer Care Center at 800-582-8686. Interpretive services are not based upon the non-availability of a family member or friend for translation. Members may choose to use family or friends; however, they should not be encouraged to substitute them for the interpretation service.

Switch to the new version of the Sandata Mobile Connect app

A new version of the Sandata Mobile Connect app is available. Caregivers using the old version need to update to the new app. This will help your agency fully benefit from improved functionality and the latest security updates.

Follow these steps:

1. Choose the correct app store for your phone and download – Apple Store or Google Play.
2. Use your same username (email address) and password.
3. Log in and get started!

Workforce Development

Vocational Rehabilitation: Did you know?

- Members who are receiving services though Vocational Rehabilitation may still be able to receive employment services though Behavioral Health. Providers first must coordinate with VR staff to ensure they are not duplicating services.
- Anyone can complete a VR referral! Just make sure you have the proper releases. The referral form can be found on the VR website below.
- You can become a vendor for VR! You just need to apply though the office of procurement at app.az.gov or contact the Office of Procurement Helpline at 602-542-7600, email app@azdes.gov and https://spo.az.gov/.
- B-UHP is here to help! Do you have questions related to working or collaborating with Vocational Rehabilitation? Please reach out to healthplanemployment@bannerhealth.com

For more information on Vocational Rehabilitation or the services they offer please visit https://des.az.gov/services/employment/rehabilitation-services/vocational-rehabilitation-vr

Risk Adjustment

Antidepressant Medication Management

Major depression can lead to serious impairment in daily functioning, including change in sleep patterns, appetite, concentration, energy, and self-esteem, and can lead to suicide. Consistent medication treatment of major depression can improve a person's daily functioning and well-being and can reduce the risk of suicide.

Commonly identified barriers for patients with antidepressant medication adherence are the length of time it takes for medications to begin working effectively and the experienced side effects.

Antidepressant medications can take 4-8 weeks before patients begin to see improvements in their mood. Discussing this timeline with patients at the time medications are prescribed can better prepare, encourage, and support them in being consistent with their medications long enough to determine effectiveness.

Common side effects of antidepressants can include sexual problems, weight changes, dizziness, upset stomach, or feeling tired, among others. Ensuring patients are aware of the potential side effects from the beginning is important.

When medications are started, facilitate a discussion about how they can reach a provider should they experience significant side effects, or to discuss stopping a medication.

Providing patients with telehealth or other virtual methods of contact may be more convenient and allow for quicker access to services and support. Referring patients for psychotherapy services for added support and education on their diagnosis, symptoms, and treatment options is also strongly recommended.

Diabetes and Cardiovascular Disease Screening

Routine screening for diabetes and cardiovascular disease are highly important for our patients, as heart disease and diabetes are among the top leading causes of death in the United States. The risk of these diseases is increased for patients who are prescribed antipsychotics with a serious mental illness.

To better support screening and monitoring for diabetes and cardiovascular disease, it is encouraged to schedule routine appointments with patients dependent upon their specific needs and risk levels. Those patients who are taking prescribed antipsychotics should have both HbA1c and LDL-C screenings completed at least annually. Those patients who are diagnosed with Diabetes Type 1 or 2 are also recommended to have HbA1c screenings at least annually.

During these visits have discussions about lifestyle risk factors, such as alcohol and tobacco use, providing additional support, resources, and education on how to appropriately manage these risks. Additionally, discuss positive lifestyle factors that patients can engage in or continue such as physical activity, healthy diets, and consistent screening and monitoring. Remember to give them the opportunity to ask questions and use terms they can easily understand.

CHC Cyberattack-Remittance Appeal Guidance

Attn: Banner–University Care, Banner Medicare Advantage and AARP United Medicare Complete Providers:

There is a possibility that you may have received a remittance advice during the CHC Cyberattack that did not include the standard appeals language. Attached is information to assist you with appeals.

Banner Medicare Advantage Providers:

Non-Contracted Providers may submit a post-payment reconsideration if the provider completes a waiver of liability (WOL), which ensures the non-contracted provider will not bill the enrollee regardless of the appeal outcome. All appeals must be submitted in writing and received by Banner Medicare Advantage within sixty (60) days of receipt of the remittance notification. Along with the WOL, non-contracted providers must submit documentation that supports their appeal (copy of original claim, claim records, etc.).

WOL can be found in the "Downloads" section online at:
https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms

Contracted Programs, unless otherwise provided for in contact, must submit a post-payment reconsideration within 60 days of this remittance advice.

Please ensure to submit claims for members with dual eligibility to the appropriate secondary payer. Please refer to AHCCCS Contractor Operations Manual (ACOM) 201 for Medicare Cost Sharing for Members Covered by Medicare and Medicaid.

Please mail reconsideration requests to:

Banner – Medicare Advantage

ATTN: Grievance & Appeals

5255 E Williams Circle, Ste 2050

Tucson, AZ 85711

Fax: (866) 873-0029

Resubmissions attempting to achieve clean claim status must be received within 12 months from the date of service, or 12 months from the date of eligibility posting, whichever is later and must include the words "resubmission" or "reconsideration."

Please mail claims resubmissions to:

P.O. Box 38549

Phoenix, AZ 85069-7169

Banner-University Family Care - AHCCCS Complete Care (ACC) Providers

Your rights if you disagree with our processing of your claim:

Unless your contract states otherwise, in accordance with Arizona Revised Statutes (ARS) § 36.2903.01(B)(4), a grievance that is related to a claim for covered services (called "provider claim disputes") must be filed in writing with B – UFC/ACC within 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later.

Provider Claim Disputes must be labeled as such and must include a formal cover letter providing the factual and legal basis for the dispute.

Please mail provider claim disputes to:

B – UFC/ACC

Attn: Grievances and Appeals Department

5255 E Williams Circle, Ste 2050

Tucson, AZ 85711

If you need to correct your claim, please submit a corrected claim rather than filing a provider claim dispute.

Please mail claims resubmissions to:

P.O. Box 35699

Phoenix, AZ 85069

Banner-University Family Care - Arizona Long Term Care System (ALTCS) Providers:

Unless your contract states otherwise, in accordance with Arizona Revised Statutes (ARS) § 36.2903.01(B)(4), a grievance that is related to a claim for covered services (called "provider claim disputes") must be filed in writing with B – UFC/ALTCS within 12 months from the date of service, 12 months after the date of eligibility posting, or within 60 days after the payment, denial, or recoupment of a timely claim submission, whichever is later.

Provider Claim Disputes must be labeled as such and must include a formal cover letter providing the factual and legal basis for the dispute.

Please mail provider claim disputes to:

B-UFC/ALTCS

Attn: Grievances and Appeals Department

5255 E Williams Circle, Ste 2050

Tucson, AZ 85711

If you need to correct your claim, please submit a corrected claim rather than filing a provider claim dispute.

Please mail claims resubmissions to:

P.O. Box 37279

Phoenix, AZ 85069

United Healthcare/BPN Providers:

Process for Non-Contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or downcoding of services. To appeal a claim denial, submit a written request within 60 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed Waiver of Liability form (you may obtain a copy by going to:
- https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/model-waiver-of-liability_feb2019v508.zip
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records or documentation

Mail the appeal request to:

UnitedHealthcare

P.O. Box 6106, Cypress, CA 90630

MS:CA124-0 157.

Payment Dispute Process for Non-contracted Medicare Providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted health care professionals may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider contends the amount paid by the Plan for a Medicare covered service is less than the amount that would have been paid under Original Medicare. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing the claim payment
- Any additional information, clinical records or documentation to support the dispute

Contracted Providers

When disputing a claim payment for any reason (i.e., denial, underpayment, etc.), the provider must submit the request to BHN Reimbursement Services to:

Attn: BHN Reimbursement Services Provider Payment Disputes

AARP United Medicare Complete

PO BOX 16423

Mesa, AZ 85211

If you have additional questions relating to a dispute decision made, you may contact us at:

Phone: 480-684-7070 Toll free 1-800-827-2464

Mail: Banner Health PO Box 16423 Mesa, AZ 85211-6423

Email: ProviderExperienceCenter@bannerhealth.com

Billing Alerts

Section 190S(n) of the Social Security Act prohibits a provider from billing an individual with coverage as a Qualified Medicare Beneficiary (QMB), with or without there Medicaid coverage, or someone receiving Supplemental Security Income benefits and Medicare for the Medicare deductible or coinsurance.

Grievances & Appeals

Reminder of Requirements for Filing a Claim Dispute

As part of our ongoing efforts to ensure a smooth and efficient review process, we want to remind you of the requirements for filing a claim dispute.

To help us expedite the resolution of any disputes, please ensure that the following information and documentation are included with your claim dispute submission:

1. A cover letter on appropriate letterhead or appeal letter indicating your reason for filing the claim dispute. Please include the following information in your letter:
    a. Date of request
    b. Claim number
    c. The factual and legal basis for the claim dispute and your expected resolution
    d. The enrollee's AHCCCS ID number, full name, date of service, and date of birth
    e. Writer's name, address, telephone and fax number and/or email address.
2. Supporting documentation, including:
    a. A copy of the EOB or RA from B – ALTCS
    b. A copy of the original claim(s)
    c. Corrected claim(s), if applicable
    d. A copy of the Medicare or primary insurer EOB(s), if applicable
    e. A copy of the authorization, if applicable
    f. If you are a contracted provider with specific rates in your contract, a copy of the applicable pages from your contract when challenging the rate of pay.

Additionally, requests that are for multiple members, claims or dates of service will need to be separated and individually appealed.

To submit a dispute, please use the following methods:

Mail:

Banner – University Family Care/ACC & ALTCS

Attn: Grievance & Appeals Department

5255 E Williams Circle, Ste 2050 Tucson, AZ 85711

Banner Medicare Advantage

Attn: Grievance & Appeals

5255 E Williams Circle, Ste 2050 Tucson, AZ 85711

Fax:

Banner – University Family Care/ACC & ALTCS

Fax: (866) 465-8340

Banner Medicare Advantage

Fax: (866) 873-0029

We are committed to providing you with timely and accurate responses to your claim disputes. Adhering to these requirements will help us process your disputes more efficiently and effectively.

Compliance Corner

Balance Billing and Charging Members

For providers who receive funds from Banner-University Family Care/ACC (B-UFC/ACC) or Banner-University Family Care/ALTCS (B-UFC/ALTCS) on behalf of AHCCCS (Medicaid), there is a requirement to complete AHCCCS registration.
In this process, providers agree to not bill or attempt to collect payment directly or through a collection agency from anyone claiming to be AHCCCS eligible without either verifying that the individual was not eligible on the date of service, or the services provided were not AHCCCS-covered services. If a provider collects payment from a person who later obtains AHCCCS eligibility on the date of service, the provider shall refund the amount collected to the person.
The providers must comply with the Arizona Revised Statute §36-2903.01 and Arizona Administrative Code R9-22-702 which prohibits the provider from charging, collecting, or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. Registered providers must accept payment as payment in full.
There are only a few exceptions for a provider to demand or collect payment from a member including:

- Collecting a copayment.
- Recovering from the member funds provided to the member from a third party for an AHCCCS covered service.
- Obtaining payment from a member for medical expenses incurred when the member intentionally withheld or provided inaccurate information regarding AHCCCS enrollment or eligibility that caused the provider's payment to be reduced or denied.
- Providing a service that is not covered or excluded if the member signs a document in advance indicating the understanding that the service is not covered, and they will be responsible for payment.
- Submitting a prior authorization that is denied by the Medicaid Health Plan and the member signs a document in advance of receiving the services that the service was denied, and they are responsible for payment.
- Requesting services by a non-contracted provider under the circumstances where the Medicaid Health Plan is not responsible for "Out of Network" services and the member signs a document prior to receiving the services that they agree to be financially responsible.

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

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

- Qualified Medicare Beneficiary Plus (QMB+): AHCCCS (Medicaid) provides full Medicaid coverage and pays the Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance, and copayments). The member may still have copayments for Part D prescription drugs.
- Specified Low-Income Medicare Beneficiary Plus (SLMB+): AHCCCS (Medicaid) provides full Medicaid coverage and pays the Medicare Part B premium. Generally, if the service or benefit is covered by Medicare and AHCCCS (Medicaid), the cost share is paid by AHCCCS (Medicaid). The member may have cost sharing for services or benefits not covered by AHCCCS (Medicaid).
- Full Benefit Dual Eligible (FBDE): AHCCCS provides full Medicaid coverage and may provide some assistance with the Medicare cost sharing. Generally, if the service or benefit is covered by Medicare and AHCCCS (Medicaid), the member's cost share is paid by AHCCCS (Medicaid). The member may have cost sharing for services or benefits not covered by AHCCCS (Medicaid).

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

If you identify or suspect FWA or non-compliance issues, immediately notify the Banner Plans and Networks 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
Banner - University Family Care/ALTCS 833-318-4146
Banner - Medicare Advantage/Dual 877-874-3930
Banner Medicare Advantage Customer Care
Banner Medicare Advantage Prime HMO – 844-549-1857
Banner Medicare Advantage Plus PPO -1-844-549-1859

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

News of Note

Provider Excellence Center

- **Reminder:** Please review the list of users from your practice who have access to either the BHN web portal or eServices. If you need to make any changes (additions or deletions), please reach out to the ProviderExperienceCenter@bannerhealth.com to ensure our user records are current.

Provider Contracting
Update to AHCCCS Minimum Network Subcontractor Provisions

- AHCCCS has made several significant changes to the AHCCCS Minimum Subcontractor Provisions (MSPs) that are effective October 1, 2024, which are incorporated into your contract with BUHP or BPA. Please visit the AHCCCS website to review the changes and new requirements. Here is the link to the document: https://www.azahcccs.gov/PlansProviders/Downloads/MSPs_100124.pdf

Manage and Schedule NEMT Rides Online for Our Members

- MTM now has a self-service portal for providers to manage and schedule transportation for members. The MTM Link portal can be used to request transportation, cancel trips, make changes, and check the location of drivers in route with real-time GPS location.
- After signing up, users can log into MTM Link and search for Members using the Person Management Window. Trips can be scheduled and submitted by inputting trip details for the member and selecting a return ride.
- The portal also provides a calendar view where existing trip details can be searched. Users can also add notes in member profiles so that anyone interacting with the member or trip can see. MTM Link can be found here for sign up: https://tinyurl.com/5y5brmyb