

March 2019

Care Coordination: FFS Programs

Did you know?

- There can be confusion regarding the coordination of care responsibility for Fee for Service American Indian and Alaskan Native members who receive services at a Behavioral Health Hospital.
- For instance, members should not be discharged with 7 days of medication without a follow-up appointment for ongoing routine services to an outpatient behavioral health provider, to include coordinating transportation.
- Members who require ongoing routine outpatient behavioral health care is of the utmost importance.
- Every attempt shall be made by the treating BH hospital to avoid an unsafe discharge or a condition where a FFS member is referred to a PCP in lieu of a qualified Behavioral Health Provider for ongoing psychiatric medication monitoring.
- A FFS member's tribal affiliation should be identified to determine a possible connection with a Tribal Regional Behavioral Health Authority (TRBHA) or the member's Tribe.
- As an AHCCCS registered provider, a Behavioral Health Hospital has a Provider Participation Agreement in place with AHCCCS and has agreed to abide by that agreement which includes adherence to AHCCCS policies.

For more information regarding FFS Programs, please [visit our website](#).

Did you know?

- For appropriate and acceptable coordination of care for a FFS member leaving the Behavioral Health Hospital, the expectation is that a follow-up appointment would be secured at a community clinic, of the member's choice prior to discharge.
- Keep in mind that a FFS member may choose Indian Health Services or a 638 clinic for ongoing care; coordination of care is expected with these organizations as well.
- As a reminder, an American Indian/Alaskan Native who is eligible for AHCCCS may be enrolled in the American Indian Health Program (AIHP) or another AHCCCS Complete Care Plan.
- Members should not be steered towards managed care; they must be

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PROVIDER EDUCATION DATES

- General Direct Care Agency Training
3/14/19
10:00 AM - 11:00 AM
- One on One Provider Training Dates
3/7/19; 3/21/19; 3/28/19

ELECTRONIC PAYMENT SIGN UP

Contact:
ISDCustomerSupport@azahcccs.gov
-OR-
Call 602-417-4451

CONTACTS

Prior Authorization Questions FFS
PA Line (602) 417-4400

Claims Customer Service
Billing Questions
(602) 417-7670

Provider Registration Process
Questions - (602) 417-7670
Fax Applications (602) 256-1474

Technical Assistance with Online
Web Portal Please email
ProviderTrainingFFS@azahcccs.gov

Care Coordination: FFS Programs

afforded their federally recognized freedom of choice.

For Coordination Of Care requirements in AHCCCS policy; please review [AMPM Chapter 500 of the AHCCCS Medical Policy Manual \(AMPM\)](#).

Did you know?

A Discharge Plan should be developed and planning begins upon admission and is updated periodically during the inpatient stay to ensure a safe, timely and effective discharge. It helps health care providers to coordinate outpatient treatment and helps make a smooth return to the community while fostering a regular routine. Effective discharge planning applies to short-term and long-term hospital and institutional stays and includes:

- A follow-up appointment with the primary care doctor (PCP) and/or specialist within seven (7) days;

- Safe and clinically appropriate placement, and community support services;
- Communication of the member's treatment plan and medical history across all involved providers;
- Prescription medications and medical equipment;
- Nursing services and therapies, if appropriate;
- Referral to appropriate community resources;
- Referral to a Disease Management or care management provider (if needed);
- A post-discharge follow-up call to the member within three (3) days of discharge to confirm the member's well-being and the progress of the discharge plan;
- Additional follow-up actions as needed based on the member's needs.

For more information regarding discharge planning see [R9-10-209 on page 36](#).

Notice of Non-Discrimination

Arizona Health Care Cost Containment System (AHCCCS) complies with applicable Federal civil rights laws, does not discriminate, and does not treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that AHCCCS, or an AHCCCS-registered contractor or provider, failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the AHCCCS Office of Administrative Legal Services.

You can file a grievance in person or by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination. Submit your grievance to:

General Counsel, AHCCCS Administration
Office of Administrative Legal Services, MD 6200
701 E. Jefferson
Phoenix, AZ 85034
Fax: 602 253 9115
Email: EqualAccess@azahcccs.gov.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Or by phone at:

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Addressing the Increase of Syphilis in Arizona

Arizona is currently in a syphilis outbreak in women and babies. Arizona now has the 4th highest rate of syphilis in the country.

Based on the recommendation from the Arizona Department of Health Services (ADHS), with support from the Center for Disease Control (CDC), the Arizona Health Care Cost Containment System (AHCCCS) is covering three syphilis screenings during pregnancy statewide effective immediately.

That means that for the duration of the Arizona syphilis outbreak, AHCCCS will cover all of the augmented screening recommendations statewide:

1. All pregnant women at first prenatal visit, early in the third trimester, and at delivery, regardless of risk.
2. Opt-out screening in both men and women who use drugs.
3. Sexually active men who have sex with men: testing annually and every 3-6 months if at increased risk.
4. Sexually active persons with HIV: testing at least annually and every 3-6 months if at increased risk.



For additional resources on syphilis prevention, screening and treatment, please refer to:

- [2015 CDC Guidelines](#)
- azdhs.gov/syphilis for updated information on the outbreak

BHRF Notification

*Article updated 4/1/19 to detail updated requirements.

Effective 4/1/2019, all admissions and continued stays at Behavioral Health Residential Facilities (BHRF) (Provider Type B8) for AIHP and TRBHA members will require authorization.

NOTE: Authorization is NOT required for IHS/638 BHRF Facilities.

All new BHRF admissions will require notification of admission to AHCCCS for initial coverage of up to 5 days of care. During this initial 5 day time frame, the BHRF will be responsible for submitting an Authorization request and ensuring compliance with criteria listed in AMPM Policy 320-V – Behavioral Health Residential Facilities and 9 A.A.C.10.

- If the Authorization request and the supporting admission documentation are not received within the initial 5 day time frame, claims may be denied.

Admission documentation that is required for the Authorization request includes:

1. Behavioral health assessment in compliance with 9 A.A.C. 10, to determine Behavioral Health Condition and Diagnosis. Assessment should be recent, and not older than 1 year. Done by a BHP, or by BHT cosigned by a BHP, utilizing standardized instrument that is able to determine the appropriate level of care.
2. Treatment Plan – completed in compliance with 9A.A.C.10 by the Inpatient/Outpatient or TRBHA Treatment Team. Included in the plan should be an intervention specifying the BHRF level of care as necessary for the member as a least restrictive level of care required to treat the Behavioral Health Condition, identified in the Assessment. This plan shall not be older than 3 months from the request submission date.

NOTE: All criteria for admission still must be met from the date of admission.

Behavioral Health Residential Facility (BHRF) Notification Continued

For members currently in a BHRF, the facility must submit an authorization request to get the continued stay authorized by 5/31/2019. Criteria for admission and continued stay will be detailed in the new AMPM Policy 320-V – Behavioral Health Residential Facilities.

Specific authorization submission and documentation procedures will be available on the FFS web page on the AHCCCS web site.

Please look for upcoming notifications on training opportunities that will be available on the FFS web page.

Prior Authorization Requests shall be submitted on the [AHCCCS Online Provider Portal](#).

[Guidelines related to requirements for prior authorization and its accompanying documentation.](#)

Covered Behavioral Health Services Guide – Important Update

In early 2019, information contained within the AHCCCS Covered Behavioral Health Services Guide (CBHSG) will be transitioned into the following areas:

- [AMPM 310-B, Behavioral Health Services Benefit](#)
 - Title XIX/XXI benefit information.
- [AMPM 320-T, Non-Title XIX/XXI Behavioral Health Services Benefit](#)
 - Non-Title XIX/XXI service information.
- The Provider Billing Manuals
 - Billing information for all providers, both FFS and MCOs, will be transferred to the Provider Billing Manuals.

- [Chapter 19, Behavioral Health Services, of the Fee-For-Service Provider Billing Manual](#)
- [Chapter 12, Behavioral Health Services, of the IHS/Tribal Provider Billing Manual](#)
- Appropriate AMPM Policies as necessary, including:
 - AMPM 310-BB, Transportation; and
 - AMPM 310-V, Behavioral Health Residential Facilities (BHRFs).

For MCO providers having additional questions, please contact the MCO directly.

For FFS providers having additional questions, the DFMS Provider Training team can be reached at ProviderTrainingFFS@azahcccs.gov.

Q. Are Contracts Needed for FFS Members?

A: Fee-For-Service providers do not need to contract with AHCCCS AIHP, Tribal ALTCS, or a TRBHA to continue providing Medicaid Title XIX/XXI services to FFS members. **A provider simply must be an AHCCCS registered provider.**

Providers must follow the AHCCCS Medical Policy Manual (AMPM) and Fee-for-Service Provider Billing Manual.

For information on providing services to an ACC Plan enrolled member (not a FFS member), please contact [the ACC plan](#).

Pharmacy Updates

As of April 1st, 2019 OptumRx PBM Changes for IHS & 638 Rx Claims Processing include:

- PBM Claims Adjudication for Reimbursement of:
 - The All Inclusive Rate (AIR); and
 - Specialty & High Dollar Medications
- Eligibility for the AIR and Specialty Medication Plan includes all Native Americans enrolled in:
 - AHCCCS Fee-For Service, and
 - AHCCCS Contracted Managed Care Organizations

Pharmacies will need OptumRx's BIN and PCN numbers for claims adjudication of the AIR.

- **BIN = 001553**
- **PCN = AIRAZM**
- **OPTUM RX Help Desk Phone Number; Toll Free: 1 (855) 577-6310**

Claims Submission Reminders:

- Prescription claims, with a service date through March 31st, must be submitted to AHCCCS within 1 year from the Service Date.
- Prescription claims with a service date after March 31st must be submitted to the PBM, OptumRx, for claims adjudication and reimbursement.

Pharmacy AIR Reminders

There has been no change to the number of AIRs per member per day. The total AIRs for a member may not exceed 5 per day. For pharmacy, there may be one pharmacy AIR reimbursement per day per member per IHS/638 pharmacy. Additional pharmacy claims submitted on the same day, after the first claim is adjudicated for the AIR, will pay at zero dollars.

- AIR Annual Adjustment – Claims will be recycled and adjustments provided by OptumRx.

AIR Plan Prescription Utilization Parameters

Maximum Days Supply Allowable for Dispensing

- Non-Controlled Substances – up to 90 days
- Controlled Substances – up to 30 days
- ADHD Medications – up to 90 days

Refill Utilization Percentages

- Non-Controlled Substances – 80% or greater
- Controlled Substances – 85% or greater

All Inclusive Rate Plan PBM Set-Up

- OptumRx will load the AHCCCS Fee-For-Service Drug List for claims adjudication.
- Federally and State Reimbursable Drugs not listed on the AHCCCS FFS Drug List are available through the prior authorization process.
- AMPM Policy 310-V Sections F & G Opioid Requirements:
 - All Long-Acting opioids medications currently require prior authorization, which will be in effect beginning on May 1, 2019.
 - The Short-Acting Opioids 5-day limits for adults and children will be implemented on June 1, 2019.

AIR & Medicare PBM Plan Set-Up

This is to provide prescription coverage for members eligible for Medicare.

Medicare Part D

- AHCCCS and its Contractors are prohibited from using federal and/or state funds to pay for any part of medications eligible for coverage under Medicare Part D.

Medicare Part B

- AHCCCS is a secondary payer
- AHCCCS and its Contractors will reimburse IHS & 638 Tribal Pharmacies, up to 20% of the Medicare Part B Reimbursement. This applies to claims adjudication for all plan set-ups at the PBM.

Pharmacy Updates Continued

AHCCCS is the primary payer for OTC medication listed on the AHCCCS Dual Eligible Drug List. IHS & 638 Tribal Pharmacies may submit OTC claims for drugs listed on the AHCCCS FFS Dual Eligible Drug List for the AIR reimbursement.

Specialty Medication Plan Plan PBM Set-Up

Pharmacies will need OptumRx's BIN and PCN for claims adjudication of the AIR.

- **BIN = 001553**
- **PCN = SPCAZM**

OPTUM RX Help Desk Phone Number;

- **Toll Free: 1 (855) 577-6310**

Specialty Medication Claims are transactions outside of the AIR and paid in accordance with the CMS approved State Plan Amendment and the CMS Outpatient Drug Rule.

Reimbursement is at the lesser of the:

- Federal Supply Actual Acquisition Cost or Wholesale Acquisition Cost
- Plus a Professional Dispensing Fee.

Claims will not be recycled when the AIR is annually adjusted.

The claims adjudication process uses a set dollar threshold.

- AIR plus a penny is the proposed Set Dollar Threshold= \$455.01
- If the AIR changes, the Set Dollar Threshold will be adjusted
- CMS approved this methodology as it allows for greater flexibility than using a defined drug list. It means that claims adjudication is based on the

cost of the prescription, and it eliminates the Drug List updating process.

- The PBM uses MediSpan & First DataBank to identify federally & state reimbursable drugs.

Specialty Plan RX Utilization Parameters

OptumRx will load the AHCCCS Fee-For-Service Drug List for claims adjudication.

Maximum Days Supply Allowable for Dispensing

- Up to 30 days

Refill Utilization Percentages

- Non-Controlled Substances – 80% or greater
- Controlled Substances – 85% or greater

Specialty Medication Plan PBM Set Up

Specialty medications will be grandfathered for the first 30-days of the implementation beginning April 1st with the following parameters:

- Member must be eligible;
- Medication must be federally and state reimbursable; and
- Rx Cost does not exceed a high dollar limit.

KidsCare Claims Adjudication

KidsCare Claims will Continue to Adjudicate under the Current BIN and PCN numbers below:

- **BIN = 001553**
- **PCN = AZM**

OPTUM RX Help Desk Phone Number;

- **Toll Free: 1 (855) 577-6310**