DFSM Tribal ALTCS

3rd Quarter Case Management Supervisor Meeting

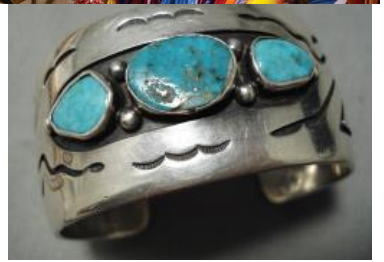
Thursday, July 28, 2022

AHCCCS
Arizona Health Care Cost Containment System

WELCOME TO ALL!

Agenda Overview

- **Morning Prayer:** Reyedel Charley, White Mountain Apache Tribe
- **Rachel Conley**: Welcome, Signature Requirements, AMPM Policy Updates, Introduce new Tribal ALTCS Specialist, Member Complaints, EVV/Sandata, and Signature Requirements
- **Ice Breaker:** Cheryl and Bandana
- **Soni Fisher:** AMPM Policy Definitions detail
- **Bandana Chetty:** Turnaround Time Report
- **Cheryl Begay:** Voluntary Withdrawal, IFS AMPM Policy 1620-17
- **Rachel Conley**:
- **Vanessa Torrez: Common Missing Information, DME Documentation, Orthotic Requirements, PA Correction Form, Returned Fax**
- **Rachel Conley: Closing**



Meeting Reminders

- Please mute your computer's microphone and/or phone when not speaking.
- Use the chat feature to add in comments/questions.
- Ask questions after the speaker has finished.
- Sit back, listen in and enjoy the meeting!
- This meeting will be recorded.







DFSM Tribal ALTCS

Member Complaints, Grievance & Appeal Signature Requirements

AMPM Updates

Rachel Conley, Tribal ALTCS Administrator

AHCCCS
Arizona Health Care Cost Containment System

Member Complaints (Grievance)

COMPLAINT (Grievance)

A member is not satisfied with the services being provided or the way an AHCCCS member is being treated. Filing a complaint brings attention to the problem so that it can be resolved.

ANYONE CAN FILE A COMPLAINT

Release of Information (ROI) is not needed to file a complaint on behalf of an AHCCCS member. However, only the member or guardian will receive follow up correspondence, unless there is a signed ROI.

FILING A COMPLAINT WILL NOT AFFECT A MEMBER'S HEALTH CARE SERVICES

Any retaliation would be considered a violation of the member's rights. If a member believes making a complaint has resulted in some form of retaliation, the member can file a follow up complaint for that issue.

Most complaints should be resolved within 10 business days, but should not take longer than 90 days.

Grievance

Applicants, members, and/or their authorized representatives can file a grievance when they have a complaint about anything that does not involve appealing a decision, such as a denial or discontinuance of services or benefits.

Examples

- General Complaints
- Environmental hazard conditions at a doctor's office (dirt or clutter, unsanitary practices, overcrowded waiting areas)
- Impoliteness or rudeness of providers (doctors, doctor's office staff, hospital personnel, etc.)
- Impoliteness or rudeness of office staff (eligibility offices, AHCCCS Offices, Department of Economic Security Offices, Department of Health Services Offices, etc.)

Appeal

An appeal is a request from an applicant, member, provider, health plan, or other approved entity to reconsider or change a decision, also known as an action.

An action includes any denial, reduction, suspension, or termination of a service or benefit, or a failure to act in a timely manner.

Examples

- Denial of request for surgery
- Denial of a request for a wheelchair
- Denial of basic health care services
- Denial or discontinuance of AHCCCS eligibility

Applicants have the right to make a complaint, file a grievance, or appeal a decision.

Addressing & Resolving a Member Complaint

A COMPLAINT CAN BE MADE IN-PERSON, OVER THE PHONE, OR IN WRITING

The member's health plan is required to acknowledge the written complaint within five (5) working days from receipt.

- Complaints over the phone, it is considered acknowledged at that time.
- A member can ask for an email confirmation.

EXAMPLES OF COMPLAINTS

- A provider or employee does not return phone calls
- A provider or employee is rude
- Scheduled transportation does not arrive or is late
- A request to change a doctor or team is not being honored, and/or
- Problems getting an appointment within AHCCCS timelines.

Tribal ALTCS members have the right to file a grievance, make a complaint, or file an appeal.
https://www.azahcccs.gov/Members/GetCovered/RightsAndResponsibilities/grievanceandappeals.html

Reporting Quality of Care (Health Care Provider)

Report Concerns About the Quality of Care Received

AHCCCS is committed to ensuring that all members receive quality health care and able to access services. If you or any AHCCCS member has experienced a barrier to getting health care services or have concerns about the quality of services received.

*Submitter Information
*Member Information
*Provider Information
*Information About This Issue

Submit concerns that include (but are not limited to):

*The inability to receive health care services
*Concerns about the quality of care received
*Issues with health care providers or health plans; or timely access to services.

https://www.azahcccs.gov/ACMS/default.aspx

Policy Updates & Unwinding of PHE

Updates were made to the following policies to comply with Home and Community Based Settings Rule and/or Revised for standard five year review. Effective Dates of these policy are 10/01/22.

- 1240-B
- 1240-E
- 1240-J
- 1620-D
- 1620-E
- 1620-10 Exhibit
- 1230-A
- 1620-15 Exhibit
- 1240

Long Term Care Flexibilities

The following long term care flexibilities will expire at the end of the quarter in which the PHE ends:

- Removal of hourly service limitation (40 hours in 7-day period) for spouses who provide paid care,
- Authority to make retainer payments to habilitation and personal care providers,
- Authority to use an electronic method of service delivery: case management, personal care that requires only verbal cueing, in-home habilitation,
- Ability to conduct evaluations, assessments, and person-centered service planning meetings remotely, and
- Allowance for electronic method of sign off on required documents such as the person-centered plan.

https://www.azahcccs.gov/AHCCCS/Downloads/COVID19/AHCCCS_COVID19_PHE_Unwinding_Plan_20220714_V1.pdf

Signature Requirements

Valid signatures may be electronic or physically handwritten, however both shall have legible name of the signer printed, signer's credentials (specific license type of professional credentials), and date of signing. The signature must be unique to that individual and linked to the medical record. Providers shall adhere to all electronic signature requirements as described in detail in AHCCCS policy AMPM 940, ARS 44-7031 and applicable CMS rules.

Not allowed: Rubber stamps, copy/paste signatures, manually typed or word-processed name or "electronic signature" or typed timestamp if not part of certificate of secure electronic system. Per ARS 18-106, "An electronic signature shall be unique to the person using it, shall be capable of reliable verification and shall be linked to a record in a manner so that if the record is changed the electronic signature is invalidated."

References:

ARS

ARS 18-106

https://www.azleg.gov/ars/18/00106.htm

ARS 44-7031

https://www.azleg.gov/viewdocument/?docName=https://www.azleg.gov/ars/44/07031.htm

AHCCCS AMPM 940- MEDICAL RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/900/940.pdf







DFSM Tribal ALTCS

Ice Breaker

Presented by: Cheryl Begay, Tribal ALTCS Case Management Coordinator

Bandana Chetty, Tribal ALTCS Case Management Coordinator

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ICEBREAKER
Cheryl/Bandana

GUESS THE PLACE!!

GRAND CANYON

SEDONA – CHAPEL OF THE HOLY CROSS

CITY OF PHOENIX

FOUNTAIN HILLS – Once the tallest in the world up to 560FT (170m) water fountain.

Picacho Peak

HOOVER DAM

ICE BREAKER

Thank you for participating in our Tribal ALTCS Ice Breaker.







DFSM Tribal ALTCS

AMPM Policy Definitions detail

Presented by: Soni Fisher, DFSM Tribal ALTCS Manager

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AMPM Policy Definitions detail

AHCCCS has made changes to the Policies to remove the definitions from the individuals policies, and place all of the Policy Definitions in one location within the AMPM Policy, and they are in alphabetical order.

It is located under Resources and called the "*Contract and Policy Dictionary*". The link to the document is below:

- https://www.azahcccs.gov/Resources/Downloads/ContractAndPolicyDictionary.pdf

AMPM Policy Definitions detail

Although not an exhaustive list, some of the most common definitions that apply directly to Tribal ALTCS are on the following pages:

Page 3: ACUTE CARE ONLY (ACO)

1. The enrollment status of a member who is otherwise financially and medically eligible for ALTCS but who: Refuses Home and Community Based Services (HCBS) offered by the case manager.

2. Has made an uncompensated transfer that makes the individual ineligible.

3. Resides in a setting in which Long Term Services and Supports (LTSS) cannot be provided, or

4. Has equity value in a home that exceeds $552,000. These ALTCS enrolled members are eligible to receive acute medical services but not eligible to receive Long Term Care (LTC) institutional, alternative residential or HCBS.

AMPM Policy Definitions detail

Page 5: ADVANCE CARE PLANNING A part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member/ Health Care Decision Maker (HCDM) to:

1. Educate the member/HCDM and Designated Representative (DR) about the member's illness and the health care options that are available to them.

2. Develop a written plan of care that identifies the member/HCDMs choices for treatment, and 3. Share the member/HCDMs wishes with family, friends, and his or her physicians.

AMPM Policy Definitions detail

Page 7: AHCCCS FEE-FOR-SERVICE (FFS) PROGRAM An AHCCCS program administered by the AHCCCS/Division of Fee-For-Service Management (DFSM) using the original Medicaid payment model, where a fee is paid for each medically necessary service provided (e.g., office visit, test, procedure). Members enrolled in an FFS program may receive AHCCCS-covered services from any AHCCCS-registered provider. Note: Providers do not need to separately contract with any FFS program to render and bill for Medicaid Title XIX/XXI services provided to FFS members. Providers can bill FFS after they enter into a provider participation agreement with AHCCCS Provider Registration. Providers with active registration with AHCCCS Provider Registration serve as the FFS provider network.

Page 7: AHCCCS MEDICAL POLICY MANUAL (AMPM) Provides information to Contractors and Providers regarding services that are covered within the AHCCCS program.

AMPM Policy Definitions detail

Page 9: AHCCCS REGISTERED PROVIDER A contracted provider or non-contracting provider who enters into a provider agreement with AHCCCS and meets licensing or certification requirements to provide AHCCCS-covered services.

Page 9: ALTERNATIVE HOME AND COMMUNITY BASED SERVICES (HCBS) SETTING A living arrangement where a member may reside and receive HCBS. The setting shall be approved by the director, and either (1) licensed or certified by a regulatory agency of the state, or (2) operated by the IHS, an Indian tribe or tribal organization, or an urban Indian organization, and has met all the applicable standards for state licensure, regardless of whether it has actually obtained the license (A.A.C. R9-28-101). The possible types of settings include:

1. For an individual with an intellectual/developmental disability:
    a. Community residential setting,
    b. Group home,
    c. State-operated group homes,

AMPM Policy Definitions detail

d. Group foster homes,

e. Adult behavioral health therapeutic homes,

f. Behavioral health residential facilities,

g. Behavioral health respite homes, and

h. Substance abuse transitional facilities.

2. For an individual who is Elderly and Physically Disabled (E/PD):

a. Adult foster care homes,

b. Assisted living homes or assisted living centers, units only,

c. Adult behavioral health therapeutic homes,

d. Behavioral health residential facilities,

e. Behavioral health respite homes, and

f. Substance abuse transitional facilities.

AMPM Policy Definitions detail

Page 12: ARIZONA LONG TERM CARE SYSTEM An AHCCCS program which delivers long-term, acute, behavioral health and case management services as authorized by A.R.S. § 36-2931 et seq., to eligible members who are either elderly and/or have physical disabilities, and to members with developmental disabilities, through contractual agreements and other arrangements.

Page 12: ARIZONA LONG TERM CARE SERVICES (ALTCS) LOCAL OFFICE The Arizona Long Term Care System (ALTCS) local office currently responsible for the member's financial eligibility case record.

AMPM Policy Definitions detail

Page 12: ARIZONA LONG TERM CARE SERVICES (ALTCS) TRANSITIONAL PROGRAM A program available for eligible Arizona Long Term Care System (ALTCS) members who, at the time of medical reassessment, have improved either medically, functionally, or both, to the extent that they no longer need institutional care, but who still need significant Long-Term Services and Supports (LTSS). The eligible member will continue to require some LTSS, but at a lower level of care. The ALTCS Transitional program allows those members who meet the lower level of care, as determined by the Pre-Admission Screening (PAS), to continue to receive all ALTCS covered services that are medically necessary. Refer to 9 A.A.C. 28, Article 3.

Page 13: ASSISTED LIVING CENTER (ALC) Revised: 10/21 An assisted living facility that provides resident rooms or residential units to eleven or more residents (A.R.S. § 36-401).

AMPM Policy Definitions detail

Page 13: ASSISTED LIVING FACILITY (ALF) A residential care institution that provides supervisory care services, personal care services or directed care services on a continuing basis. All approved residential settings in this category are required to meet Arizona Department of Health Services (ADHS) licensing criteria as specified in A.A.C. R9-10 Article 8.

Page 13: ASSISTED LIVING HOME (ALH) An Alternative Home and Community Based Services (HCBS) Setting that provides room and board, supervision, and coordination of necessary services to 10 or fewer residents.

Page 13: AUTHORIZED REPRESENTATIVE An individual who is authorized to apply for medical assistance or act on behalf of another individual as specified in A.A.C. R9- 22-101, A.A.C. R9-28-401.

AMPM Policy Definitions detail

Page 15: BED HOLD A 24 hour per day unit of service that is authorized by an ALTCS member's case manager or the behavioral health case manager or a subcontractor for an acute care member, which may be billed despite the member's absence from the facility for the purposes of short term hospitalization leave and therapeutic leave as specified in the Arizona Medicaid State Plan, 42 CFR 447.40 and 42 CFR 483.12, 9 A.A.C. 28.

Page 15: BEHAVIORAL HEALTH DISORDER Any behavioral, mental health, and/or substance use diagnoses found in the most current version of the Diagnostic and Statistical Manual of Mental Disorders excluding those diagnoses such as intellectual disability, learning disorders and dementia, which are not typically responsive to mental health or substance use treatment.

AMPM Policy Definitions detail

Page 16: BEHAVIORAL HEALTH FACILITY A health care institution, as specified in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes the individual to:

1. Have a limited or reduced ability to meet the individual's basic physical needs.

2. Suffer harm that significantly impairs the individual's judgment, reason, behavior, or capacity to recognize reality.

3. Be a danger to self.

4. Be a danger to others.

5. Be an individual with a persistent or acute disability as specified in A.R.S. § 36-501, or

6. Be an individual with a grave disability as specified in A.R.S. § 36-501.

AMPM Policy Definitions detail

Page 16: BEHAVIORAL HEALTH INPATIENT FACILITIES (BHIF) A health care institution, as specified in A.A.C. R9-10-101, that provides continuous treatment to an individual experiencing a behavioral health issue that causes that individual to:

1. Have a limited or reduced ability to meet the basic physical needs.
2. Suffer harm that significantly impairs the judgment, reason, behavior, or capacity to recognize reality.
3. Be a danger to self.
4. Be a danger to others.
5. Be persistently or acutely disabled as specified in A.R.S. § 36-501, or
6. Be gravely disabled.

Page 17: BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF) As specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that: 1. Limits the individual's ability to be independent, or 2. Causes the individual to require treatment to maintain or enhance independence.

AMPM Policy Definitions detail

Page 17: BEHAVIORAL HEALTH RESIDENTIAL FACILITY (BHRF) As specified in A.A.C. R9-10-101, a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

1. Limits the individual's ability to be independent, or
2. Causes the individual to require treatment to maintain or enhance independence.

Page 19: CAREGIVER A caregiver is an adult who is providing for the physical, emotional, and social needs (i.e., caring for) a child who is under the care, custody, and contractor. Examples of Caregivers can include birth parent(s), foster parent(s), adoptive parent(s), kin or relative(s), group home staff. Caregivers can be licensed or unlicensed.

Page 19: CASE MANAGEMENT A collaborative process, which assess, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

AMPM Policy Definitions detail

Page 19: CASE MANAGER An individual assigned as responsible for locating, accessing, and monitoring the provision of services to individuals in conjunction with a clinical team as specified in A.A.C. Title 9, Chapter 21 and Chapter 28, and Title 6, Chapter 6.

Page 20: CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) A federal agency under the Department of Health and Human Services, based in Atlanta, Georgia, that provides information and tools to promote health, prevent disease, injury and disability and prepare for new health threats.

Page 20: CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) The federal agency within the United States Department of Health and Human Services (HHS), which administers the Medicare (Title XVIII) and Medicaid (Title XIX) programs and the State Children's Health Insurance Program (Title XXI).

AMPM Policy Definitions detail

Page 23: CLINICAL RECORD Refer to the term Medical Record.

Page 65: MEDICAL RECORD All communications related to a patient's physical or mental health or condition that are recorded in any form or medium and that are maintained for purposes of evaluation or treatment, including records that are prepared by a health care provider or by other providers. Records do not include materials that are prepared in connection with utilization review, peer review or quality assurance activities as specified in A.R.S. § 12- 2291.

Page 34: DIRECT CARE SERVICES The services provided by Direct Care Workers DCW are collectively known as Direct Care Services. There are three types of services within ALTCS that are provided by Direct Care Workers (DCWs); these include Attendant Care, Personal Care, and Homemaker

AMPM Policy Definitions detail

Page 34: DIRECT CARE WORKER (DCW) An individual who assists an elderly individual or an individual with a disability with activities necessary to allow them to reside in their home. These individuals, also known as Direct Support Professionals, must be employed/contracted by DCW Agencies or, in the case of member-directed options, employed by ALTCS members in order to provide services to ALTCS members.

Page 34: DIRECT CARE WORKER (DCW) - AGENCY An agency that registers with AHCCCS as a service provider of Direct Care Services that include Attendant Care, Personal Care, Homemaker or Habilitation. The agency, by registering with AHCCCS, warrants that it has a workforce (employees or contractors) with the abilities, skills, expertise, and capacity to perform services as specified in AHCCCS policy.

Page 36: ELECTRONIC VISIT VERIFICATION (EVV) A computer-based system that electronically verifies the occurrence of authorized service visits by electronically documenting the precise time a service delivery visit begins and ends, the individuals receiving and providing a service, and type of service performed.

AMPM Policy Definitions detail

Page 41: FAMILY OR FAMILY MEMBER A biological, adoptive, or custodial mother or father of a child, or an individual who has been appointed as a legal guardian or custodian of a child by a court of competent jurisdiction, or other member representative responsible for making health care decisions on behalf of the member. Family members may encompass family of choice for adult members, which includes informal supports.

Page 42: FEE FOR SERVICE (FFS) - PROVIDER Any AHCCCS registered provider who provides services to FFS members.

Page 47: HEALTH CARE DECISION MAKER (HCDM) An individual who is authorized to make health care treatment decisions for the patient. As applicable to the situation, this may include a parent of an unemancipated minor or an individual lawfully authorized to make health care treatment decisions as specified in A.R.S. §§ Title 14, Chapter 5, Article 2 or 3; or A.R.S. §§ 8- 514.05, 36-3221, 36-3231 or 36-3281.

AMPM Policy Definitions detail

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AMPM Policy Definitions detail

Page 49: HOME AND COMMUNITY BASED SERVICES (HCBS) Home and community-based services, as specified in A.R.S. § 36-2931 and A.R.S. § 36-2939.

Page 50: HOME DELIVERED MEAL A service that provides a nutritious meal containing at least one-third of the Federal recommended daily allowance for the member, delivered to the member's own home.

Page 53: INFORMAL SUPPORT Non-billable services provided to a member by a family member, friend, or volunteer to assist or perform functions such as, but not limited to:

1. Housekeeping,
2. Personal care,
3. Food preparation,
4. Shopping,
5. Pet care, or
6. Non-medical comfort measures.

AMPM Policy Definitions detail

Page 54: INSTITUTIONAL SETTING

1. Institutional settings:

    a. A nursing facility as specified in 42 U.S.C. 1396 r(a),

    b. An Institution for Mental Diseases (IMD) for an individual who is either under age 21 or age 65 or older,

    c. An Intermediate Care Facility for the Mentally Retarded (ICF-MR) for an individual with intellectual/developmental disabilities,

    d. A hospice (free-standing, hospital, or nursing facility subcontracted beds) as specified in A.R.S. § 36-401.

2. Home and Community Based Services (HCBS) settings:

    a. An individual's home as specified in R9-28-101(B), or

    b. Alternative HCBS settings as specified in R9-28-101(B).

AMPM Policy Definitions detail

Page 55: INTERGOVERNMENTAL AGREEMENT (IGA) When authorized by legislative or other governing bodies, two or more public agencies or public procurement units by direct Contract or agreement may contract for services or jointly exercise any powers common to the contracting parties and may enter into agreements with one another for joint or cooperative action or may form a separate legal entity, including a nonprofit corporation to Contract for or perform some or all of the services specified in the Contract or agreement or exercise those powers jointly held by the contracting parties as specified in A.R.S. Title 11, chapter 7, article 3 and A.R.S. § 11-952.A.

Page 66: MEDICAL SUPPLIES Health care related items that are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury as specified in 42 CFR 440.70.

Page 66: MEDICARE A Federal program authorized by Title XVIII of the Social Security Act, as amended

AMPM Policy Definitions detail

Page 68: MEMBER An eligible individual who is enrolled in AHCCCS, as specified in A.R.S. § 36-2931, § 36-2901, § 36-2901.01 and A.R.S. § 36- 2981. Also referred to as Title XIX/XXI member or Medicaid member.

Page 73: NOTICE OF ADVERSE BENEFIT DETERMINATION (NOA) The written notice provided to the affected member/Health Care Decision Maker (HCDM) which explains the Adverse Benefit Determination made by the Contractor or AHCCCS regarding the service authorization to deny, reduce, suspend, or terminate a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested as specified in 42 CFR 438.210(c), 42 CFR 438.404, and 42 CFR 438.400(b).

AMPM Policy Definitions detail

Page 74: NURSING FACILITY Revised: 10/21 As defined in 42 U.S.C. 1396r(a), an institution (or a distinct part of an institution) which:

1. Is primarily engaged in providing to residents—

a. Skilled nursing care and related services for residents who require medical or nursing care,

b. Rehabilitation services for the rehabilitation of injured, disabled, or sick individuals, or

c. On a regular basis, health-related care, and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and

d. Is not primarily for the care and treatment of mental diseases,

2. Has in effect a transfer agreement (meeting the requirements of 42 U.S.C. 1861(l)) with one or more hospitals having agreements in effect under section 1866, and

3. Meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary

as meeting the requirements of paragraph (1) and subsections (b), (c), and (d).

AMPM Policy Definitions detail

Page 79: PERSON-CENTERED An approach to planning designed to assist the member to plan their life and supports. This model enables individuals to increase their personal self-determination and improve their own independence.

Page 79: PERSON-CENTERED SERVICE PLAN (PCSP) A written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP shall also reflect the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

Page 82: PREPAID MEDICAL MANAGEMENT INFORMATION SYSTEM (PMMIS) An integrated information infrastructure that supports AHCCCS operations, administrative activities, and reporting requirements.

AMPM Policy Definitions detail

Page 83: PRIOR AUTHORIZATION (PA) A process by which AHCCCS or the Contractor, whichever is applicable, authorizes, in advance, the delivery of covered services based on factors including but not limited to medical necessity, cost effectiveness, compliance with this Article and any applicable contract provisions. Prior Authorization (PA) is not a guarantee of payment as specified in A.A.C. R9-22-101.

Page 88: QUALITY OF CARE (QOC) CONCERN An allegation that any aspect of care, or treatment, utilization of behavioral health services or utilization of physical health care services that caused or could have caused an acute medical or psychiatric condition or an exacerbation of a chronic medical or psychiatric condition and may ultimately cause the risk of harm to an AHCCCS member.

Page 89: REDUCTION OF SERVICE A decision to reduce the frequency or duration of an ongoing behavioral health service. A Reduction of Service does not include a planned change in service frequency or duration that is initially identified in the individual's service plan and agreed to in writing by the individual receiving services or their Health Care Decision Maker (HCDM).

AMPM Policy Definitions detail

Page 93: ROOM AND BOARD (R&B) The amount paid for food and/or shelter. Medicaid funds can be expended for room and board when an individual lives in an institutional setting (e.g., nursing facility, Intermediate Care Facility [ICF]). Medicaid funds cannot be expended for room and board when a member resides in an Alternative Home and Community Based Service (HCBS) Setting (e.g., Assisted Living Home, Behavioral Health Residential Facilities [BHRF]) or an apartment like setting that may provide meals.

Page 96: SERIOUS MENTAL ILLNESS (SMI) A designation as specified in A.R.S. § 36-550 and determined in an individual 18 years of age or older.

Page 96: SERVICE PLAN A complete written description of all covered health services and other informal supports which includes individualized goals, family support services, peer-and-recovery support, care coordination activities and strategies to assist the member in achieving an improved quality of life.

AMPM Policy Definitions detail

Page 96: SHARE OF COST (SOC) The amount an ALTCS member is required to pay toward the cost. of long term care services.

Page 104: THIRD-PARTY LIABILITY (TPL) The legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Page 106: TRANSPORTATION - NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) BROKER An entity which may provide administrative functions such as scheduling, verifying enrollment, validating service appointments when appropriate, as well as billing.

Page 107: TREATMENT PLAN A written plan of services and therapeutic interventions based on a complete assessment of a member's developmental and health status, strengths and needs that are designed and periodically updated by the multi-specialty, interdisciplinary team.

AMPM Policy Definitions detail

Page 107: TRIBAL ARIZONA LONG TERM CARE SYSTEM (TRIBAL ALTCS) FEE-FOR-SERVICE PROGRAM A program managed by AHCCCS to provide covered, medically necessary ALTCS services to ALTCS American Indian members who reside on a Tribal reservation in Arizona or resided on a reservation immediately before being placed in a nursing facility or alternative Home and Community Based Services (HCBS) setting offreservation.

Page 109: UNIFORM ASSESSMENT TOOL (UAT) A standardized tool that is used by Contractors to assess the acuity of nursing facility residents and commonly used for residents residing in Assisted Living Centers (ALC), Assisted Living Holmes (ALH) and Adult Foster Care (AFC) settings. The use of the Uniform Assessment Tool (UAT) is not intended to impact how Contractors determine authorizations for specialty levels of care (e.g., wandering dementia, medical sub-acute and behavioral management).

Page 111: WHOLE PERSON CARE A health care delivery system that addresses the full spectrum of an individual's needs – medical, behavioral, socioeconomic, and beyond to encourage better health outcomes.

ANY QUESTIONS?

THANK YOU!!

10-minute BREAK







DFSM Tribal ALTCS - Turnaround Time Reports

Presented by: Bandana Chetty, Tribal ALTCS CM Coordinator

AHCCCS
Arizona Health Care Cost Containment System

PRIOR AUTHOIZATION REQUEST DATA

Tribal ALTCS Comments	SUMMARY
DUPLICATE	356
MISSING INFORMATION	329
MULTIPLE MEMBERS	7
NO PA REQUIRED	109
PA APPROVED	1577
PA UNDER REVIEW	75
PENDED PA	57
BLANK	15
TOTAL	2525

Assignment	DUPLICATE	MISSING INFORMATION	MULTIPLE MEMBERS	NO PA REQUIRED	PA APPROVED	PA UNDER REVIEW	PENDED PA	(blank)	Grand Total
>80% CES	4	2			20	3		1	30
100% CES		1							1
ALF BH	80	46	1	6	138			4	275
CONTRACTOR CHANGE	1					2			3
DME	97	205	6	32	500	41	40	1	922
E1399		1		4	3				8
HOMEMOD	9	24		6	17	6	12	1	75
MISC/OTHERS					6	1			7
OPEN LINE REQUEST	43	20		41	594	8	1	2	709
OUT OF STATE PLACEMENT	13	6		1	46	2			68
SNF	109	24		19	253	12	4	6	427
Grand Total	**356**	**329**	**7**	**109**	**1577**	**76**	**57**	**14**	**2525**

ANY QUESTIONS?

THANK YOU!!







DFSM Tribal ALTCS

- DE-130 Voluntary Withdrawal Form
- AMPM Policy 1620-17 Changes – Informal Support (IFS)

Cheryl Begay, Tribal ALTCS CM Coordinator

AHCCCS
Arizona Health Care Cost Containment System

Clarify the process for Voluntary Withdrawals

- Cases discontinued for Voluntary Withdrawal may take longer than the standard timeframes. This may be caused when more than one discontinuance reason is used.
- HEAplus applies the adverse action rules for the other reason, which can delay the discontinuance and cause an eligibility error.
- This issue may also cause a delay in the customer accessing coverage in the new state when that state requires confirmation of AZ eligibility ending before they will approve Medical Assistance.

Clarification for Voluntary Withdrawal (cont.)

- **Example:** The customer calls on September 24th to withdraw immediately because he moved to Utah, New Mexico or Colorado and is applying for benefits here. If the worker selects both the VW-immediate and residency reasons, HEAplus will follow the adverse action rules for residency and Medical Assistance will not end until 11/1/2021.
- **TCM must select ONLY the VW reason the customer chose when processing a request to stop MA benefits.**

CONSIDERATIONS PRIOR TO MEMBER REQUEST TO VOLUNTARY WITHDRAW

- PCSP (Person-Center Service Planning)
- Physical Disabilities
- Chronic Health Conditions
- Informed choice

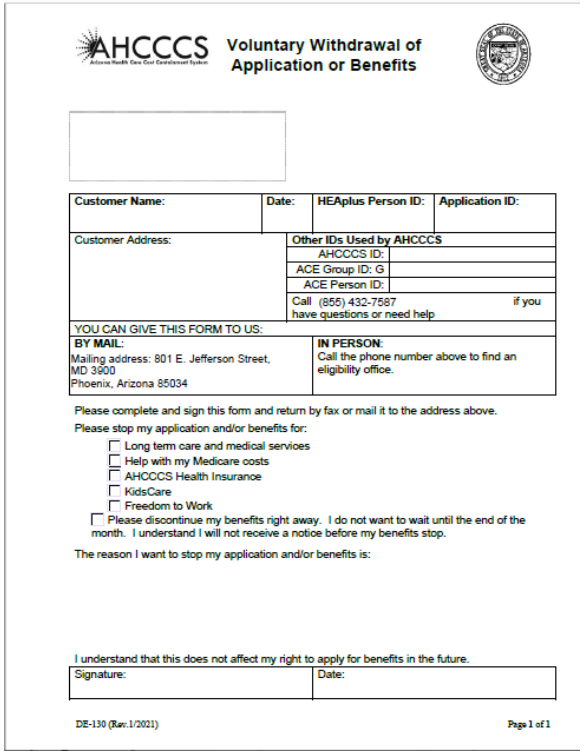
- Self-Determination is being in control of your life.

- CMS Rules on HCBS
- ALTCS, HCBS, CMS including Arizona State Medicaid
- What does the person want, what is possible and does the person understand the risks and trade-offs?
- Understands options, outcomes & potential risks/consequences.

DE-130 Voluntary Withdrawal Form

AHCCCS
Arizona Health Care Cost Containment System

DE-130 Voluntary Withdrawal Form



AHCCCS Voluntary Withdrawal of Application or Benefits

Customer Name:	Date:	HEAplus Person ID:	Application ID:

Customer Address:	Other IDs Used by AHCCCS
	AHCCCS ID:
	ACE Group ID: G
	ACE Person ID:
	Call (855) 432-7587 if you have questions or need help

YOU CAN GIVE THIS FORM TO US:

BY MAIL:	IN PERSON:
Mailing address: 801 E. Jefferson Street, MD 3900 Phoenix, Arizona 85034	Call the phone number above to find an eligibility office.

Please complete and sign this form and return by fax or mail it to the address above.

Please stop my application and/or benefits for:

- ☐ Long term care and medical services
- ☐ Help with my Medicare costs
- ☐ AHCCCS Health Insurance
- ☐ KidsCare
- ☐ Freedom to Work
- ☐ Please discontinue my benefits right away. I do not want to wait until the end of the month. I understand I will not receive a notice before my benefits stop.

The reason I want to stop my application and/or benefits is:

I understand that this does not affect my right to apply for benefits in the future.

Signature:	Date:

DE-130 (Rev.1/2021) Page 1 of 1

- https://www.azahcccs.gov/Members/ALTCSlocations.html

INFORMAL SUPPORT (IFS) AMPM POLICY 1620-17 CHANGES

INFORMAL SUPPORT (IFS) POLICY AMPM 1620-17 CHANGES

- AMPM Policy 1620-17 ***Home and Community Based Services Needs Tool Guidelines*** was recently updated on 06/01/2021.
- There are two sections that Case Managers need to specifically pay attention to.
- https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1600/1620-17.pdf

INFORMAL SUPPORT (IFS) POLICY AMPM 1620-17 CHANGES

- The Names and Relationships of Informal Supports (IFS) MUST be **clearly** noted on **Page 1 of the HNT**.
- If the member lives with others, the time others in the Household are away from the home on a regular basis for obligations must be noted in the review documentation.

NAME/RELATIONSHIP OF INFORMAL SUPPORTS THAT WILL BE ASSISTING WITH CARE:

List the individuals who are available to provide informal support.

On the worksheet, enter "IFS" on the specific tasks and days for which the informal support is present to provide the care.

Listing the IFS information is mandatory, as it is always necessary to clearly document what care is already being provided to the member in order to demonstrate what needs remain unmet.

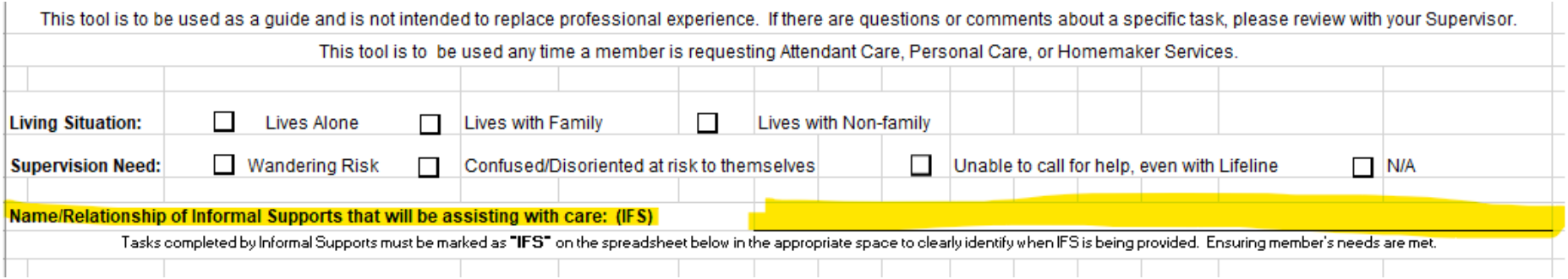
In addition to informal supports, if the member is receiving care from another source, such as Medicare home health or hospice, be sure to include this.

DAYS/HOURS OTHERS NOT AVAILABLE TO ASSIST MEMBER:

If the member lives with others, indicate the time others in the household are away from the home on a regular basis for other obligations.

INFORMAL SUPPORT (IFS) POLICY AMPM 1620-17 CHANGES

- Page 1 of the HNT - THE NAMES AND RELATIONSHIPS OF INFORMAL SUPPORTS MUST BE CLEARLY NOTED ON PAGE 1 OF THE HNT


This tool is to be used as a guide and is not intended to replace professional experience. If there are questions or comments about a specific task, please review with your Supervisor.

This tool is to be used any time a member is requesting Attendant Care, Personal Care, or Homemaker Services.

Living Situation: ☐ Lives Alone ☐ Lives with Family ☐ Lives with Non-family

Supervision Need: ☐ Wandering Risk ☐ Confused/Disoriented at risk to themselves ☐ Unable to call for help, even with Lifeline ☐ N/A

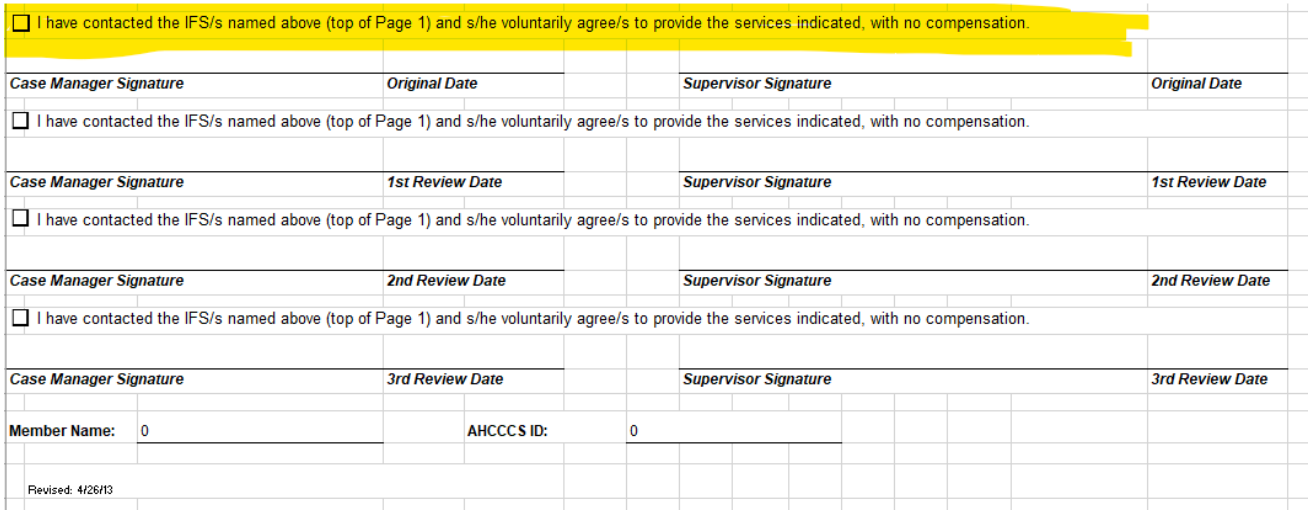
Name/Relationship of Informal Supports that will be assisting with care: (IFS)

Tasks completed by Informal Supports must be marked as **"IFS"** on the spreadsheet below in the appropriate space to clearly identify when IFS is being provided. Ensuring member's needs are met.

INFORMAL SUPPORT (IFS) POLICY AMPM 1620-17 CHANGES

SIGNATURES

Upon completion, the case manager is required to sign and date the HNT and must attest that *"I have contacted the IFS/s named above (top of Page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation"* by checking the box above the signature line.
If a member's assessed units/hours exceed the number of units/hours that the case manager is allowed to approve, the supervisor's signature line can be used as a way to indicate that the supervisor has reviewed the HNT and is in agreement with the assessed units/hours. With the exception of Tribal ALTCS Programs, supervisor signatures are optional.



☐ I have contacted the IFS/s named above (top of Page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

Case Manager Signature	*Original Date*	*Supervisor Signature*	*Original Date*

☐ I have contacted the IFS/s named above (top of Page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

Case Manager Signature	*1st Review Date*	*Supervisor Signature*	*1st Review Date*

☐ I have contacted the IFS/s named above (top of Page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

Case Manager Signature	*2nd Review Date*	*Supervisor Signature*	*2nd Review Date*

☐ I have contacted the IFS/s named above (top of Page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

Case Manager Signature	*3rd Review Date*	*Supervisor Signature*	*3rd Review Date*

Member Name: 0 **AHCCCS ID:** 0

Revised: 4/26/13

INFORMAL SUPPORT (IFS) POLICY AMPM 1620-17 CHANGES

- If something should happen to the member, the IFS could say "***I told the Case Manager that I have a job outside of the home. Show me where it's stated that I would take full responsibility of my family member***".
- They could contest it in court, and if the Case Manager does not have this verbiage marked on the HNT, then a Managed Risk Agreement (MRA) should be in place to protect the Tribal Case Manager, the Tribal Program and AHCCCS.

Questions?

Thank You.

Your Hard Work and Dedication is Greatly Appreciated

AHCCCS
Arizona Health Care Cost Containment System







Tribal ALTCS

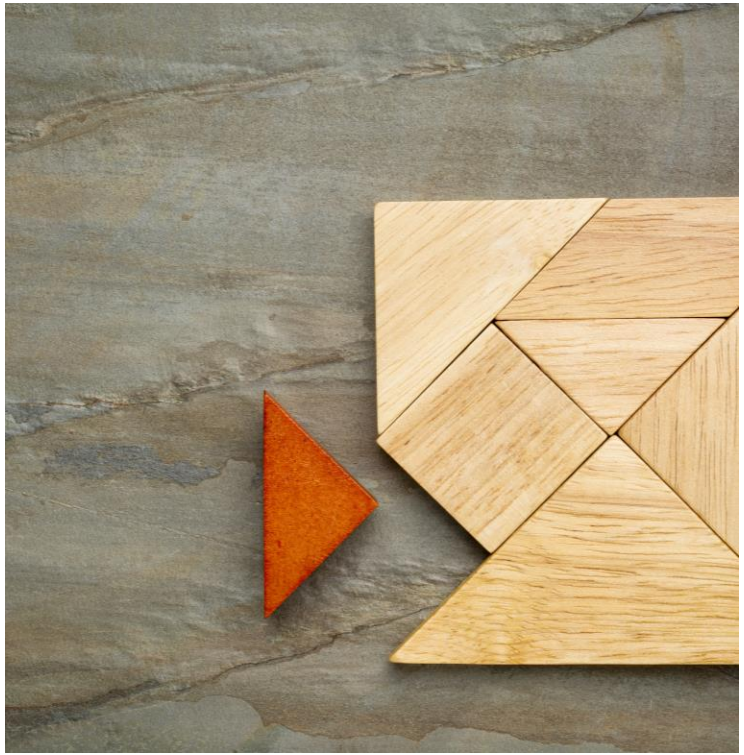
PRIOR AUTHORIZATION:

Common Missing information, DME Documentation, Orthotic Requirements, PA Correction Form, Returned Fax

Vanessa Torrez, Tribal ALTCS Nurse

AHCCCS
Arizona Health Care Cost Containment System

Common Missing Information



- PROVIDER ID NUMBER
- WRONG MEMBER ID NUMBER
- INITIAL PA REQUEST: Rx, F2F, CLINICAL NOTES FROM MD/DO/DPM/NP/PA to Support Medical Necessity
- NEED NEW Rx
- NEED VALID SIGNATURE
- NEED UPDATED CLINICALS FOR INCREASE
- NEED PA CORRECTION FORM

The following information shall be supplied at the time of the PA request:

Refer to AMPM Policy: 310-P, 810, 820, 1620-F

a. Prescription or order with ordering provider's name, and dated signature with credentials listed,

b. Diagnosis indicated by ordering provider,

c. Description of medical condition necessitating the supplies/equipment, and medical justification for supplies/equipment with anticipated outcome (medical/ functional),

d. Clinical documentation, including documentation that meets face-to face encounter requirements, (AMPM Policy 310-P),

e. Description of supplies/equipment requested,

f. Duration for use of equipment,

g. Item price plus any additional costs and expected cost if rented,

h. Provider identification number, and

i. Home evaluation, when requested by DFSM

ORTHOTIC AND PROSTHETIC DEVICES

Orthotics Defined- Orthoses refer to the devices used to correct or enhance the use of part of your body. Orthotic devices provide comfort and support to the limb.

Prosthetics Defined- A prosthesis is an artificial limb, to replace a limb on a person's body.

Orthotic devices are covered for member when medically necessary as specified below: (Refer to: AHCCCS Policy - 430):

- Orthotics are covered for AHCCCS members under the age of 21 as specified in AMPM Policy 430.

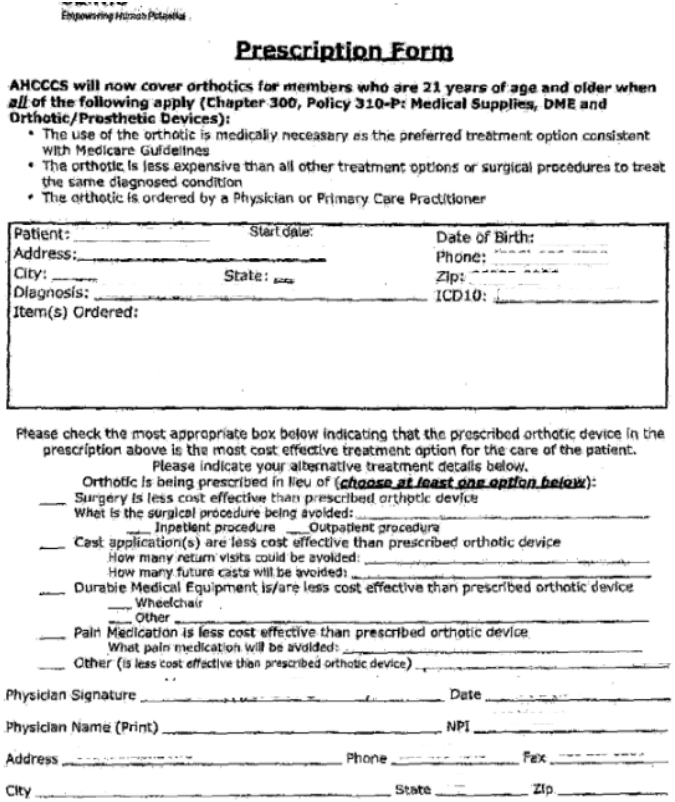
Orthotic Coverage Guidelines: (Refer to: AHCCCS Policy - AMPM 310-JJ.III.A.2.b.):

Orthotics are covered for AHCCCS members 21 years of age and older if all of the following apply:

- ✓i. The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines,
- ✓ii. The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition, and
- ✓iii. The orthotic is ordered by a Physician or PCP.

Orthotic requirements for members 21 years of age

"The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition" statement".



Empowering Human Potential

Prescription Form

AHCCCS will now cover orthotics for members who are 21 years of age and older when *all* of the following apply (Chapter 300, Policy 310-P: Medical Supplies, DME and Orthotic/Prosthetic Devices):

- The use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare Guidelines
- The orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition
- The orthotic is ordered by a Physician or Primary Care Practitioner

Patient: _____ Start date: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State: ___ Zip: _____
Diagnosis: _____ ICD10: _____
Item(s) Ordered:

Please check the most appropriate box below indicating that the prescribed orthotic device in the prescription above is the most cost effective treatment option for the care of the patient.
Please indicate your alternative treatment details below.
Orthotic is being prescribed in lieu of (***choose at least one option below***):

___ Surgery is less cost effective than prescribed orthotic device
What is the surgical procedure being avoided: _____
___ Inpatient procedure ___Outpatient procedure

___ Cast application(s) are less cost effective than prescribed orthotic device
How many return visits could be avoided: _____
How many future casts will be avoided: _____

___ Durable Medical Equipment is/are less cost effective than prescribed orthotic device
___ Wheelchair
___ Other _____

___ Pain Medication is less cost effective than prescribed orthotic device
What pain medication will be avoided: _____

___ Other (is less cost effective than prescribed orthotic device) _____

Physician Signature _____ Date _____
Physician Name (Print) _____ NPI _____
Address _____ Phone _____ Fax _____
City _____ State _____ Zip _____

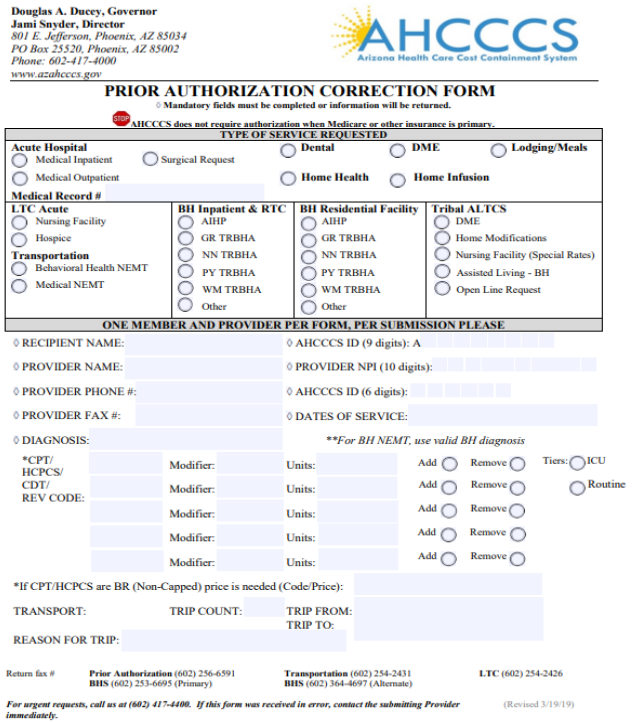
MAINTENANCE AND REPAIR

Maintenance and repair of component parts is covered for Orthotic and Prosthetic devices. Reasonable repairs or adjustments of purchased Orthotics and Prosthetics are covered for all members to make the device serviceable and/or when the repair cost is less than purchasing another unit. Components will be replaced when documentation is provided at the time authorization is sought to establish that the component is not operating effectively.

PRIOR AUTHORIZATION CORRECTION FORM

WHEN IS A PA CORRECTION FORM NEEDED?

- Submit any changes on a PA Correction form with a copy of Provider Quote.
- DOWNLOAD THE FORM FROM THE WEBSITE (LINK BELOW), COMPLETE. INDICATE SPECIFIC INSTRUCTIONS WHAT CPT TO ADD, TO KEEP OR REMOVE. THEN SUBMIT via FAX.
- https://www.azahcccs.gov/PlansProviders/Downloads/PriorAuthorizations/PACorrectionForm.pdf
- Submit any changes on a PA Correction form with a copy of Provider Quote.



Douglas A. Ducey, Governor
Jami Snyder, Director
801 E. Jefferson, Phoenix, AZ 85034
PO Box 25520, Phoenix, AZ 85002
Phone: 602-417-4000
www.azahcccs.gov

AHCCCS
Arizona Health Care Cost Containment System

PRIOR AUTHORIZATION CORRECTION FORM

◊ Mandatory fields must be completed or information will be returned.

AHCCCS does not require authorization when Medicare or other insurance is primary.

TYPE OF SERVICE REQUESTED

Acute Hospital
- ◯ Medical Inpatient
- ◯ Surgical Request
- ◯ Medical Outpatient

- ◯ Dental
- ◯ DME
- ◯ Lodging/Meals
- ◯ Home Health
- ◯ Home Infusion

Medical Record #

LTC Acute	BH Inpatient & RTC	BH Residential Facility	Tribal ALTCS
◯ Nursing Facility	◯ AIHP	◯ AIHP	◯ DME
◯ Hospice	◯ GR TRBHA	◯ GR TRBHA	◯ Home Modifications
Transportation	◯ NN TRBHA	◯ NN TRBHA	◯ Nursing Facility (Special Rates)
◯ Behavioral Health NEMT	◯ PY TRBHA	◯ PY TRBHA	◯ Assisted Living - BH
◯ Medical NEMT	◯ WM TRBHA	◯ WM TRBHA	◯ Open Line Request
	◯ Other	◯ Other	

ONE MEMBER AND PROVIDER PER FORM, PER SUBMISSION PLEASE

◊ RECIPIENT NAME:
◊ AHCCCS ID (9 digits): A
◊ PROVIDER NAME:
◊ PROVIDER NPI (10 digits):
◊ PROVIDER PHONE #:
◊ AHCCCS ID (6 digits):
◊ PROVIDER FAX #:
◊ DATES OF SERVICE:
◊ DIAGNOSIS:
**For BH NEMT, use valid BH diagnosis

*CPT/ HCPCS/ CDT/ REV CODE:	Modifier:	Units:	Add ◯ Remove ◯	Tiers: ◯ ICU ◯ Routine
	Modifier:	Units:	Add ◯ Remove ◯	
	Modifier:	Units:	Add ◯ Remove ◯	
	Modifier:	Units:	Add ◯ Remove ◯	
	Modifier:	Units:	Add ◯ Remove ◯	

*If CPT/HCPCS are BR (Non-Capped) price is needed (Code/Price):

TRANSPORT: TRIP COUNT: TRIP FROM: TRIP TO:

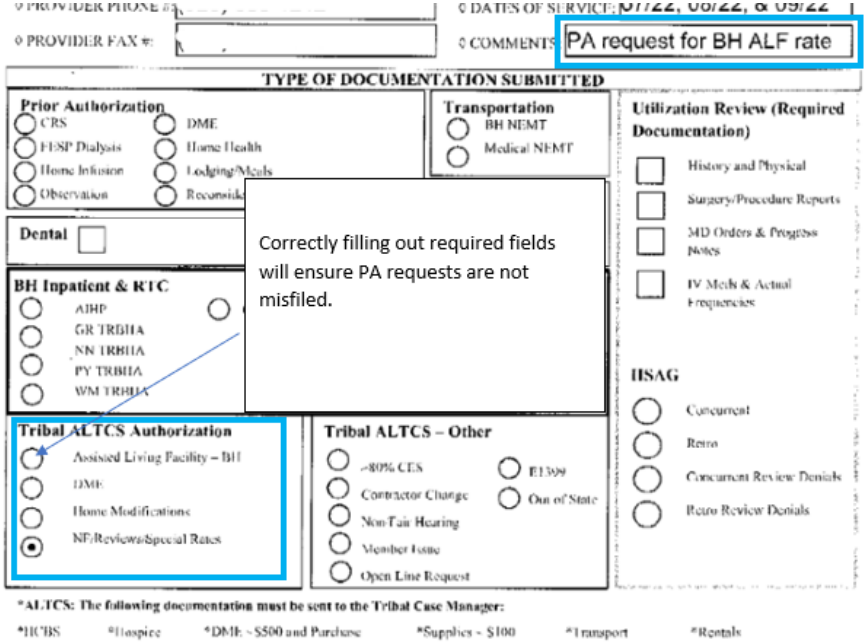
REASON FOR TRIP:

Return fax # **Prior Authorization** (602) 256-6591 **BHS** (602) 253-6695 (Primary) **Transportation** (602) 254-2431 **BHS** (602) 364-4697 (Alternate) **LTC** (602) 254-2426

For urgent requests, call us at (602) 417-4400. If this form was received in error, contact the submitting Provider immediately.

(Revised 3/19/19)

Please fill out the PA required fields, not doing so will result in Misfiling of PA requests.



RETURNED FAX:

AHCCCS
Arizona Health Care Cost Containment System

Douglas A. Ducey, Governor
Thomas J. Betlach, Director

Dear Provider:

We have received your recent fax. In order to provide the best customer service, complete and correct information is required to process your submission.

Your fax is being returned because either you are not using one of our mandatory forms or the form is incomplete. The mandatory forms must be the first or second page when you are faxing to AHCCCS Fee For Service.

If you need a copy of the form, you may go to our website at:

http://www.azahcccs.gov/commercial/FFSclaiming/priorauthorization/priorauthorization.aspx

There are three forms to choose from:

- Prior Authorization Request Form
- Prior Authorization Medical Documentation Form
- Prior Authorization Correction Form

If you have any questions regarding how to complete the Fee For Service form you are submitting please contact the AHCCCS Prior Authorization Unit at:

- Phoenix Area: (602) 417-4400
- All Others: (800) 433-0425 (In State)
  (800) 523-0231 (Out of State)

Sincerely,

Prior Authorization Unit
Division of Fee-for-Service Management
Arizona Health Care Cost Containment System (AHCCCS)

Common PA NOT REQ'D FOR ACUTE OR LTC

* HCBS
*DME < $500 & Purchase
*Transport Services
*SNF Levels : 0191 , 0192 , 0193

*Supplies < $100
*Hospice
*Therapy Services

*Pharmacy

PLEASE SEND THE MEDICATION REQUEST FORM DIRECTLY TO OPTUM: Please complete this form and fax to Optum Rx at 1(866) 463-4838 .

If you have any questions regarding this process, please contact Optum Rx's Customer Service at (855) 577-6310


Tribal ALTCS Nurse Contact Information:
(602) 417-4169 Direct Line
(602) 254-2426 Fax
PA Office: 602-417-4400
Vanessa.Torrez@azahcccs.gov

AHCCCS
Arizona Health Care Cost Containment System

Thank you
Any Questions?

Tribal Plan Recognitions