

**DATE:** September 29, 2017  
**To:** Holders of the AHCCCS Medical Policy Manual  
**FROM:** Contracts and Policy Unit  
Division of Health Care Management, AHCCCS  
**SUBJECT:** AHCCCS Medical Policy Manual (AMPM)

This memo describes revisions and/or additions to the AMPM.

Please direct questions regarding policy updates to the Contracts and Policy Unit at 602-417-4295 or 602-417-4055 or email at [DHCMContractsandPolicy@azahcccs.gov](mailto:DHCMContractsandPolicy@azahcccs.gov).

**PLEASE NOTE:** We are currently converting the AMPM Headers and Footers to a new format, aligning Policy language for consistency, and changing Exhibits to Attachments. Changes will be done over the next several months. In addition, Arizona Law 2015, Chapter 19 Section 9 (SB 1480) enacts that from and after June 30, 2016 the provisions of behavioral health services under Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is transferred to and shall be administered by AHCCCS. We are in the process of transferring all pertinent documents to AHCCCS.

**UPDATES AND REVISIONS TO THE AHCCCS MEDICAL POLICY MANUAL (AMPM)**

To view the policies and attachments, please access the following link:

**AHCCCS MEDICAL POLICY MANUAL (AMPM)**

**CHAPTER 300, POLICY 310-D1, Dental Services for Members 21 Years of Age and Older**

AMPM Policy 310-D1 was revised to include the adult emergency dental benefit pursuant to A.R.S. 36-2907(A), as amended by Arizona Senate Bill 1527 (2017). It was also revised for clarity and consistency in language and format. *The effective date for this policy will be 10/1/2017.*

**Chapter 300, Policy 310-D2, Arizona Long Term Care System (ALTCS) Adult Dental Services**

AMPM Policy 310-D1 was revised to include the adult emergency dental benefit pursuant to A.R.S. 36-2907(A), as amended by Arizona Senate Bill 1527 (2017). This Policy provides for an annual ALTCS dental benefit of \$1000, as well as an emergency dental benefit of \$1000. Finally, the policy was modified for clarity and consistency. *The effective date for this policy will be 10/1/2017.*

**CHAPTER 300, POLICY 310-HH, END OF LIFE CARE**

AMPM Policy 310-HH is a new policy that establishes guidelines, medical criteria and requirements for End of Life care and the provision of Advance Care Planning. The End of Life concept of care strives to preserve member rights and dignity, while receiving appropriate health care services and practical supports. *The effective date for this policy will be 10/1/2017.*

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**CHAPTER 300, POLICY 310-J, HOSPICE SERVICES**

AMPM Policy 310-J has been revised to include applicability to all Contractors and FFS Programs, to clarify guidelines for allowable hospice services for terminally ill members pursuant to A.R.S. §36-2907, A.R.S. §36-2989 and 42 CFR 418.20. It clarifies that members under age 21 may receive curative treatment concurrently with hospice services. Further, the definition of palliative care was removed, and the various components comprising hospice services were defined. *The effective date for this policy will be 10/1/2017.*

**CHAPTER 300, POLICY 320-P, SERIOUS MENTAL ILLNESS ELIGIBILITY DETERMINATION**

AMPM 320-P was updated to include applicability to ALTCS EPD and Tribal ALTCS, due to retention of Serious Mental Illness (SMI) designation in contracts effective October 1, 2017. Language was added to clarify that assessments begin at age 17.5, and outline which entity receives information regarding decertifications. *The effective date for this policy will be 10/1/2017.*

**CHAPTER 500, POLICY 520, MEMBER TRANSITIONS**

AMPM Policy 520 was revised to incorporate new managed care regulations at 42 CFR 438.62, requiring specific continued services during the transition period for members transitioning from a FFS to MCO Provider, or transitioning to adulthood in the behavioral health system. Revisions also accounted for out of service area/placement system updates to ensure non-integrated members receive appropriate physical and behavioral health services.

Post Approved Not Yet Effective Change: Clarification was provided in Section L surrounding “the RBHA referral process for SMI members to become enrolled with a RBHA in the other GSA for both behavioral health and physical health services. A change of address to another GSA will cause a non-integrated member to become enrolled with an Acute Care Contractor in the other GSA for Physical Health Services and assigned to the RBHA in the other GAS for behavioral health services.”

- **ATTACHMENT A, ENROLLMENT TRANSITIONS INFORMATION (ETI) FORM**

No changes.

- **ATTACHMENT B, OUT OF SERVICE AREA PLACEMENT REQUEST**

No changes.

**CHAPTER 500, POLICY 550, MEMBER RECORDS AND CONFIDENTIALITY**

AMPM Policy 550 was revised in line with new AHCCCS formatting and terminology, and reworded for flow and clarity. We also emphasized adherence to all applicable privacy regulations, including Health Insurance Portability and Accountability Act (HIPAA) at 45 CFR Part

164, Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2), and the requirement to safeguard information on applicants and beneficiaries at 42 CFR 431.300 *et seq.* *The effective date for this policy will be 9/29/2017.*

#### **CHAPTER 500, POLICY 560, CRS CARE COORDINATION AND SERVICE PLAN MANAGEMENT**

AMPM 560 was revised to align with the AHCCCS Contractor Operations Manual (ACOM), and AHCCCS formatting and terminology. It was also adjusted for better flow and clarity. *The effective date for this policy will be 9/29/2017.*

#### **CHAPTER 900, POLICY 970, PERFORMANCE MEASURES**

AMPM Policy 970 was revised to align with the YH18-0001 ALTCS E/PD RFP/Contract, and incorporate new Managed Care Regulations at 42 CFR 438.320. It was updated and edited to improve clarity and flow of information. AHCCCS also updated references, added supplemental data sources and a new Quality Rating section. *The effective date for this policy will be 10/1/2017.*

#### **CHAPTER 900, POLICY 980, PERFORMANCE IMPROVEMENT PROJECTS**

AMPM Policy 980 was revised to align with the YH18-0001 ALTCS E/PD RFP/Contract, and incorporate new Managed Care Regulations at 42 CFR 438.320. The Purpose and definitions were updated and aligned across Chapter 900 Policies, and edits were made improve clarity and flow of information and remove duplicative language.

A minor change was made post Tribal Consultation Notice/Public Comment period to align the definition of Grievance with Contract. *The effective date for this policy will be 10/1/2017.*

- **ATTACHMENT A, PROTOCOL FOR CONDUCTING PERFORMANCE IMPROVEMENT PROJECTS**

Attachment A (formerly Exhibit 1 under AMPM 980), was revised to reflect current PIP practices and protocol, which relates specifically to the validation, rather than the selection of Performance Improvement Projects (PIPs). Language was reordered to match that found in the methodology provided for AHCCCS-mandated PIPs and aligns with the CMS Protocol Reference. Lastly, the Policy was edited to improve clarity and flow.

- **ATTACHMENT B, PERFORMANCE IMPROVEMENT PROJECT REPORTING TEMPLATE**

Attachment B (formerly Exhibit 2 under AMPM 920), was replaced with a new, more comprehensive and user friendly reporting tool. Attachment B captures all necessary data, including results and conclusions, methodologies, interventions, goals and PDSAs, and timeframes, and includes guidance on the information sought, including quantitative and qualitative data.

**CHAPTER 1000, POLICY 1020, MEDICAL MANAGEMENT SCOPE AND COMPONENTS**

AMPM Policy 1020 was revised to incorporate Behavioral Health language and align with new Managed Care Regulations, including prior authorization changes relative to 72 hour expedited service requests, 24 hour acknowledgement of drug requests, 72 hour emergency drug fill and 72 hour expedited determination for request for drugs. New reach-in care coordination for members who are being released from the Justice System was developed in conjunction with the Governor's Vivitrol Treatment Program as required by Executive Order 2017-01.

In addition, changes were made post Tribal Consultation/Public Comment period. AHCCCS added ALTCS to contractor care management, and adding a clarifying sentence to differentiate Care Managers and Case Managers, *"Care managers identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Contractor care managers work closely with ALTCS contractor case managers and provider case managers to ensure the most appropriate plan and services for members."*

In response to concerns noted in a public comment, AHCCCS clarified Section C, Discharge Planning, by removing, *"The discharge planning process shall include the involvement and participation of the member/guardian/designated representative, as applicable. The member/guardian/ designated representative, as applicable, must be provided with the written discharge plan with instructions and recommendations identifying resources, referrals and possible interventions to meet the member's assessed and anticipated needs after discharge,"* and replacing it with:

*"The Contractor staff participating in the discharge planning process shall ensure the member/guardian/ designated representative, as applicable:*

- 1. Is involved and participates in the discharge planning process*
- 2. Understands the written discharge plan, instructions and recommendations provided by the facility*
- 3. Is provided resources, referrals and possible interventions to meet the member's assessed and anticipated needs after discharge."*

AHCCCS also revised Section D, removing subsections g, h, and i under a new Section D2, which states:

*"Contractors shall develop and implement policies for processing and making determinations for prior authorization requests for medications. The Contractor shall ensure the following:*

- 1. A decision to a submitted prior authorization request for a medication is provided by telephone, fax, electronically or other telecommunication device within 24 hours of receipt of the submitted request for prior authorization,*
- 2. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication device within 24 hours of the submitted request when the prior*

*authorization request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven business days from the initial date of the request,*

- 3. At least a 4-day supply of a covered outpatient prescription drug is provided to the member in an emergent situation. [42 CFR 438.3(s)(6)]."*

A sentence was added in Section I, 1., at k., stating the Contractor shall establish policies and procedures that reflect integration of services to ensure continuity of care by *"Ensuring policies reflect care coordination for members presenting for care outside of the Contractor's provider network."*

Finally, the following language was added to support mental health parity:

Section C -

*"The Contractor shall develop and implement a system that includes at least two modes of delivery for providers to submit prior authorization requests such as telephone, fax, or electronically through a portal on the Contractor's website.*

*The Contractor shall ensure providers who request authorization for a service are notified that they have the option to request a peer to peer discussion with the Contractor Medical Director when additional information is requested by the Contractor or when the prior authorization request is denied. The Contractor shall coordinate the discussion with the requesting provider when appropriate."*

*"The Contractor criteria for decisions on coverage and medical necessity for both physical and behavioral services must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals."*

Section E - *"A corrective action plan must be included for staff who do not meet the minimum compliance goal of 90%."*

Section H - *"A decision in response to an urgent request must be made as expeditiously as the member's condition warrants and no later than 72 hours from receipt of the request."*

*The effective date for this policy will be retroactive to 7/1/2017.*

#### **CHAPTER 1600, POLICY 1610, COMPONENTS OF ALTCS CASE MANAGEMENT**

AMPM Policy 1610 added guiding principles as discussed in Contract, was revised to align with the YH18-0001 ALTCS E/PD RFP/Contract and underwent minor technical revisions consistent with applicability of the Policy, its purpose, and aligning language across AHCCCS Policies. *The effective date for this policy will be 10/1/2017.*

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**CHAPTER 1600, POLICY 1620-A, INITIAL CONTACT VISIT STANDARD**

AMPM Policy 1620-A was revised to align with the YH18-0001 ALTCS E/PD RFP/Contract, and underwent minor technical revisions consistent with applicability of the Policy, its purpose, and aligning language and formatting consistency across AHCCCS Policies. *The effective date for this policy will be 10/1/2017.*

**CHAPTER 1600, POLICY 1620-B, NEEDS ASSESSMENT/CARE PLANNING STANDARD**

AMPM Policy 1620-B was reworked to better address behavioral health care, such as adding SMI grievance procedures and defining requirements for care planning, incorporating references, and aligning with the YH18-0001 ALTCS E/PD RFP/Contract and Rules (A.A.C. Title 9, Chapter 21) regarding behavioral health services for persons with serious mental illness. *The effective date for this policy will be 10/1/2017.*

**CHAPTER 1600, POLICY 1620-C, COST EFFECTIVENESS STUDY STANDARDS**

AMPM Policy 1620-C underwent minor technical revisions consistent with applicability of the Policy, its purpose, and aligning language across AHCCCS Policies. A reference was added to the *Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management*, (formerly, ACOM policy 411) available on the AHCCCS website. *The effective date for this policy will be 10/1/2017.*

**CHAPTER 1600, POLICY 1620-D, PLACEMENT SERVICE PLANNING STANDARD**

AMPM Policy 1620-D was amended to comport with the YH18-0001 ALTCS E/PD RFP/Contract and Rules (A.A.C. Title 9, Chapter 21) regarding behavioral health services for persons with serious mental illness and revised to align with new format and policy language. AHCCCS specified that case managers shall not use referral agencies to identify placement options for member in lieu of their contracted network of providers, clarified protocols and practices for residency agreements and MCOs responsibilities, and delineated Contractor expectations. A reference was added to the *Tutorial Guide for Pre-Paid Medical Management Information Systems Interface for ALTCS Case Management*, (formerly, ACOM policy 411) available on the AHCCCS website. *The effective date for this policy will be 10/1/2017.*

**CHAPTER 1600, POLICY 1620-E, SERVICE PLAN MONITORING AND REASSESSMENT STANDARD**

AMPM Policy 1620-C was modified to align with the YH18-0001 ALTCS E/PD RFP/Contract and Rules (A.A.C. Title 9, Chapter 21) regarding behavioral health services for persons with serious mental illness, and to integrate new format and policy language. Terminology was updated in line with Managed Care Regulations, appropriate references were added, the timeframe for submission of Member Change Report was clearly defined and language was added to clarify CMs role in communicating with HCBS providers. *The effective date for this policy will be 10/1/2017.*



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**CHAPTER 1600, POLICY 1620-G, BEHAVIORAL HEALTH STANDARDS**

AMPM Policy 1620-G was revised to align with the YH18-0001 ALTCS E/PD RFP/Contract and Rules (A.A.C. Title 9, Chapter 21) regarding behavioral health services for persons with serious mental illness updating referral standards and clarifying responsibilities for discussion and consultation with the Behavioral Health Professional, rather than relying on documentation. References were updated, as was Policy format and language.

This Policy was amended post Tribal Consultation Notice/Public Comment period to align with the current Contract definition of “Behavioral Health Professional.” *The effective date for this policy will be 10/1/2017.*

**CHAPTER 1600, POLICY 1620-L, CASE FILE DOCUMENTATION STANDARD**

AMPM Policy 1620-L was revised in line with the YH18-0001 ALTCS E/PD RFP/Contract and state Rules. Specifically, revisions illustrated the importance of establishing a secure and organized record keeping system, adherence to HIPAA and the Confidentiality of Substance Use Disorder Patient Records regulations, clarifying when a Managed Risk Agreement should be utilized, and ensuring that ALTCS CMs are documenting and following up on reported gaps/non-provisions of services. *The effective date for this policy will be 10/1/2017.*

- **EXHIBIT 1620-1, CASE MANAGEMENT TIMEFRAMES**

Exhibit 1620-1 was revised to align with Chapter 1600, Section 1620 timeframes, clarifying calendar days for initial service start up.

- **EXHIBIT 1620-2,ALTCS MEMBER CHANGE REPORT**

Exhibit 1620-2 underwent minor technical revisions. While the Member Change Report is now electronic, an eMCR cannot be submitted electronically when members are disenrolled, so this Exhibit was retained in hard copy form.

- **EXHIBIT 1620-4, ACUTE CARE ONLY “D” PLACEMENT GUIDELINES**

Exhibit 1620-4 was reviewed and had a minor grammatical change.

- **EXHIBIT 1620-7, FEE-FOR-SERVICE (FFS) OUT-OF-STATE NURSING FACILITY PLACEMENT REQUEST FORM**

A statement was added to Exhibit 1620-7 regarding request for renewals to ensure that placement continues to be appropriate for a member.

- **EXHIBIT 1620-9, ALTCS ENROLLMENT TRANSITION INFORMATION (ETI) FORM**

Exhibit 1620-9 was edited for clarity of reporting the dental benefit used for both ALTCS routine dental, and the emergency dental benefit as a result of Senate Bill 1527, which amended A.R.S. 36-2907(A).

Minor changes were made as a result of public input received as part of the Tribal Consultation Notification/Public Comment period. AHCCCS added a Header to separate dental benefit fields from “Hospitalized Members” section, modified field to specify “ALTCS Routine Dental Benefit Used,” and added a field to specify “Emergency Dental Benefit Used.”

- **EXHIBIT 1620-11, SAMPLE CRITICAL GAP REPORT FORM**

This Exhibit was Reserved, as it has not been used in practice and is duplicative of other options members have to report gaps in service, such as reporting directly or using the AHCCCS Nurse Wise line.

- **EXHIBIT 1620-13, ALTCS MEMBER SERVICE PLAN**

Minor revisions were made to Exhibit 1620-13, to align formatting language across policies.

- **EXHIBIT 1620-15, ASSISTED LIVING FACILITY (ALF) RESIDENCY AGREEMENT**

Exhibit 1620-15 underwent minor technical revisions to incorporate uniform language and grammatical corrections.

- **EXHIBIT 1620-16, ASSISTED LIVING FACILITY (ALF) FINANCIAL CHANGE AGREEMENT**

Exhibit 1620-16 underwent minor technical revisions to incorporate uniform language.

- **EXHIBIT 1620-17, HCBS MEMBER NEEDS ASSESSMENT**

This exhibit was overhauled to address inconsistencies in definitions and ensure consistency between tools and instructions. Each time the Needs Assessment of reviewed, the Case Manager shall acknowledge they have contacted informal supports, to ensure they will continue to act as supports to the member. The Exhibit was updated from a Word document to Excel, to include formulas for ease of use.

- **EXHIBIT 1620-18, ALTCS MEMBER SERVICE OPTIONS – DECISION TREE**

This is a new Exhibit which AHCCCS adopted into Policy. It clarifies key decision points for Member-directed service options, to allow members to have flexibility and control of managing and directing their own care. It also explains the differences between the Traditional, Agency with Choice and Self-Directed Attendant Care service options to assist the member in making an informed choice.



A minor change was implemented post Tribal Consultation Notification/Public Comment period as a result of a public comment received. Under the Traditional model, a sentence was clarified to read, “Agencies are required to tell you if they employ or contract with direct care workers **and explain the difference between the two business models from the member’s perspective.**”

#### **CHAPTER 1600, POLICY 1630, ADMINISTRATIVE STANDARDS**

AMPM Policy 1630 was adjusted to coincide with the YH18-0001 ALTCS E/PD RFP/Contract and Rules (A.A.C. Title 9, Chapter 21) regarding behavioral health services for persons with serious mental illness. Case Manager qualifications were updated and new case weights established for members determined to have an SMI. Each case manager’s caseload must not exceed the established weighted value. New requirements for Case Manager training were added, including an overview of ALTCS, Contractor-specific case management procedures, responsibility to report fraud, waste and abuse, processes for making referrals for SMI Determinations and standards related to the provision of services for members determined to have an SMI, end of life care and person centered planning, services and supports including covered services and how to access those services within the Contractor’s network, and HIPAA and the Confidentiality of Substance Use Disorder Patient Records regulations. *The effective date for this policy will be 10/1/2017.*

- **EXHIBIT 1630-1, ATTENDANT CARE GUIDELINES**

This Exhibit was Reserved as it is duplicative of the HNT instructions.

- **EXHIBIT 1630-2, CASE MANAGEMENT PLAN CHECKLIST**

This document was adopted as an Exhibit for ease of use and access, as it has been historically provided to Contractors on an annual basis.

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#### **APPROVED NOT YET EFFECTIVE**

*To view the policies and attachments, please access the following link:*

[AMPM Approved Not Yet Effective](#)

*The following Policies are posted for reference. However, the below Policies will not be in effect until the date referenced in each Policy. Policies which are newly approved but not yet effective will be added at the beginning of this section.*