Banner
University Health Plans

www.bannerhealth.com/bhpprovider
800-582-8686, TTY 711
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Provider Update

March 2025

In this issue:

AHCCCS Update

AHCCCS has implemented 2 new Provider Types effective 12/1/2024; Counseling Only (CF) and ABA Organizations (AB).

Counseling Only (CF): ADHS issues licenses classified as counseling only. In the past, they were being enrolled as an IC or 77, which is not appropriate because it allows them to bill for services outside the scope of the counseling license. The new provider type ensures that provider organizations that hold this license type are only able to be reimbursed for services within the scope of their license.

ABA Organizations (AB): Organizations that provide ABA services can be issued an unclassified organization through ADHS. AHCCCS received feedback from external stakeholders that they wanted a streamlined way to enroll for these newly established organizations/provider types. They used to enroll as a group biller and associate their individual BCBAs to the group. Now, they can enroll the ABA organization and be reimbursed on the organizational level for ABA services provided at their organization.

Behavioral Health Pediatric Best Practice Guidelines

Banner – University Health Plans (B – UHP) has developed a set of Behavioral Health Pediatric Best Practice Guidelines which are based on the most current evidence-based literature. These guidelines are intended to be member focused, and population-outcome based, with the intent of improvement in quality of care. 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 widely disseminated, and their implementation will be monitored on an ongoing basis. We have recently discussed the assessment and treatment of anxiety disorders in children and adolescents. The clinical guidelines developed by the American Academy of Child and Adolescent Psychiatry were utilized.

Additional information and resources on best practice guidelines are available on the Medical Necessity Criteria and Clinical Practice Guideline webpage: https://tinyurl.com/y3sdad5f

We would gladly receive any feedback regarding the adoption of the Anxiety Guidelines for pediatric members under B – UHP. Please send questions or concerns to the Medical Director, Howard Lin MD, at howard.lin@bannerhealth.com.

Skilled Nursing Facilities (SNF's), Subacute, and Post Acute Rehabilitation Reporting Requirements

ACC / ALTCS Members

It is the policy of the Banner – University Health Plans (B – UHP) to make certain that the organization and its providers have the necessary information to ensure that all **Incidents, Accidents, and Deaths (IADs) are reported timely to the health plan per AHCCCS MEDICAL POLICY MANUAL (AMPM) 961**

Incident, Accident, and Death (IAD) Reporting

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

All providers shall register an account in the AHCCCS QM Portal within 30 days of becoming an AHCCCS registered provider. For new user registration to the AHCCCS QM Portal go to https://qmportal.azahcccs.gov and click on Create New Account link.

We encourage all B – UHP SNF, SUBACUTE AND POST ACUTE Providers to reach out for any questions, or if you would like the health plan to arrange technical assistance, regarding submission of IAD reports by **Email to:** BUHPRequests@bannerhealth.com.

Appointment Availability Standards Requirement

The Appointment Availability Standards are important to ensure Medicaid and Medicare members receive access to care timely. It is important to share these requirements with your scheduling team and office staff.

You can find the applicable Appointment Availability Standards in the Provider Manuals below as well as the AHCCCS website here: https://tinyurl.com/5wur5txp

- ACC and ALTCS: Banner – University Family Care Provider Manual
- Banner Medicare Advantage Dual: Banner Medicare Advantage Provider Manual

We would also like you to be aware that participation in the telephone surveys is **required** and conducted on a semi-annual basis by Contact One. Contact One is the vendor used to complete the surveys, who will identify themselves when calling your office. Failure to comply could result in a resurvey and/or a Corrective Action Plan (CAP).

Should you have any questions, please reach out to your Care Transformation Consultant or Specialist.

Annual Model of Care Training Requirement for all Banner Medicare Advantage-Dual Providers

The 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 Annual Model of Care Training and submit the Attestation per CMS.

This training and attestation take a minimal amount of time to complete (approximately 30 minutes).

Instructions:

1. Review the training content located here: https://tinyurl.com/ywsecrup.
2. Complete the *Annual Attestation*: https://tinyurl.com/r5avb5xx.

When completing your online attestation, please ensure you are documenting each practitioner's individual NPI on the attestation form.

Contracting Questions

If you have any questions about your contract or rates, please contact the Contracting department at: BPAProviderContracting@bannerhealth.com

Member Advocate

BUHP does not prohibit, or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

- The member's health care, medical needs, or treatment options, including alternative treatment that may be self-administered, even if needed services are not covered by B – UHP
- Any information the member needs to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment

The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions. (42 CFR 438.102) Providers must provide information regarding treatment options in a culturally competent manner, including the option of refusing treatment, and must ensure that members with disabilities have effective communication in making decisions regarding treatment options.

Translation Interpretation Services

Banner University Health Plans provides language interpretive services and translation assistance at no-cost.

If a member cannot speak with us or one of our health plan providers because of a language barrier, please contact our Customer Care Center at least 5 working days prior to the member's office visit.

- Customer Care Center hours of operation: Monday – Friday open from 7:30am-5pm
- Provide the representative with the member's AHCCCS ID number and the nature of the interpretation services required.
- You will be placed on hold while the representative connects you with the interpretation services.
- Customer Care Center phone numbers:
  - Banner – University Family Care/ACC: 800-582-8686
  - Banner – University Family Care/ALTCS: 833-318-4146
  - Banner Medicare Advantage Dual: 877-874-3930

March BUHP Provider Education Forums

Noon – 1:30 p.m. Tuesday, March 25th
Noon – 1:30 p.m. Thursday, March 27th
Call in info: 480-378–7231 **Conf ID:** 899 690 533#
Microsoft Teams: https://bit.ly/3DTmgIm

**The same information will be presented during both meetings.*

BMA Member FIT Kit Campaign

2025 FIT Kit Campaign

Banner Medicare Advantage is deploying the annual FIT Kit campaign (previously known as the FluFIT campaign). The objective of this campaign is to provide FIT kits to eligible members as they come in for their end of year office visits. Provider offices will receive information for the 2025 FIT Kit campaign via their Care Transformation Consultant (CTCs) and then decide if they'd like to participate. For providers who decide to participate in this campaign, they will be connected to a Sonora Quest Labs representative who can help order FIT kits.

This campaign will run from April 2025 to December 2025.

Timeline	
April	Care Transformation Consultants (CTCs) share campaign information
April - May	Provider offices opt in/out of campaign
May - December	Provider offices hand out FIT kits

Compliance Corner

Fraud, Waste and Abuse and False Claims

Covered services or items from Arizona Healthcare Cost Containment System (AHCCCS) and Medicare which are provided to Medicare beneficiaries or AHCCCS Members are subject to the Federal and State fraud, waste and abuse laws pertaining to those payments. Banner Medicaid and Medicare Health Plans have expectations for providers to furnish quality care, care that is necessary and that is cost effective. The documentation of those services or items by providers is the foundation for the claims sent to Banner Medicaid and Medicare Health Plans. In turn, payment of such claims is based upon the provider's content of these services/items represented in the claim submissions.

As a result, when a provider submits a claim for services/items performed for a Medicaid Member or Medicare Beneficiary, the provider is filing a bill/claim with the Federal Government. As a part of the claim submission process, the provider is certifying they have complied with billing requirements and are eligible to receive payment based upon the item/service they provided.

If the provider knew or should have known that the claim submitted was not correct or was a "false claim", then the payment is a violation of the Federal False Claims Act.

Common examples of false or improper claims include, but are not limited to, the following:

- Billing for services using a code that pays a higher reimbursement even if it is not the correct code (upcoding),
- Billing for services that the provider did not render,
- Billing separately for services that were already bundled into another service code such as a global surgery fee,
- Billing for services not medically necessary,
- Billing for services the provider was not qualified to provide,
- Billing for services without proper documentation including signing and dating progress notes,
- Providing prescriptions for medications not indicated or warranted by the member/beneficiaries' condition.

All providers serving Banner Medicaid and Medicare Members/Beneficiaries complete the Medicare Enrollment Application and/or the State-Specific Medicaid Enrollment Application. They also obtain a National Provider Identifier (NPI). Once a provider becomes eligible to serve Medicaid Members and Medicare Beneficiaries, the provider has a responsibility to understand and acknowledge that they are responsible for ensuring the claims submitted under their name and number are in fact accurate and true.

False Claims Act (FCA) cases prosecuted by the Department of Justice for the fiscal year ending September 30, 2024, yielded more than $2.9 billion in settlements from these civil cases.

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 via phone 520-874-2847 (office) or 520-548-7862 (cell).

Contact the Medicare Compliance Officer via phone 602-747-1194 or email BMAComplianceOfficer@BannerHealth.com

Banner Medicaid and Medicare Health Plans Customer Care Contact Information

Health Plan Customer Care Center
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 Prime HMO: 844-549-1857

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

Chronic Kidney Disease

March is National Kidney Month and the perfect time to raise awareness about the importance of kidney health. Chronic Kidney Disease (CKD) affects approximately 1 in 7 adults in the United States, but many do not experience symptoms until their disease progresses. Early detection and treatment by Primary Care Providers (PCPs) can significantly improve outcomes for patients at risk.

Screening for CKD should be completed annually for high-risk individuals, especially those with diabetes and hypertension, cardiovascular disease, and/or a history of kidney disease. To measure renal function appropriately, both an eGFR (estimated glomerular filtration rate) blood test to evaluate kidney function and uACR (urine albumin-to-creatinine ratio) urine test to assess kidney damage are recommended. Diagnosis of CKD is confirmed if there are at least 2 eGFR rates <90mL/min/1.73m^2 at least 3 months apart.

Once CKD is confirmed, it is important to discuss potential treatment options including starting an ACE-inhibitor and encouraging compliance with all prescribed diabetes and blood pressure medications. Be sure to educate patients on lifestyle changes that can help slow disease progression such as adopting a kidney friendly diet, regular physical activity, keeping weight in check and smoking cessation.

Early referrals to a Nephrologist have been proven to decrease morbidity and mortality associated with CKD. Patients with CKD 4 should be referred to a Nephrologist for specialized care.

See the BPN Renal Care Toolkit to learn more about Renal Care Best Practices at https://tinyurl.com/mt5u38fk.

A great resource for those newly diagnosed with CKD or those who need assistance as their disease progresses is **Kidney Smart®**, offered by DaVita Kidney Care, which is a program that provides free education for patients, family members and caregivers. Topics include the causes of kidney disease, how to manage kidney disease through diet and lifestyle choices, treatment options and much more. Patients can register for classes by going to https://tinyurl.com/yc49mbmy.

Member Engagement & Employment Services

Do you have members who struggle to make ends meet, lack social connection, or have difficulty managing symptoms? Being employed can have a profound impact on one's life. It is an AHCCCS requirement that staff discuss employment with all members. This means that conversations about employment take place with everyone, not just those who are requesting employment support or expressing the desire to work. This may include discussing:

- Interest in employment
- Current meaningful activities in which they are engaging
- How satisfied they are with their daily activities
- If they have worked before
- How increased income may impact benefits
- Sessions using www.az.db101.org
- Referrals to Vocational Rehabilitation

Frame conversations around what members would like to do for work, rather than if they'd like to work. Employment Services are available to all members though their Behavioral Health benefit. If you have questions about providing those services, where to go, or anything employment related please reach out to healthplanemployment@bannerhealth.com

For more information about the AHCCCS policy around member engagement please see ACOM 447.

BUFC Provider Manual Updates

Appendix – Behavioral Health Specific

- Updates to Medical Necessity Denials for all Levels of Care
- Update to Transcranial Magnetic Stimulation and Electroconvulsive Therapy
- Addition of Applied Behavioral Analysis (ABA) Services
- Updates to Discharge Plan/Summary required information
- Updates to BHRF Discharge Readiness
- Updates to Concurrent Review for BHRF
- Updates to BHRF Exclusionary Criteria
- Addition to Prior Authorization Procedures for Behavioral Health Partners grid
- Therapeutic Foster Care updates to the medical necessity criteria for admission and the behavioral health grid codes

ESPDT

- Update to fluoride varnish details
- Addition of Genetic Testing – Rapid Wholesome Genome Sequencing
- Addition of information regarding Human Donor Milk
- Notation pertaining to group prenatal care
- Addition of Doula service information
- Notation pertaining to Family Planning – Genetic Testing
- Addition to Well Women's Preventative Care Services
- Update to Blood Lead Testing
- Addition to Family Planning Services

The Importance of Understanding Language Barriers in Healthcare

Understanding language barriers is crucial to delivering respectful, competent, and inclusive care. Language barriers refer to communication challenges that arise when providers and patients do not share the same primary language, which may significantly impact the quality of healthcare received. As healthcare providers, it is essential to create an accessible environment by utilizing appropriate interpretation services and culturally responsive communication. Many patients with limited English proficiency face significant health disparities, including higher rates of medical errors, decreased preventive care utilization, misdiagnosis, and barriers to medical services. By integrating language-inclusive practices, providers can build trust, reduce healthcare disparities, and ensure that all patients receive equitable and compassionate care.

In our commitment to understanding and addressing language barrier disparities, we are seeking valuable input from our provider network. Your insights are essential to developing effective solutions that improve care for patients with limited English proficiency.

We kindly request your feedback on the following questions:

- What challenges do you encounter when providing care to patients who speak different languages?
- What resources or support would help you better serve patients with language barriers?
- What successful strategies have you implemented in your practice to overcome language barriers?

Please share your responses by emailing BUFCQMProviderfeedback@bannerhealth.com Your participation will directly contribute to enhancing healthcare accessibility and quality for all our members.

Thank you for your dedication to providing inclusive, patient-centered care.

Children and Adults System of Care

Updated CALOCUS Training and Implementation

All children receiving behavioral health services are required to have a CALOCUS conducted, upon initiation of behavioral health services and updated every 6 months. All behavioral health providers should ensure the availability of staff that have been trained and can complete the CALOCUS should the clinical need arise. Not all staff at all providers must be trained.

Training Changes: The American Academy of Child and Adolescent Psychiatry (AACAP) and the American Association for Community Psychiatry (AACP) have partnered on the CALOCUS-CASII; all CALOCUS training will now be done by AACAP. AHCCCS has contracted with AACAP for the new online self-paced training and will be covering the cost for providers to be trained in CALOCUS.

Refer to the AHCCCS CALOCUS FAQs for additional information. If you have questions about the CALOCUS, contact Hilary.Mahoney@bannerhealth.com. If you have questions about training for the CALOCUS, contact Selena.Mcdonald@bannerhealth.com.

New Prior and Ongoing Authorization for ABA Services

Effective March 3, 2025 B – UFC implemented a Prior and Ongoing Authorization for ABA Codes 97153, 97154, 97155, 97156, 97157 and 97158. Assessment code 97151 and 97152 will not require a PA for in-network providers.

All new ABA services must be submitted for prior authorization. All ongoing authorization must be submitted with the following timeframes.

- Birth months January-April (OA packet due during the month of March)
- Birth months May-August (OA packet due during the month of April)
- Birth months September-December (OA packet due during the month of May)

ABA providers are required to renew the authorization every 6 months. Authorizations must include the typed ABA Authorization Form which can be found on the B – UFC website and supporting documentation. Authorization requests must be faxed to the number on the form. Providers must keep a copy of the form as evidence of submission. Authorizations will be completed within 14 days of submission.

If you have questions, contact your assigned Care Transformation Specialist or the buhpcaremgmtbhmailbox@bannerhealth.com.

Training for Children and Adopted Families on Relias

B - UFC partnered with Center for Adoption Support and Education (CASE) National Training Institute to provide Adoption Competency Training to clinicians and others in the behavioral health field. The training is self-paced and takes about 30 hours to complete through Relias. CEUs are available through NASW. Coaching is available to interested practitioners who want to implement the program to fidelity. The first coaching with CASE starts in May 2025. For information about the how to access the training in Relias contact Selena.McDonald@bannerhealth.com.

Transition to Adulthood

Behavioral health providers are required to ensure young adults are provided with the supports and services they need to acquire the capacities and skills necessary to navigate the transition to adulthood. Service delivery should be individualized, strengths-based, and culturally responsive. Providers across the System of Care should work in partnership to ensure continuity of care and skill building.

Supporting Youth to Successfully Transition to Adulthood Training:

This training is appropriate for case managers, clinicians, and other behavioral health workers who serve youth and young adults ages 14 to 24. The training reviews AHCCCS requirements for Transition Age Youth, the services and supports appropriate to meet the needs of this age group,

- July 23, 2025 at 12pm – Register here: https://tinyurl.com/25c5sr46
- October 23, 2025 at 11am – Register here: https://tinyurl.com/4yp8xnvh

For questions, email Tanya.Fujishiro@bannerhealth.com.

Updates to AHCCCS Policy AMPM 320 V- Behavioral Health Residential Facilities

AHCCCS Policy AMPM 320 V has been revised to clarify prior authorization requirements for medically necessary services that are beyond the scope of the BHRF. The updated policy also emphasizes BHRF providers are prohibited from requiring members to change providers of choice as a condition of admission or continued participation in treatment. Additional changes include:

- Adding references for respite services, billing, and additional guidance.
- Clarifying that Secure Behavioral Health Residential Facility (Secure BHRFs) need to both be established and then enrolled with AHCCCS.
- Revising to include minimum requirements in the BHRF Overview and Requirements section.
- Strengthening expectations for treatment planning.
- Revising for person centered language.
- Enhancing continued stay expectations.
- Adding Durable Medical Equipment (DME) and home health services as examples

AMPM 930 – Implementation and Fidelity of SAMHSA Evidence-Based Practices (EBPs)

SAMHSA EBPs are intended to support members living with a Serious Mental Illness (SMI), and are shown through research to be effective in meeting the needs of members. The AHCCCS identified EBPs include:

- Permanent Supportive Housing (PSH),
- Assertive Community Treatment (ACT),
- Supported Employment (SE),
- Consumer Operated Services (COS)/PROs,

SAMHSA EBP Kits shall be utilized by contracted and non-contracted providers when delivering these services to individuals with an SMI designation. EBPs requirements for training, implementation, internal auditing and compliance with an AHCCCS funded third party audit. Information will be available in the Provider Manual and B – UFC website.

Questions? Contact ASOC@bannerhealth.com.

AHCCCS Behavioral Health Covered Services Guide Training

B – UFC is offering an overview of the changes to AHCCCS Behavioral Health Covered Services Guide, B2 Matrix and the Same Day Disallow Table. To register for one of these trainings use the link below.

- March 28, 2025 11:00-11:30am Register Here
- July 29, 2025 2:00-2:30pm Register Here
- November 17, 2025 9:00-9:30am Register Here

Children's Services – EPSDT / Well Child Visits

EPSDT Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening program is a comprehensive visit for the prevention, treatment, correction, and improvement of physical and behavioral health conditions for all eligible members under 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and other medically necessary mandatory and optional services for eligible members under 21 years of age. Screenings include but are not limited to:

- ☐ A comprehensive documented history of an unclothed physical exam, growth, development, Nutrition and behavioral health assessment will be performed by provider according to the AHCCCS EPSDT Periodicity Schedule.
- ☐ Developmental surveillance
- ☐ Developmental screenings
- ☐ Behavioral health screening and services:
- ☐ Lab testing & screening
- ☐ Oral Health Screening
- ☐ Immunizations
- ☐ Blood Lead screening, testing, reporting.

*Additional detail on screening requirements can be found in the Banner University Family Care – Provider Manual, under Section 4 – Clinical Services, Children's Services, EPSDT.

*New Testing Requirement for EPSDT members:

Syphilis testing is require annually for all EPSDT-eligible members 15 years and older. Testing may be performed for members under age, 15 based on risk, at the discretion of the provider. See AMPM Policy 430, Section III., A., #9. c. (page 5) for more details.

EPSDT Forms/Records:

Providers shall use either the AHCCCS *EPSDT Clinical Sample Templates* or their age-specific EMR (electronic medical record) to document age-specific visits/screenings for AHCCCS members under 21. To use the EMR, all elements from each Clinical Sample Template must be present.

EPSDT Clinical Sample Templates may be downloaded from www.azahcccs.gov , the select "Shared" ⟶ "Medical Policy Manual" ⟶ "430 Attachment E". Or, use the direct link: https://tinyurl.com/4bnn5au5

A copy of each completed EPSDT record shall be signed, in the medical record AND a copy sent to the member's Health Plan. Submitting EPSDT / Well-Child visits records to the Health Plan immediately after the visit is very important to successful member care coordination. It allows the health plan's EPSDT staff to:

- Outreach to members/caregivers
- Identify and address key screening gaps
- Identify and help resolve potential barriers to member care
- Facilitate referrals initiated during the well-child visit

Submitting EPSDT Visit Records:

Secure email: BUHPEPSDTForms@BannerHealth.com
Secure Fax: 520-874-7184
US Mail: Banner University Health Plans - Attn: EPSDT
5255 E. Williams Cir, Suite 2050, Tucson, AZ 85756

Developmental Screenings:

Developmental screening are a separately billable EPSDT service by PCPs. PCPs shall be trained in use and scoring of the Developmental Screening tool used. Accepted tools are described in the CMS Core Measure *Developmental Screening in the First Three Years of Life.* Any abnormal screening finding shall result in appropriate referrals and follow-up.

- General Developmental screening at the 9, 18 and 30-month EPSDT visits.
- ASD specific screening should occur at the 18 and 24-month EPSDT visits.

Oral Health Screenings and Fluoride Varnish Applications

Oral health screenings are a required element of an EPSDT visit to be completed by a Primary Care Provider (PCP). Oral health screenings are intended to identify oral pathology, including but not limited to tooth decay, oral lesions, and the provide application of fluoride varnish when appropriate. **Fluoride Varnish** may be:

- Applied during an EPSDT visit for members as early as six (6) months old with at least one (1) erupted tooth.
- Reapplied during and EPSDT visit up to every three (3) months, between six months and five years of age.
- Billed separately from the EPSDT visit, using CPT Code 99188 IF the provider has completed the AHCCCS required training. Recommended training is available at

http://www.smilesforlifeoralhealth.org . Providers must submit their training certificate to the health plan prior to reimbursement.

Application of fluoride varnish does not take the place of an oral health visit. Additional information on fluoride varnish application guidelines is available in the AHCCCS Medical Policy Manual (AMPM) Policy 431.

News of Note

- **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.

Subject: Important EVV Updates - February 2025

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PUBLIC NOTICE

AHCCCS E.V.V.

ELECTRONIC VISIT VERIFICATION

This communication is intended for provider agencies subject to Electronic Visit Verification (EVV) requirements and EVV vendors. Please read this entire communication for the most up-to-date information on EVV compliance. This communication presents a number of significant EVV updates. AHCCCS understands that providers and vendors may have questions that we may not be able to answer at this time. It was important for us, however, to share with you what we do know at this point in time while maintaining our commitment to continue to provide ongoing updates and a number of tools and resources to support understanding and engagement.

EVV 2.0

Effective October 1, 2025, AHCCCS has decided to bring EVV in-house and build an EVV aggregator. This means that AHCCCS will not be re-soliciting for an EVV vendor after our contract with Sandata expires on September 30, 2025. AHCCCS is currently contracted with Sandata to serve as both an EVV vendor and also to perform EVV aggregator services. The decision included considerations related to streamlined EVV oversight and management, long-term sustainability of a single EVV aggregator, and provider choice of EVV vendors.

AHCCCS has not required providers to use Sandata; however, we recognize that many do.

For providers **who do not** use Sandata as an EVV vendor, they **will not** have to make any changes. Your EVV vendor will send data to AHCCCS instead of sending it to Sandata. AHCCCS will continue to use the same technical specifications that EVV vendors use to send data to Sandata. EVV vendors will have to test with AHCCCS to ensure the successful submission of data. More information on the testing process with AHCCCS is forthcoming.

For providers **who use** Sandata as their EVV vendor, you **will need** to contract directly with Sandata or another EVV vendor of your choice, and will be responsible for the cost. Only a small number of providers currently use Sandata. The majority of providers use their own selected EVV vendor and pay for their service.

This transition is planned for October 1, 2025. A more specific timeline will follow. AHCCCS wanted to share this information with the provider and EVV vendor community as soon as possible to support timely preparation for the transition.

Tools and Resources

Alternate Vendor Review Tool - The tool is designed to assist provider agencies in evaluating their chosen or prospective alternate vendor's compliance with AHCCCS policy. Ultimately, the provider agency is directly responsible for overseeing their direct contract with their chosen vendor and ensuring compliance with EVV. The review tool may also be used by provider agencies as part of a vetting process when choosing a new EVV vendor. The tool comes complete with a companion instructional resource and links to AHCCCS policy and guidance documents. The tool, instructions, and a recorded webinar with information on how to use the tool have been posted to the EVV webpage.

Webinar - AHCCCS has scheduled a webinar to provide preliminary information on the transition and begin to answer questions. AHCCCS intends to hold multiple informational webinars leading up to the transition. Webinars will be recorded and posted to the EVV webpage.

Webinar Title: EVV 2.0

Date: Tuesday, February 18, 2025

Time: 3 PM (MST)

Registration Link: https://events.teams.microsoft.com/event/fdf48445-96dc-40ba-8a67-124f3929fe5b@eacd16bf-dc0e-44db-8e3f-be370c71feca

Frequently Asked Questions (FAQs) - AHCCCS is preparing an FAQ document that will be updated throughout the transition process as information becomes available. We encourage you to use Google Form to submit your questions so they can be catalogued and posted to the EVV webpage with a response. It is important to note that we may not be in a position to answer every question right away, but your questions will help prioritize planning and communications based on your informational needs. Please make sure to sign up for EVV notices for updates to the FAQs.

Live in Caregiver Data

AHCCCS is requiring all provider agencies to identify direct care workers who are live-in caregivers. The information will be used to monitor the implementation of the new parents as a paid caregiver service model option and support general workforce development data collection. Administrators of provider agencies that utilize the Sandata EVV system, have been notified and asked to identify all existing live-in caregivers by March 31, 2025. In the near future, providers who use alternate vendors will have to also comply with these same requirements. More information is forthcoming on the timeline for compliance.

Alternate Vendor Technical Specification Updates

AHCCCS is in the process of updating the technical specifications for alternate vendors. One update will include the requirements related to the live-in caregiver designation noted directly above. The other updates will support compliance with scheduling and visit maintenance requirements. AHCCCS included

some intent language on these forthcoming changes in the "Business Requirements for Alternate EVV Data Collection Components" posted to the EVV webpage in October 2022. Once the updates are posted and a deadline for development is determined, AHCCCS and Sandata will host a technical assistance webinar for providers and their alternate vendors. It is important to note, that this same (updated) version of the technical specifications will be used when vendors are required to submit data directly to the AHCCCS EVV aggregator later in 2025.

Differential Adjusted Payment Opportunity for all EVV Participating Providers

AHCCCS will be offering a Differential Adjusted Payment (DAP) opportunity for EVV participating providers if they meet certain performance metrics outlined in the DAP notice related to autoverified visits. If the metric threshold is met, the providers will qualify for a specific percentage increase for EVV service between October 1, 2025 through September 30, 2026. Providers may sign up to receive DAP notices on the DAP webpage.

Stay Informed

Please sign up for email notices about EVV.

Dear Healthcare Providers,

The Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Department of Health Services (ADHS') Childhood Lead Poisoning Prevention Program (AzCLPPP) are collaborating to address lead exposure in Arizona's children and enhance blood lead screening rates. According to AzCLPPP's 2022 data, only 6.1% of children at 12 and 24 months were screened for lead, with 461 children had blood lead levels at or above the CDC Blood Lead Reference Value (BLRV) of 3.5 micrograms per deciliter (µg/dL). Additionally, only 37% of AHCCCS beneficiaries in this age group were tested for lead. These low screening rates limit our ability to assess the burden of pediatric lead poisoning and to take effective interventions. Increasing testing is crucial to protect children from lead exposure's harmful effects.

Blood Lead Testing Recommendations for Children in Arizona: ADHS strongly recommends that all children in Arizona receive blood lead testing through capillary test or venous draw at 12 months, again at 24 months, and between 24 to 72 months if they have not been tested before.

AHCCCS Lead Screening Requirements (AHCCCS AMPM Chapter 400) :

- **Blood lead testing is required for all members at 12 months and 24 months of age.** Members between 24 months and six years must be tested if they have not been previously tested or missed earlier tests. Blood lead levels may be measured at times other than those specified if thought to be medically indicated.
- Use a venous blood sample to confirm results when finger stick samples indicate blood lead levels greater than or equal to BLRV of 3.5 µg/dL. Follow-up and care coordination is required for members with blood lead results above 3.5 µg/dL.
- Laboratories and Medical providers must report all lead results to the AzCLPPP.

Additional Recommendation for Refugee Children: In addition to AHCCCS requirements, we encourage you to follow the CDC's screening recommendations for refugee children to further enhance lead testing efforts:

- Initial Testing: Test all refugee children ≤ 16 years of age within 90 days of their arrival.
- **Follow-Up Testing**: All refugee children **≤ 6 years of age** should have **follow-up lead tests 3 to 6 months after resettlement**, regardless of the initial test results.

We need your help to improve lead testing rates and ensure prompt intervention for at-risk children in Arizona by testing all eligible children for lead exposure. Testing is the only way to detect exposure, as lead poisoning often does not have symptoms. Thank you for your dedication to the well-being of our state's children. If you have questions, you can contact the AzCLPPP at healthyhomes@azdhs.gov.

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