

Cochise Health Systems

*A program contractor for Arizona Long Term Care System and
A division of Cochise Aging & Social Services*

Please note: Links to Policies & Procedures/ Protocols/ Forms/ Provider Network/ etc. located on page 5 of this document

Dear CHS Provider:

I would like to welcome our new Providers to Cochise Health Systems (CHS), and thank our current Providers for your participation in our managed health care program. As one of the Long Term Care Program Contractors for the Arizona Long Term Care System (ALTCS), CHS is responsible for providing long term care and acute care services to over 900 citizens in Cochise, Graham and Greenlee Counties. Your professional medical skills, together with those of other health care professionals, are essential to the provision of quality, cost effective care to our members.

The CHS Provider Manual has been developed to assist you in the provision of care to CHS members and to ensure that we are able to reimburse you promptly for your services. The manual also contains CHS policies (pink section) and protocols (blue and salmon sections) that are important for you to understand and follow while providing services to CHS members. CHS provides a printed copy of the entire manual to all new contractors.

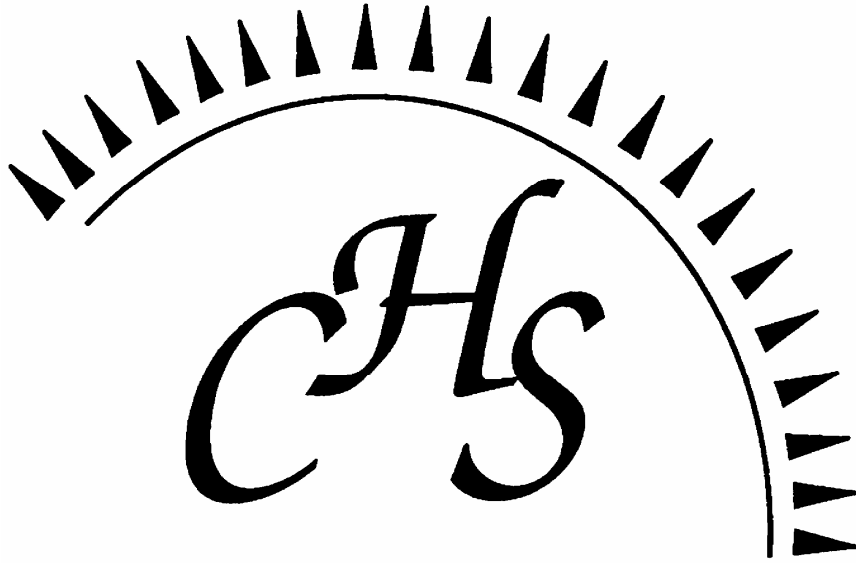
On a quarterly basis, as policies and procedures or the network changes at CHS, a notice will be sent to all providers with specific areas of change. CHS providers can now go to the website to retrieve these updates for your manuals. Any provider who does not have access to the website may contact our office at (520) 432-9600 (Contracts Section) to request a printed copy of the updates. The website address is: <http://www.co.cochise.az.us/CASS/CHS.htm>. The link at the right side of the page will take you to the Provider Manual documents.

Your review and understanding of the CHS Provider Manual is essential. Any questions, problems, or suggestions concerning the manual are encouraged and should be directed to the CHS Member-Provider Relations Supervisor. Please review the COCHISE HEALTH SYSTEMS CONTRACTED PROVIDER NETWORK, which is the yellow section in the manual. If there are any discrepancies in your network listing (i.e., addresses, phone numbers and AHCCCS Identification Numbers), please call us so that we may make the requested change in the quarterly update.

With regards,

Mary Gomez, BSN MN
Director
Cochise Health Systems

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I. INTRODUCTION

1.1 BACKGROUND OF COCHISE HEALTH SYSTEMS (CHS)

Cochise Health Systems (CHS) is a division within Cochise Aging and Social Services whose purpose is to provide quality, cost effective long term care to its members.

CHS has developed its membership through a subcontract with the Arizona Long Term Care System (ALTCS) and is responsible for providing covered long-term care and medical services to eligible members in Cochise, Graham and Greenlee Counties.

1.2 THE ARIZONA LONG TERM CARE SYSTEM

ALTCS was developed to provide quality long term care for people who cannot pay for the care they need and who meet ALTCS eligibility standards. ALTCS is part of the Arizona Health Care Cost Containment System (AHCCCS), the State's health care program for the needy.

Eligible applicants are generally separated into two basic groups: The developmentally disabled and the elderly and physically disabled. These groups may include children and pregnant women needing long term care services. CHS's contract with ALTCS covers only the elderly and physically disabled.

ALTCS provides several long term care options - from institutional services such as Skilled Nursing Facilities and intermediate care facilities to Home and Community Based Services. The various settings for Home and Community Based services are provided in the eligible applicant's home or in residential care settings such as Foster Care Homes and Assisted Living Homes.

Those who qualify for ALTCS benefits are automatically eligible for the full scope of other AHCCCS services and will continue to receive these benefits as long as they are members of ALTCS. AHCCCS members receive health care services ranging from routine laboratory services, doctor's office visits and prescriptions to hospitalization and major surgery. Members are enrolled with program contractors, such as CHS, which functions similarly to a private Health Maintenance Organization (HMO).

Anyone can apply but to be eligible a person must be a resident of the State of Arizona, a U.S. citizen or qualified legal immigrant, meet specific financial requirements, and be medically eligible.

ALTCS will determine the financial eligibility of each applicant, unless the applicant already is financially eligible through Supplemental Security Income (SSI) or Temporary Assistance to Needy Families (TANF). The applicant must be an Arizona resident, a U.S. citizen or qualified legal immigrant as defined in ARS § 36-2903.03, and have countable income and resources below certain thresholds.

Every applicant who is financially eligible must meet the Pre-Admission Screening (PAS) requirements before being enrolled in the ALTCS program. The PAS is conducted by an ALTCS registered nurse or social worker with consultation by a physician, if necessary, to evaluate the

person's medical status. The PAS is used to determine whether the person is at risk of placement in a nursing facility or an intermediate care facility for the developmentally disabled.

Once the applicant is determined to be eligible for ALTCS services, he/she is enrolled with a program contractor such as CHS. Members are assigned on a daily basis. A Case Manager is assigned to oversee the specifics of the program and provide a one-to-one contact with the ALTCS member. The member and the Case Manager, in collaboration with the assigned Primary Care Physician and other sources, will discuss long term care options and facilitate the development of a care plan which promotes dignity, independence, individuality, privacy and choice. The Case Manager can arrange transportation for the member if medically necessary, review the medical progress of the member, and deal with the related concerns of the member, their family or friends during the period of eligibility.

Case Managers, in shared responsibility with the member, family or significant others will provide information and teaching to assist the member and their family in making informed decisions; act as an advocate; provide information to providers regarding members changing needs; assist members and families in accessing community services that may not be covered by ALTCS; and strive to maximize efficient use of resources while providing members flexible and creative service delivery options.

1.3 CHS ORGANIZATIONAL CHART

To provide insight to contracted providers as to how CHS is organized, the CHS Organizational Chart is included herein as Attachment A.

1.4 CHS MANAGED CARE PHILOSOPHY

Cochise Health Systems utilizes case management, in conjunction with member and family participation, as the process through which appropriate, cost effective and quality medical care, medically-related social services, and behavioral health services are identified, planned, obtained and monitored for individuals found to be eligible for ALTCS services. CHS may utilize industry accepted standards of prior authorization, concurrent and retrospective review, discharge planning and quality of care evaluation processes to approve, co-ordinate and monitor the provision of covered services to our members.

The Quality Management and Utilization Management Plans have been posted on the CHS website and may be accessed at www.cochise.az.gov/CASS/CHS.htm.

1.5 CHS OFFICES AND IMPORTANT TELEPHONE NUMBERS AND WEBSITE

To assist providers in reaching the appropriate CHS staff, the following list of important addresses and telephone numbers is provided:

COCHISE HEALTH SYSTEMS
P.O. BOX 4249
1415 MELODY LN BLDG A
BISBEE, AZ 85603
(520) 432-9600
(520) 432-9697 FAX

COCHISE HEALTH SYSTEMS
3275 W. 8th St., STE D
THATCHER, AZ 85552
(928) 348-8857
(928) 348-8860 FAX

The CHS website may be accessed directly at www.cochise.az.gov. This website also contains links to the Notice of Privacy Practices, Member Handbook in English and Spanish, the Provider Newsletter, the CHS Formulary, and the CHS Provider Manual & Claims/Eligibility Inquiry.

Phone numbers for Authorizations during regular office hours, after hours notification of ER visits and/or admissions, and after hours provider questions regarding CHS members:

(520) 432-7485 (Local Area) or 1-800-285-7485 (Graham, Greenlee and Pima Counties)

The phone number for our transportation hot line is 1-888-677-4332

II. MEMBER ELIGIBILITY AND ENROLLMENT

2.1 ALTCS ELIGIBILITY

All members who are assigned to CHS have been determined eligible for the Arizona Long Term Care System (ALTCS), which is Arizona's version of the Federal Medicaid program for long term care. Eligibility for the ALTCS program is determined by ALTCS eligibility workers. For eligibility information in Cochise County call 520-459-7050 or 888-782-5827. For Graham and/or Greenlee Counties call 888-425-3165. **CHS DOES NOT DETERMINE ALTCS ELIGIBILITY.**

When a member becomes ineligible for ALTCS but remains eligible for the acute care program, the member needs to choose an acute health plan. In such cases, CHS shall obtain the member's choice of health plans and submit that choice to AHCCCS. When the reason for termination is due to a voluntary withdrawal obtained by the case manager or the member fails the PAS, obtaining the members' choice of acute care health plans is part of the transition planning.

2.2 PRIOR PERIOD COVERAGE AND REGULAR ENROLLMENT

There are two levels of eligibility for ALTCS. The first is Prior Period Coverage (PPC) and the other is regular enrollment with CHS.

Prior Period Coverage (PPC) with CHS is the period from the eligibility effective date, up to the effective date of enrollment with CHS. CHS is not responsible for Prior Quarter coverage. This is retained by AHCCCS FFS. Cochise Health Systems is notified of the PPC at the same time they are notified that the member has been **enrolled** with CHS. During the PPC period, CHS is responsible for paying for certain covered services. (Please refer to the CHS policies [in pink] and PPC protocols [in salmon] located at the back of this manual.) Generally these services are limited to acute care and nursing home placement. Beginning October 1, 2006, PPC also covers some home and community based services under PPC.

Billing of PPC requires an AHCCCS Provider I.D. number and the billing must be separate from any billing for service provided after the applicant has been enrolled as a CHS member. The time limit for submission of initial claims for PPC claims is six months from the date of enrollment with CHS.

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Most notification, Quality Review, Prior Authorization, Case Management and in Network provider requirements detailed in the Provider Manual and your contract do not apply to the PPC time period. All claims are subject to medical review and denial for lack of medical necessity.

CHS members previously assigned to other AHCCCS acute care plans are not normally eligible for PPC unless the date of ALTCS application pre-dates acute care eligibility.

The following is a list of the categories of eligibility types that an ALTCS eligible member can have. Each member is determined eligible for a rate code that indicates his eligibility type and whether he or she is eligible for Medicare, Part A.

RATE CODES		CATEGORY OF ELIGIBILITY
Normal Enrollment	Prior Period Coverage	
1000	100Z	TANF with Medicare
1010	101Z	TANF Non-Medicare
1020	102Z	TANF with QMB
2100	210Z	SSI, Aged with Medicare Part A
2110	211Z	SSI, Aged without Medicare Part A
2120	212Z	SSI, Aged QMB Dual
2200	220Z	SSI, Disabled with Medicare Part A
2210	221Z	SSI, Disabled without Medicare Part A
2220	222Z	SSI, Disabled, Qualified Medicare Beneficiary
2300	230Z	SSI, Blind with Medicare Part A
2310	231Z	SSI, Blind without Medicare Part A
2320	232Z	SSI, Blind, Qualified Medicare Beneficiary
3000		Med. Needy/Med. Indigent with Medicare Part A
3010		Med. Needy/Med. Indigent without Medicare Part A
4100		Eligible Assistance Children with Medicare Part A
4110		Eligible Assistance Children without Medicare Part A
4200		Eligible Low Income Children with Medicare Part A
4210		Eligible Low Income Children without Medicare Part A
4300		S.O.B.R.A. Children with Medicare Part A
4310		S.O.B.R.A. Children without Medicare Part A
4320		S.O.B.R.A. Children, Qualified Medicare Beneficiary
5000		S.O.B.R.A. Women with Medicare Part A
5010		S.O.B.R.A. Women without Medicare Part A
5020		S.O.B.R.A. Women, Qualified Medicare Beneficiary
8020		QMB Only
9997		S.O.B.R.A. Supplemental Payment

The rate codes listed above indicate whether or not a member has Medicare Part A coverage. The rate codes do not indicate whether a member has Medicare Part B, Medicare Part D, or some other third party insurance.

2.3 ASSIGNMENT TO CHS

As previously mentioned, CHS is assigned ALTCS eligible members on a daily basis. CHS is responsible for the member's care on the date that the member is enrolled with CHS and until the member is dis-enrolled from CHS. If the member requires health care prior to plan enrollment (during Prior Period Coverage), CHS may be financially responsible for some ALTCS services. Refer to the PPC Protocols section (salmon section) of this manual.

CHS is not responsible for home based services for Members who move outside the CHS services area. The member's Program Contractor must be changed to continue these services out of area. In these cases, please refer member to his/her Case Manager.

In Geographic Service Areas where the member has a choice of Program Contractors, the member may change Program Contractors in accordance with the *ACOM Enrollment Choice in a Choice County and Change of Program Contractor Policy*.

Members may submit Contractor change requests to CHS or the AHCCCS Administration. A denial of any Contractor change request must include a description of the member's right to appeal the denial. CHS is the only Program Contractor for Cochise, Graham and Greenlee Counties.

2.4 ALTCS IDENTIFICATION CARD

Each ALTCS eligible member will be given a number identification card by AHCCCS. This card, similar to a credit card, contains the member's name, AHCCCS ID number, and other encoded information on the magnetic strip. This ID card should be presented to the provider each time the member presents for service. The ID card does not guarantee that the member is still eligible for the ALTCS program. Providers must verify eligibility either by using their Point of Service (POS) device which allows access to AHCCCS eligibility system or use the AHCCCS telephone number listed in the last paragraph of this section for eligibility verification.

Providers are also encouraged to take the precaution of verifying the identity of the person presenting the ID card using some other form of identification, such as a driver's license or some other government-issued photo identification. This type of verification not only deters fraudulent use of the ALTCS program, but also protects the provider against performing a service for which payment may be denied.

For automated access to the **AHCCCS eligibility verification unit call (800) 331-5090.** To use the system, you must call from a touch-tone phone; know your AHCCCS provider number and the client's identification number. If the number is entered incorrectly or it is not the correct number, there will be an opportunity to speak to an operator for assistance. Ensure that the system confirms that the client is on **COCHISE HEALTH SYSTEMS**, and not on an AHCCCS acute care plan or another ALTCS Plan.

2.5 CO-PAYMENTS FOR CHS MEMBERS

CHS members are not required to pay any co-payments for ALTCS covered services as per 42 CFR438.108.

III. COVERED SERVICES

As a Program Contractor within the Arizona Long Term Care System (ALTCS), CHS is required to provide a very specific list of covered services to its enrolled members in accordance with the AHCCCS Medical Policy Manual (AMPM), AHCCCS Behavioral Health Services Guide, ACOM and as approved by the AHCCCS Director [42 CFR 438.210(a) (1) [42 CFR 438.210(a) (4)] and 438.224. The Services listed in Section 3.1 below are available to all CHS members. Sections 3.2 and 3.3 & 3.4 discuss additions to the covered services for special member groups. All covered services must be provided by or referred by the member's PCP and/or the member's Case Manager. Many services must be prior authorized by CHS before the services are provided. Retrospective authorization may be given for HCBS Services delivered under prior period coverage. The case manager must authorize these services.

If you have questions as to whether a service is covered, contact the CHS Case Manager or Prior Authorization Office.

3.1 CHS MEMBERS

All covered services are contingent upon medical necessity and are reviewed in accordance with AHCCCS Medical Policy Manual.

Acute Care Services

- * Ambulatory Surgery Services;
- * Anti-hemophilic Agents and Related Services;
- * Audiology, Pursuant to A.A.C. R9-22-212, hearing aids are not covered for members 21 and older.
- * Behavioral Management Services;
- * Children's Rehabilitative Services (CRS);
- * Chiropractic Services;
- * Dialysis;
- * Early and Periodic Screening, Diagnosis and Treatment (EPSDT);
- * Early Detection Health Risk Assessment, Screening, Treatment and Primary Prevention;
- * Emergency Services to include emergency facilities, and transportation;
- * Family planning and family extension services include covered medical, surgical, pharmacological and laboratory services, as well as contraceptive devices, and information and counseling.
- * Hospital;
- * Immunizations;
- * Incontinence Supplies as specified in AHCCCS Rule A.A.C. R9-22-212 and in the AMPM;
- * Laboratory services;
- * Maternity to include pre-conception counseling, pregnancy identification, prenatal care, treatment of pregnancy related conditions, labor and delivery services, and postpartum care;
- * Medical Foods;
- * Medical supplies, durable medical equipment, orthotic and prosthetic devices;
- * Medically necessary nutritional therapy on an enteral, parental or oral basis;
- * Oral Health to include all medically necessary dental services including emergency dental services, dental screening and preventive services;

- * Physician services, including primary care physician services;
- * Podiatry;
- * Post-stabilization Care Services coverage and payment;
- * Pregnancy termination is a covered service for a member if the member suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by, or arising from, the pregnancy itself, that would, as certified by a physician, place the member in danger of death unless the pregnancy is terminated; the pregnancy is a result of rape or incest.
- * Primary Care Provider (PCP);
- * Radiology and Medical Imaging;
- * Rehabilitation Therapy;
- * Respiratory Therapy;
- * Transplantation of Organs and Tissue, and Related Immunosuppressant Drugs within limitations of AHCCCS Medical Policy Manual (AMPM);
- * Transportation to include emergency and non-emergency medically necessary transportation.
- * Triage/Screening and Evaluation;
- * Vision Services/Ophthalmology/Optometry to include medically necessary eye care, vision examinations, prescriptive lenses, and treatment for conditions of the eye for members under the age of 21

Long Term Care Services

- * Adult Day Health Care;
- * Attendant Care which is a combination of services which may include homemaker services, personal care, coordination of services, general supervision and assistance, companionship, socialization and skills development.
- * Behavioral Management Services;
- * Emergency Alert System;
- * Group Respite;
- * Habilitation;
- * Home Delivered Meals;
- * Home Health Service;
- * Homemaker Services;
- * Home Modifications;
- * Hospice;
- * Partial Care;
- * Personal Care;
- * Private duty nursing;
- * Respite care

Long Term Care – Institutional Setting Services

- * Behavioral Health Level I – a behavioral health service facility licensed by ADHS, as defined in 9 A.A.C. 20;
- * Institution for Mental Disease (IMD);
- * Inpatient Psychiatric Residential (Available to Title XIX members under 21 years of age);
- * Nursing Facility, including Religious Non medical Health Care Institutions;

Long Term Care – HCBS Alternative Residential Setting Services

- * Adult Development Home;
- * Behavioral Health Therapeutic Home;
- * Assisted Living Facilities
 - Adult Foster Care
 - Assisted Living Home
 - Assisted Living Center
- * Behavioral Health Level II;
- * Behavioral Health Level III;
- * Child Development Foster Home;
- * Group Home for Developmental Disabled;
- * Rural Substance Abuse Transitional Agency;
- * Traumatic Brain Injury Treatment Facility;

Other services and settings, if approved by CMS and/or the Director of AHCCCS, may be added as appropriate.

3.2 MEMBERS UNDER THE AGE OF 21 YEARS

The following services are available for these members in addition to all other medically necessary covered services:

- * Audiology
- * Blood lead screening, TB Screening, according to age & risk;
- * Children's Rehabilitative Services (CRS);
- * Chiropractic Services;
- * Emergency Eye Care, Vision examinations, prescriptive lenses, and treatment for members under the age of 21
- * EPSDT, is a program of comprehensive health care services, including primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and/or physical or mental illness discovered by the screenings for members under age 21. Health screenings, including developmental/behavioral health screenings must be in accordance with the AHCCCS EPSDT Periodicity Schedules. (Refer to EPSDT Protocol-blue section.);
- * Eye, ear, and speech exam, including appropriate vision and hearing testing;
- * Health education, including nutritional assessment and therapy;
- * Hearing aids and eyeglasses;
- * Immunizations
- * Inpatient Psychiatric Residential;
- * Lab and Radiology services;
- * Medical foods;
- * Medically necessary Nutritional therapy on an enteral, parental or oral basis;
- * Oral Health care, including annual screenings for members 3 through 20 years of age. Members may be referred by the PCP, or may use a Cochise Health Systems' dentist without a referral. Self-Referral to an oral health professional for members from ages 0-21 is covered under EPSDT;
- * Organ & tissue transplants.

3.3 BEHAVIORAL HEALTH SERVICES

Every CHS member is eligible for behavioral health services as listed below:

- * Behavior Management (behavioral health personal care, family support/home care training, self-help/peer support);
- * Behavioral Health Case Management Services (limited);
- * Behavioral Health Nursing Services;
- * Emergency Behavioral Health Services;
- * Emergency and Non-Emergency Transportation;
- * Evaluation and Assessment;
- * Individual, Group and Family Therapy and Counseling;
- * Inpatient hospital services – (ADHS/BHS may provide services in alternative settings that are licensed by ADHS/DLS/OBHL, in lieu of services in an inpatient hospital. These alternative settings must be lower cost than traditional inpatient settings. The cost of the alternative setting will be considered in capitation rate development);
- * Non-Hospital Inpatient Psychiatric Facilities Services (Level I residential treatment centers and sub-acute facilities);
- * Community Service Agency;
- * Behavioral Health Residential Services, Level 2 and Level 3;
- * Outpatient Clinic Services;
- * Laboratory and Radiology Services for Psychotropic Medication Regulation and Diagnosis;
- * Opioid Agonist Treatment;
- * Partial Care (Supervised day program, therapeutic day program and medical day program);
- * Psychosocial Rehabilitation (living skills training, health promotion, supportive employment services);
- * Psychotropic Medications, including adjustment and monitoring;
- * Respite Care (with limitations);
- * Rural Substance Abuse Transitional Agency Services;
- * Screening;
- * Behavioral Health Therapeutic Home Care Services;

A direct referral for a behavioral health evaluation may be made by any health care professional in coordination with the case manager and PCP assigned to the member. Services must be in accordance with CHS Behavioral Health Services Policy, AHCCCS policies and 9 A.A.C. 28, Article 11. Please refer to the pink section of the provider manual for Behavioral Health policies.

For more information refer to the AHCCCS Behavioral Health Guide available on the AHCCCS website at: www.azahcccs.gov/commercial/Downloads/BehavioralHealthServicesGuide.pdf

3.4 MEDICARE SERVICES AND COST SHARING

(Refer to Section 2.2 for Specific Rate Codes)

AHCCCS has members enrolled who are eligible for both Medicaid and Medicare. These members are referred to as “dual eligible”. Generally, program contractors are responsible for payment of Medicare coinsurance and/or deductibles for covered services provided to dual eligible members within CHS’s network. However, there are different cost sharing

responsibilities that apply to dual eligible members based on a variety of factors. CHS is responsible for adhering to the cost sharing responsibilities presented in AHCCCS Medicare Cost Sharing policy as specified in the ACOM. Program Contractors shall have no cost sharing obligation if the Medicare payment exceeds what the Program Contractor would have paid for the same service of a non-Medicare member.

3.5 EXCLUDED SERVICES

The following services are examples of services that are **not provided** by the ALTCS program or CHS:

- * Any Non-Emergency Service that requires authorization and has not been authorized;
- * Hearing Aids, Eye Examinations for Prescription Lenses, Prescription Lenses;
- * Services Determined by the AHCCCS Medical Director to be Experimental or Provided Primarily for the Purpose of Research.
- * Services or Items Furnished Only for Cosmetic Purposes;
- * Services Provided in an Institution for the Treatment of Tuberculosis;
- * Sex Change Operations and Reversal of Voluntarily Induced Sterilizations;
- * Treatment of the Basic Conditions of Alcoholism and Drug Addiction for Persons 21 years of Age and Older.

3.6 MEMBER OUT-OF-NETWORK AREA TRAVEL

CHS members who are temporarily absent from the network area are eligible for acute emergency services only. Providers are requested to notify either the CHS Case Manager or any CHS administrative office if they become aware of a member leaving the network area for any reason.

3.7 MAINSTREAMING CHS MEMBERS & CULTURALLY COMPETENT SERVICES

All Providers must take affirmative action so that members are provided covered services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual preference, genetic information or physical or mental disability. Providers shall take a member's literacy and cultural needs into account in the provision of services. Contractor must also make interpreters, including assistance for the visual or hearing impaired, available to members to ensure appropriate delivery of covered services. See Administrative Policy ADM011 (pink section), with CHS Cultural Competency Plan included.

Examples of prohibited practices include, but are not limited to, the following, in accordance with Title VI of the US Civil Rights Act of 1964, 42 USC, Section 2001, Executive Order 13166, and rules and regulations promulgated according to, or as otherwise provided by law:

- a. Denying or not providing a member any covered service or access to an available facility;
- b. Providing to a member any medically necessary covered service which is different, or is provided in a different manner or at a different time from that provided to other members, other public or private patients or the public at large, except where medically necessary;

- c. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service; restricting a member in a way in his or her enjoyment of any advantage or privilege enjoyed by others receiving any covered service;
- d. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual preference, income status, AHCCCS membership, or physical or mental disability of the participants to be served;

To assist providers in providing culturally competent care to our Members, CHS offers contracted Providers InterpreTalk, a phone service that facilitates communication with non-English speakers, which is available 24 hours a day, 7 days a week. If you are interested in using these services to assist you in providing culturally and linguistically sensitive services to our members, please contact us at 520-432-9600.

3.8 PROVIDER USE OF EMERGENCY ROOM

The emergency room should not be used as a back up to the physician's office schedule. When appropriate, members living at home will always be seen in the physician office. Residents of nursing facilities shall be seen in the nursing facility. Providers shall refer to the Protocol for Hospital Emergency Services (blue section) in this manual for the appropriate use of the emergency room. We are contracted with Urgent Care Clinics; please see Provider Network (yellow pages) for address and hours of operation.

3.9 PHYSICIAN APPOINTMENT STANDARDS

Physician appointments and in-office wait times for scheduled office visits will meet the criteria defined in the Protocol for Appointment Standards (blue section) in this manual.

3.10 CORPORATE COMPLIANCE

Fraud is defined by Federal law (42 CFR 455.2) as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law."

2.43.a In accordance with ARS Section 36-2918.01, and the ACOM, Chapter 100, Contractor is required to immediately notify the AHCCCS Office of Program Integrity (OPI) regarding any suspected fraud or abuse [42 CFR 455.17].

2.43.b As stated in ARS § 13-2310, incorporated herein by reference, any person who knowingly obtains any benefit by means of false or fraudulent pretenses, representations, promises or material omissions is guilty of a Class 2 felony.

2.43. c Contractor shall notify the Agency Provider Relations Supervisor or M/UM Manager in writing of any cases of suspected fraud and abuse. (Refer to the CHS Provider Manual, Policy QM002C.)

Federal False Claims Act

2.43. d Contractor shall train their staff on the following aspects of the Federal False Claims Act provisions: a) The administrative remedies for false claims and statements; b) Any state laws relating to civil or criminal penalties for false claims and statements; and c) The whistleblower protections under such laws.

Evidence of such training shall be documented in the employee's personnel files. Deficit Reduction Act (DRA) Compliance Training is available on the AHCCCS website. Please visit www.azahcccs.gov for more information.

CHS will also report the appearance of abuse, including bruising, lacerations, burns and/or any unsafe/unclear situations to Adult Protective Services and/or law enforcement officials as appropriate as defined by 42 CFR 455.2.

3.11 ADVANCE DIRECTIVES

The following providers must comply with the Federal and State laws on advance directives for adult members: Hospitals, Skilled Nursing Facilities, Assisted Living Facilities, Home Health Agencies, Hospice Agencies and all other personal care providers. In addition, these providers will provide a copy of the member's executed advanced directive (or documentation of refusal) to the member's PCP for inclusion in the member's medical record. Requirements include:

- * Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to ARS 36-3205.C.1.)
- * Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning the advance directives (including any conscientious objections);
- * Document in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed;
- * Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care;
- * Providing education for staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.
- * AHCCCS is trying to educate members and their authorized representatives about Advance Directives. PCPs are asked to discuss the importance of having an Advance Directive on file with their members. Acceptable documentation of an advance directive includes one of the following:

- A copy of the living will or health care power of attorney
- A signed and dated notation in the chart stating that a living will or health care power of attorney has been executed and where it is located. Acceptable documentation will include a notation that the patient has filed an advance directive with the Arizona Secretary of State.
- A signed and dated notation in the chart documenting member's/authorized representative's refusal to execute an advance directive.

Copies of Advance Directive forms and information can be found at www.azsos.gov

3.12 ADHS LICENSED OR CERTIFIED PROVIDERS

All providers, either licensed or certified by Arizona Department of Health Services (ADHS), shall submit copies of their most recent ADHS licensure review, substantiated complaints and other pertinent information to the Agency upon the provider's receipt of such information.

3.13 ADA GUIDELINES

Providers shall meet all applicable ADA requirements when providing services to members. All Providers are expected to make appropriate accommodations in providing services to members. Wheelchair ramps and accessible buildings and restroom facilities are the minimum requirements. Providers designing building modifications may refer to the ADA website www.ada.gov for more information regarding guidelines to assist them in determining appropriate accommodations.

3.14 MEDICARE MODERNIZATION ACT (MMA)

The Medicare Modernization Act of 2003 created a prescription drug benefit called Medicare Part D. Medicare Part D is the Prescription Drug Coverage option available to Medicare beneficiaries, including those also eligible for Medicaid. Medications that are available under this benefit will not be covered by AHCCCS. There are certain drugs that are excluded from coverage by Medicare, and will continue to be covered by AHCCCS. Those medications are barbiturates, benzodiazepines, and over the counter medication as defined in the AMPM. Prescription medications that are covered under Medicare, but are not on a Part D Health Plan's formulary are not considered excluded drugs, and are not covered by AHCCCS.

IV. PRIMARY CARE PHYSICIANS (PCP)

4.1 PCP'S RESPONSIBILITIES

The PCP provides primary health care and serves as a gate-keeper and coordinator in referring the member for specialty medical services, behavioral health and dental services. The PCP is responsible for maintaining the member's primary medical record which contains documentation of all health risk assessments and health care services of which they are aware, whether or not they were provided by the PCP.

CHS Primary Care Physicians (PCP) are responsible for the following activities [42 CFR 438.208(b) (1)]:

- * Providing or arranging for covered services as defined in their contract, including emergency medical services, to members on a twenty-four (24) hours per day basis, seven (7) days per week.
- * Providing office visits to home and community based members during regular office hours, and providing visits to all assigned members residing in the nursing facility according to AHCCCS Rules. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits in nursing facilities after the initial visit may alternate between visits by the physician and a nurse practitioner or physician extender. This requirement may change subject to changes in allowed Medicare Recovery.
- * Coordinating the provision of covered services to members by (a) counseling members and their families regarding members' medical care needs; (b) completing referrals for members to participating health care providers for specific covered services; (c) monitoring progress of members' care; and (d) managing utilization of services to facilitate the return of members' care to the PCP as soon as medically appropriate.
- * Maintaining staff membership and admission privileges in good standing at an accredited, contracted, non-Federal, acute care hospital or have physician coverage arrangements for admissions.
- * Providing covered services to members while in hospital, nursing home, or other health-care facility as determined medically necessary by PCP or CHS Medical Director.
- * Providing preventive health services in accordance with ALTCS Rules and Regulations. The preventive health services shall include, but not be limited to: Periodic health assessments, immunizations (excluding immunizations solely for travel), tuberculosis screening, and other measures for the prevention and detection of disease, including instruction in personal health-care measures and information on proper and timely use of appropriate medical resources provided by or through CHS.
- * Using contracted hospital(s), specialists, and ancillary providers.
- * EPSDT (Early Periodic Screening, Diagnosis & Treatment) Providers are required to participate in the EPSDT Program for all assigned members under the age of twenty-one (21) years in accordance with the AHCCCS EPSDT Periodicity Schedules.
- * Prescribing or authorizing the substitution of generic pharmaceuticals when appropriate.
- * Ensuring that appropriate services are rendered to members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or Aids-Related Complex (ARC) in the same manner and to the same extent as other members.
- * Agreeing to refer members to hospital emergency rooms for emergent medical services only, as defined by AHCCCS regulations.
- * Abiding by the CHS Referral and Prior Authorization policies.

- * Complying with CHS Medical Management and Utilization Management Policies (pink section) and Protocols (blue section), Medical Policies, and the Formulary.
- * Obtaining prior authorization for all elective hospital admissions.
- * Reporting of all services provided to CHS members in an accurate and timely manner.

V. SPECIALIST PHYSICIANS

5.1 SPECIALIST'S RESPONSIBILITIES

CHS contracted specialist physicians are responsible for:

- * Offering specialty care services to members in accordance with customary standards and practices.
- * Providing specialty care services to members only upon receipt of a complete CHS Referral Form from the member's PCP.
- * Ensuring that the referral form contains a valid CHS Prior Authorization Number and verifying the eligibility of the member prior to the provision of specialty care services.
- * Providing only those specialty care services authorized by the referral form unless additional services are approved telephonically by calling the Prior Authorization Number.
- * Prescribing or authorizing the substitution of generic pharmaceuticals when appropriate.
- * Agreeing to render services to members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or Aids-Related Complex (ARC) in the same manner and to the same extent as other members.
- * Providing services as applicable and within the scope of his/her specialty practice.
- * Complying with CHS Medical Management and Utilization Management Policies (pink section) and Protocols (blue section), Medical Policies and the Formulary.
- * Providing PCP with consult report for member's record in a timely manner to ensure appropriate medical care.
- * Complying with AHCCCS Policy for appointment standards

VI. ANCILLARY PROVIDERS

Ancillary Providers include nursing facilities, pharmacies, home health agencies, durable medical equipment providers, infusion care, vision, dental, transportation, therapy, and other non-physician providers. CHS has developed a comprehensive ancillary provider network (yellow section) which PCPs and specialist physicians are required to utilize.

6.1 ANCILLARY PROVIDER'S RESPONSIBILITIES

- * Rendering covered services to CHS members in accordance within the specific contract requirements.
- * Maintaining sufficient facilities, equipment and personnel to provide timely access for medically necessary covered services, including services to handicapped members according to ADA guidelines.

- * Rendering services to members who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or Aids-Related complex (ARC) in the same manner and to the same extent as other members.
- * Rendering covered services to all CHS members in an appropriate, timely, and cost effective manner. The provider will cooperate and participate in CHS Medical /Utilization Management programs, and grievance procedures in accordance with AHCCCS policies.
- * If service requires CHS authorization, Ancillary providers will provide care upon receipt of completed CHS authorized referral forms from the member's PCP.

VII. HOSPITAL SERVICES

CHS has a contracted network of hospital facilities. These facilities have been selected because the CHS Specialists Physician Network treats at these hospitals. Only contracted hospitals shall be used unless medically contraindicated. If an out-of-network referral is made by a facility/provider, that facility/provider is violating its contract and is responsible for paying the Medicare Cost Sharing amounts. If the hospital neglects to obtain authorization it may be held responsible for all visiting physician billed claims.

7.1 EMERGENCY TREATMENT

The emergency room should not be used as a back up to the physician's office schedule. When appropriate, members living at home will always be seen in the physician office. Residents of nursing facilities shall be seen in the nursing facility. Providers shall refer to the Protocol for Hospital Emergency Services (blue section) in this manual for the appropriate use of the emergency room.

- * All emergency response shall be to the closest hospital within the county.
- * Transfers out of the local hospital shall occur only if that facility is not able to provide the appropriate services.

In the event transfer is required:

- * Transfer shall be to the closest in-county hospital able to provide the appropriate services.
- * When it is necessary to transfer a patient out-of-county, the transfer shall be to ST. JOSEPH'S HOSPITAL, ST. MARY'S HOSPITAL OR TMC HEALTHCARE IN TUCSON, ONLY, unless there are no accommodations available in these facilities.

7.2 SCHEDULED ADMITS

- * All scheduled admits shall be to the closest in-county hospital able to provide the appropriate services.
- * Out-of-county admits shall be to ST. JOSEPH'S HOSPITAL, ST. MARY'S HOSPITAL OR TMC HEALTHCARE IN TUCSON, ONLY, unless there are no accommodations available in these facilities.

7.3 HOSPITAL PATIENT TRANSFER PROTOCOL

- * All Providers should refer to the CHS Hospital Patient Transfer Protocol (blue section) in the Provider Manual (following all other Protocols). This should be posted in the Emergency Room or placed in Emergency Room manuals in your facility, as appropriate.

7.4 NOTIFICATION REQUIREMENTS

Refer to section 9.8 b.

XIII. TRANSPORTATION SERVICES

8.1 EMERGENCY TRANSPORTATION

For emergency services, as described in the glossary, the provider should dial **911** for emergency transportation by ambulance.

Payment for emergency ambulance transports will be made in accordance with R9-22-211, paragraph A-4, of the Arizona Administrative Code. Ground or air ambulance provider furnishing transport in response to a 911 call or other emergency response system must notify Cochise Health Systems within **TEN (10) WORKING DAYS** from the date of the transport calling (520) 432-7485 or (800) 285-7485 to obtain an authorization number. Failure to provide notification and obtain authorization number is cause for the denial of the service. Emergency ambulance transports will be paid at 80% of the ADHS approved rates. If the company does not have ADHS approved rates, they will be paid at AHCCCS FFS rates. **NOTE:** All ambulance companies are to provide copies of new approved rates to CHS, as they are approved, if payment is requested at the increased rates.

8.2 NON-EMERGENCY TRANSPORTATION

Our transportation line is monitored frequently during regular business hours (Mon-Thurs 7:00 A.M. to 5:00 P.M. and Friday 8:00 A.M. to 5:00 P.M. except legal holidays) for the authorization and arrangement of medically necessary non-emergent transportation for eligible members. The provider may call the transportation line, at least 48 hours in advance, at (888) 677-4332 to facilitate transportation services.

If the member requires a non-emergent, medically necessary transport after regular business hours, refer to the Non-Emergency Transportation Protocol (blue section) in this manual. **IMPORTANT!!!! THERE ARE DIFFERENT PROTOCOLS FOR COCHISE, PIMA, GRAHAM AND GREENLEE COUNTIES.**

If you are unable to get a response from the contracted transportation provider call CHS 24 hour answering service at (520) 432-7485 or (800) 285-7485 and ask to have the on call nurse contact you.

Non-emergent ambulance providers must have services specifically authorized and an authorization number provided by a CHS Case Manager or Supervisor prior to the transport in order to be paid for the transport. Non-emergent ambulance transportation will be paid at AHCCCS FFS rates. Claims for non-emergent transports should not be marked as emergent.

IX. REFERRAL PROCEDURES

9.1 TRANSFER OF SECOND AND THIRD PARTY PAYER INFORMATION

All providers have a responsibility to include insurance information along with appropriate records when a patient is referred, discharged, and/or transferred to another provider. Refer also to Section 2.4, Paragraph 3 regarding eligibility verification.

9.2 REFERRAL POLICY

Primary Care Providers (PCPs) are responsible for the initiation and coordination of medically necessary referrals that are outside the scope of their practice. These referrals must be made utilizing the CHS Referral Form (see Attachment B-1, B-2) and must be made to a CHS Contracted Health Professional unless other arrangements have been prior authorized by CHS. The CHS Referral Form must be completed, meaning all fields filled out by the ordering provider, before submitting the request to Cochise Health Systems for review.

Providers should request authorization from CHS for services at least ten (10) working days before the anticipated date of service unless such a delay is medically contraindicated.

Completed CHS Referral Forms must be submitted directly to the referred provider. (It is not the responsibility of the member to carry the referral form to the service provider.)

Contracted providers may be held financially responsible for coinsurance and deductibles for referrals or transfers to providers outside the Agency's network.

CHS will not accept requests for retrospective referral authorization greater than thirty (30) calendar days past the date of service. The intent of prospective review is to ensure that health care services are provided in accordance with ALTCS program requirements, and are medically necessary and appropriate for the member. The receipt of referral requests after the date of service can defeat this purpose. For services already rendered, claims may be submitted with documentation for retrospective medical claims review. The provider must indicate "retrospective review request" in the authorization field on the CMS 1500 form.

9.3 PROHIBITED REFERRALS

Sections 1903(s) and 1877 of the Social Security Act prohibits physicians from making referrals for designated health services to health care entities with which the physician or a member of the physician's family has a financial relationship. Designated health services are:

- * Clinical laboratory services
- * Durable medical equipment and supplies
- * Home health services
- * Inpatient and outpatient hospital services
- * Occupational therapy services
- * Outpatient prescription drugs
- * Parenteral and enteral nutrients, equipment and supplies
- * Physician therapy services
- * Prosthetics, orthotics and prosthetic devices and supplies

- * Radiation therapy and supplies
- * Radiology services

9.4 REFERRAL FORM

The CHS Referral Form is to be used by the PCP or their designee, at the nursing facilities when making a medically necessary referral to a CHS contracted specialist. All referrals to specialists require prior authorization. The authorization should be requested ten (10) working days before the anticipated date of service, unless such a delay is medically contraindicated. The authorization can be requested from CHS by:

- * Faxing a copy of the completed Referral Form to CHS.
- * Mailing a copy of the completed Referral Form to CHS.

The Referral Form and instructions for its use are found at Attachment B-1 & B-2. A CHS Referral Form must be signed and dated by the referring physician (physician's signature stamp is acceptable) or their designee.

Referrals are valid for ninety (90) calendar days beginning with the date the PCP signs and dates the referral. Obstetrical service referrals are valid through termination of pregnancy plus sixty (60) days of postpartum care.

Calling CHS for prior authorization is not required for Emergency Ambulance Transport, Emergency Room Services, or for Inpatient stays; however these providers must meet Notification Requirements of Section .8 b.

Questions concerning the use of the CHS Referral Form should be directed to the M/UM Section of CHS.

9.5 CHILDREN'S REHABILITATIVE SERVICES (CRS)

The Arizona Children's Rehabilitative Services (CRS) provides rehabilitative medical care to children with special health care needs. These services are available to all medically and financially eligible children, including ALTCS eligible individuals.

CHS contracted PCPs who encounter children with certain CRS related conditions must refer the children to the appropriate CRS regional site.

Assistance in identifying a CRS related condition(s) or referring members to the appropriate CRS regional site can be obtained from the CHS Prior Authorization or Case Management Sections.

CHS remains ultimately responsible for the provision of all covered services to its members, including emergency services not related to a CRS condition, emergency services related to a CRS condition rendered outside the CRS network, and AHCCCS covered services denied by CRSA for the reason that it is not a service related to a CRS condition.

9.6 BEHAVIORAL HEALTH SERVICES

See Section 3.3 of Covered Services for a listing of covered Behavioral Management Services.

Primary Care Physicians desiring to make a referral for behavioral health services should contact the CHS Case Manager who will fill out appropriate referral forms. Referrals for behavioral health screening may be made by the Primary Care Physician or any health care professional to the case manager, who will complete the appropriate referral forms and coordinate with the Behavioral Health Professional. In emergency situations, services will be provided within 24 hours of referral. Routine appointments will be provided within thirty (30) days of screening & referral for HCBS members.

In after hours emergency situations, where the PCP believes the member is a clear and present danger to self or other's, call **911** for an emergency admit.

For ongoing behavioral health services, the behavioral health provider must submit a referral and documentation monthly to the Medical/Utilization Management Department for continued approval.

9.7 ANCILLARY REFERRALS

Participating physicians may make ancillary service referrals directly to the CHS Participating Providers for the following services in accordance with the Policies and Procedures included in this manual:

a. Laboratory & Imaging Referral

Prior authorizations are not required for routine outpatient lab and imaging services referred to a contracted participating CHS lab (see Policy UM004 in pink section of this manual). The closest contracted provider that can provide the necessary service must be used.

Refer to the network listing for contracted providers (yellow section).

b. Dental Services

- * Under 3 years: Members may be screened and/or referred by the member's PCP
- * Pediatric (ages 3 through 20 years of age): Members/guardians may self refer to contracted dentists for routine and emergency services or the member's PCP may make a referral.
- * Adult (21 years of age or older): Members must be referred by the PCP for medically necessary services. PCP must obtain CHS Prior Authorization.

c. Durable Medical Equipment (DME) Referral

- * All DME requires a Physician's order and will be authorized by CHS Case Managers if under \$500. DME items over \$500 must be prior authorized by CHS M/UM staff.

d. Vision Care

- * Prior authorization is required through the PCP for all adult medically necessary vision services.

e. Pharmacy Services

- * Prescriptions written for medications listed on the CHS Formulary and not specified "PA" do not require prior authorization. The CHS Formulary may be accessed online at www.uniteddrugs.com/formlrs/chsform.htm.
- * CHS expects that medications listed on the CHS Formulary and generic substitutions will be used whenever possible.
- * Medications not listed on the Formulary require prior authorizations (pink section).
- * All medication and prior authorization requests must be faxed between physician or SNF and pharmacy.
- * All medications must be ordered by a physician listed on the CHS Provider Network and provided by a contracted pharmacy.
- * Over the counter medications (OTC) are covered for HCBS members only with a provider's prescription, a prior authorization number, and only if less costly than legend drugs.

f. Member Non-Emergency Transportation Referral

All referrals for non-emergency medically necessary transportation for CHS members shall be directed to our toll free transportation hot line at 1-888-677-4332

9.8 BILLING INFORMATION

a. Referral Requiring Prior Authorization

For services not listed in Policy UM004 Prior Authorization Exclusions and for all specialist visits and therapies, prior authorization must be obtained by completing the referral form and sending it to CHS as outlined in Sections 9 & 10 of this manual. A claim submitted without a valid prior authorization number, and a valid signature, may result in denial of the claim.

b. Services Requiring Notification But No Referral

We request that emergency room services be reported for a notification number during the next business day by calling (520) 432-7485 or (800) 285-7485. All claims for emergency treatment may be retrospectively reviewed for appropriateness of level of care.

All emergency transportation ground or air ambulance services furnishing transport in response to a 911 call or other emergency response system must notify Cochise Health Systems within **TEN (10) WORKING DAYS** from the date of the transport calling (520) 432-7485 or (800) 285-7485 to obtain an authorization number. Failure to provide notification and obtain authorization number is cause for the denial of the service. All emergency transportation services claims will be subject to medical review.

All hospital admissions must be reported for a notification number during the next business day by calling (520) 432-7485 or (800) 285-7485. Hospital admission claims may be subject to medical review. If the hospital neglects to obtain authorization it may be held responsible for all visiting physician billed claims.

All observation stays must be reported during the next business day for notification by calling (520) 432-7485 or (800) 285-7485. Observation stays are subject to medical review. Observation stays beyond 24 hours require notification by calling (520) 432-7485 or (800) 285-7485.

9.9 REIMBURSEMENT RATE

All contracted providers are paid in accordance with the contracted rate. Non-contracted providers are paid in accordance with AHCCCS FFS rates unless otherwise negotiated.

CHS will pay co-pays and deductibles not to exceed the amount CHS would have paid if CHS was the only payer, less any amount paid by third party payers. CHS is always the payer of last resort if the Member has other coverage.

X. PRIOR AUTHORIZATION (PA)

10.1 POLICIES AND PROCEDURES

Prior Authorization (PA) is a utilization management tool employed by CHS to ensure that members receive medically necessary, cost effective health care. All requests for PA are reviewed by CHS PA staff, under the direction of the Medical Director. PA review includes, but is not limited to:

- * Verification that requested service is a covered benefit;
- * Determination if request requires medical review;
- * Determination if medical review requires additional documentation, information, medical records, etc;
- * Determination if requested service will be provided by a contracted provider in a contracted facility at the appropriate level of care;
- * Determination of whether requested service is medically necessary and appropriate;
- * Verification of member's enrollment in CHS.

If required services are determined appropriate, the PA request is approved and the referring physician is notified. If the required services are not medically necessary the requesting provider and member will be notified of denial using the CHS Notice of Action form;

10.2 AUTHORIZATION DOES NOT GUARANTEE REIMBURSEMENT

Reimbursement for services depends on member's enrollment status on the date(s) of service, medical necessity, and plan limitations and exclusions as stated in rules and regulations governing the plan and plan policies and procedures. Plan exclusions include, but are not limited to, all services related to occupational illness and injuries, and excessive, inappropriate or unallowable charges.

10.3 REQUESTING PRIOR AUTHORIZATION

Health professionals and providers, both contracted and non-contracted, must ensure that required PA has been obtained before rendering service to a CHS member. All providers of medical care share responsibility for requiring the PCP to provide the approved PA. If a PA is required, only those specific services that have been prior authorized will be considered for payment.

Requests for PA are to be directed to CHS through PCP in one of two ways:

- * Fax transmission; or
- * Written on the CHS Referral Form and mailed.

Refer to section 1.5 for telephone/fax numbers and mailing address for obtaining prior authorization or notification.

Elective requests that are approved will have a PA number assigned. Physicians will be notified of approval via mail, telephone or fax transmittal.

Written confirmations of denied PA requests are sent to the CHS member and requesting physician.

Physician will, where applicable, obtain and include the PA number on Referral Forms submitted with claims to CHS. Failure to do so may result in denial or delay of the reimbursement.

10.4 SERVICES NOT REQUIRING PRIOR AUTHORIZATION

Refer to Policy UM004 in the Policy Section (pink section) of the manual. Prior Period Coverage (PPC) services do not require prior authorization.

XI. BILLING AND REPORTING PROCEDURES

As a Program Contractor for AHCCCS, CHS is required to follow AHCCCS rules. Please Refer to AHCCCS Billing Manual for claim completion instructions, AHCCCS FFS Rates for accepted procedure codes, and AHCCCS Modifier Matrix for appropriate modifiers. Please note the AHCCCS Claim Clues and Encounter Keys provide timely information on current and proposed changes to billing requirements.

11.1 AHCCCS PROVIDER IDENTIFICATION NUMBER

All providers who participate in the AHCCCS program must register and receive a provider number from AHCCCS. The provider number is a six digit number issued by the AHCCCS Administration (AHCCCSA), and is obtained through a formal registration process. Providers are responsible for obtaining their AHCCCS ID number. If you are notified by AHCCCS that your provider number has been changed, please notify the CHS Member-Provider Relations Supervisor as soon as possible. Failure to notify CHS of a provider number change may result in claims payment errors. If you need assistance in acquiring the AHCCCS ID number, please contact AHCCCS Provider Registration at **(800) 794-6862**. We cannot accept the Clinic ID

number for professional services. Please refer to the AHCCCS Provider Profile for accepted AHCCCS Procedure Codes for your provider type.

AHCCCS rules require that all physician extenders including, but not limited to, Nurse Practitioners, Physician Assistants and Nurse Anesthetics are required to bill for services using their own AHCCCS provider number and not the provider number of their supervising or collaborating physician.

AHCCCS update National Provider Identifier (NPI) Project

Health Care Providers must communicate their National Provider Identifier's (NPIs) directly to the AHCCCS Administration, if they do business with any AHCCCS Health Plan. This requirement is in addition to the requirement that they provide this information to the AHCCCS health Plans with whom they contract and/or do business, i.e., get a check from.

The NPI will not replace credentialing and provider enrollment. It is very important to notify AHCCCS and CHS because your encounters (claims) will not process in the AHCCCS System if AHCCCS does not have your NPI loaded into the account. This could delay payment of your claim.

11.2 REPORTING CAPITATED SERVICES

Providers who receive capitation from CHS **MUST** report provision of services (encounters) on the acceptable claim form defined in Section 12.3. Failure to report accurate encounters is a breach of contract. Cochise Health Systems and AHCCCS monitor the provider's compliance with this requirement. Failure to properly report could result in financial sanctions for the provider.

11.3 ACCEPTABLE CLAIM FORMS

CHS requires all providers to use one of four forms when submitting claims. If you have any questions on what claim form to use, refer to the AHCCCS Billing Manual.

A CMS-1500 Form (Attachment C) is used when submitting claims for ALL professional services, including ancillary services and professional services billed by a hospital, and therapy services provided by a home health agency or independent therapy contractor. There was a revision to the CMS-1500 Form to accommodate the NPI numbers. As of July 2, 2007, only this new form will be accepted.

Nursing home services, hospital inpatient and outpatient services including therapies, dialysis services, and all hospice services, must be billed on the UB-04 (Attachment D) billing form. The UB-04 has replaced the UB-92 as of March 1, 2007 and must be used effective May 23, 2007. If filing a claim on a UB-04 go to www.cms.hhs.gov for detailed instructions.

ALL pharmaceutical services must be billed by electronic data exchange with United Drugs, unless specific exception is authorized by CHS.

All claims for emergency services must be billed on CMS-1500 Form or UB-04 forms.

An Emergency Room (ER) report must be submitted with the claim, and signed by the ER physician.

All claims for dental services must be billed on the Dental Claim form. Please contact the CHS Finance Section for information regarding the completion of this form.

CHS is able to accept electronic billing OR original claim forms. Please contact the CHS Finance Section if you are interested in billing electronically.

11.4 COMPLETING A CMS-1500 FORM

When filing a claim on a CMS-1500, there are certain fields on the form that are required to be completed. Listed below are the required field numbers, along with explanations of the number on the attached CMS-1500 claim form example. (See Attachment C) Fields that are not addressed are not applicable.

1. PROGRAM - This field shows all type(s) of health insurance coverage applicable to this claim.
- 1a. INSURED'S ID NUMBER - This is the patient/member's AHCCCS ID number.
2. PATIENT NAME - This is where the CHS member's name is displayed.
3. BIRTH DATE - This is the birth date and sex of the member. This data is used to verify that this is in fact a CHS enrolled member.
4. INSURED NAME - This data should be the same as item 2.
5. PATIENT ADDRESS - Another possible verification for patient name and ID number.
6. PATIENT RELATIONSHIP TO INSURED - This indicates the relationship of the patient to the insured (e.g. spouse, child or other relation). For CHS members this answer should always be self.
7. INSURED'S ADDRESS - Another possible verification for patient name and ID number. Required only when items 4, 9 or 11 are completed.
8. PATIENT STATUS - This indicates the patient's marital status and whether employed or a student.
9. OTHER INSURED'S NAME – This identifies another health benefit plan.
10. WAS THE CONDITION RELATED TO: - This identifies if the claim is work related, due to an auto accident or other type of accident.
11. INSURED'S GROUP/POLICY NUMBER - This will indicate the group policy number.
- 11a. INSURED'S DATE OF BIRTH & SEX - This is the Member's date of birth and sex and should be the same information as in Line 3.

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- 11b. EMPLOYER'S NAME OR SCHOOL NAME – Name of employer if applicable or name of school being attended.
- 11c. INSURANCE PLAN NAME OR PROGRAM NAME – This will be Cochise Health Systems.
- 11d. IS THERE ANOTHER BENEFIT PLAN? – This is used to identify additional coverage that will be listed in item 9.
- 12. PATIENT'S SIGNATURE - This authorizes the provider to release any medical information necessary to process the claim.
- 13. INSURED'S SIGNATURE - This authorizes the insurance carrier to release payment directly to the provider.
- 14. DATE OF CURRENT - This is the date of current illness, injury, or pregnancy for use in determining pre-existing conditions.
- 15. DATE OF PREVIOUS - This is the date of same or similar illness, injury, or pregnancy for use in determining pre-existing conditions.
- 16. DATES UNABLE TO WORK - Dates the patient was unable to work.
- 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE - This is the name of the referring physician.
- 17a. ID NUMBER OF REFERRING PHYSICIAN - This is the AHCCCS ID number of the referring physician. Effective May 23, 2007 this will be the NPI number.
- 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE - This indicates any related inpatient stays.
- 19. RESERVED FOR LOCAL USE
- 20. OUTSIDE LAB - This indicates if laboratory services were provided outside of the office but are included in this billing.
- 21. DIAGNOSIS OR NATURE OF ILLNESS - This is where the provider lists the general diagnosis of the member using current ICD-9 CM codes.
- 22. MEDICAID RE-SUBMISSION - This is where the provider will indicate the original remit code and claim number if this is a re-submission of a previously processed claims.
- 23. PRIOR AUTHORIZATION NUMBER - This is where a prior authorization number is entered if applicable for processing the claim.
- 24A. DATE OF SERVICE(S) - This indicates the date(s) that services were provided.
- 24B. PLACE OF SERVICE - This indicates where the service took place (e.g. doctor's office, inpatient hospital, outpatient hospital, etc.).

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- 24C. TYPE OF SERVICE - This indicates the type of service provided (e.g. surgery, anesthesia, etc.).
- 24D. PROCEDURE, SERVICES, OR SUPPLIES - This indicates the service provided using current HCPCS (including CPT) codes with modifiers as appropriate. Note there are current HCPCS and CPT codes based on AHCCCS accepted codes.
- 24E. DIAGNOSIS - This indicates the specific diagnosis related to the procedure/CPT code being billed. This should also be listed in item 21.
- 24F. CHARGES - This is the amount the provider is billing for the service provided.
- 24G. DAYS OR UNITS - If the provider provided this service over a number of days or in excess of a single unit, the quantity will be listed here.
- 24H. EPSDT/FAMILY PLANNING - This indicates if the services provided were related to the EPSDT or Family Planning programs.
- 24I. ID QUALIFIER – Identifies where NPI is indicated in non-shaded area.
- 24J. RENDERING PROVIDER ID# - Prior to May 23, 2007, enter the rendering provider's AHCCCS ID number in the shaded portion, and the rendering provider's NPI number may be entered in the non-shaded portion. On May 23, 2007 and later, do not use the shaded portion. Only enter the rendering provider's NPI number in the lower portion. Those providers that do not require NPI numbers will not use this section.
- 24K. RESERVED FOR LOCAL USE - This is used by Medicare to identify the different providers of service that are billed on the claim. CHS can only process one provider per claim so this is not used on CHS Claims.
- 25. FEDERAL TAX ID NUMBER - This may be used to verify provider ID if it does not match the provider name provided on claim.
- 26. PATIENT ACCOUNT NUMBER - The provider's office uses this to reference patient's account files.
- 27. ACCEPTS ASSIGNMENT - This field is completed if the physician/supplier accepts assignment of Medicare benefits.
- 28. TOTAL CHARGE - This is the total amount the provider is billing for the services provided.
- 29. AMOUNT PAID - This is the amount paid by any other payer. This amount is documented on the attached Explanation of Benefits.
- 30. BALANCE DUE (IF DIFFERENT THAN ITEM 28) - This indicates the amount due after any deductions for other payers.

31. SIGNATURE OF PROVIDER - This must be indicated. The acceptable signatures are as follows:
 - A) Provider's signature or that of any authorized office personnel or
 - B) Provider's signature rubber stamped or
 - C) Computer generated claim form with the provider's name in BLOCK LETTERS.
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED - This is the location the actual services were provided. This may match the billing address listed in item 33. The date signed must also be included.
33. BILLING ADDRESS - This is the information required for billing. Effective May 23, 2007 the NPI of the billing provider or group **MUST** be indicated in this box (except for Providers that do not qualify for NPI numbers, the AHCCCS ID number will still be required in this box.) CHS will accept the providers AHCCCS ID number in addition to the NPI number.

11.4 a. CMS-1500 DOCUMENTATION

All claims that involve Medicare or other insurance must be accompanied by an explanation of benefit (EOB) or remittance advice. **CHS IS THE PAYER OF LAST RESORT.** Medicare must be billed first before billing for Medicare covered services rendered to CHS members. CHS members may also have some other type of third party insurance. Providers are responsible for identifying any other insurance and billing the other insurance before billing for services rendered to CHS members.

If billing for a consultation, please attach a copy of the consultation report.

All multiple surgeries, and surgeries over \$500, must have an operative report attached. Referral forms with valid PCP signature or signature of designee are required for review for all acute care services not rendered in an ER or inpatient setting.

For HCBS services, attach a copy of the referral form from the Case Manager for the services being billed.

11.4 b. HCBS DOCUMENTATION

For ALL HCBS claims submitted to CHS, a copy must be submitted of documentation that verifies, by member signature or mark, the dates and times of services contained on the claim. The HCBS provider may utilize its own forms to obtain the members verification (signature or mark). If someone other than the member signs, the relationship to the member must be designated next to the signature **each time**.

11.5 COMPLETING A UB-04 (CMS-1450)

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, and emergency room services, plus it is used for charges from a Dialysis clinic, nursing home, residential treatment center, hospice, and therapy services. CHS is required to report Medicare payment information at the line level on all claims, including UB-04's. Therefore, we can no longer accept Medicare

EOB's that have totals for the allowed, non-allowed charges, etc. CHS will return any claim submitted without the Medicare EOB submitted. There will be no exceptions. Please see the AHCCCS Billing Manual for further information.

General Procedures:

When filling out a UB-04 (See Attachment D) there are certain fields that are required to be completed. The following fields are necessary to expedite claim processing:

- Item 1 Provider name, address and telephone number - name of the provider submitting the bill and the complete mailing address to which the provider wishes payment sent.

- Item 3 Patient control number - number assigned to patient by facility to facilitate retrieval of individual records.

- Item 4 Type of bill - A code indicating the specific type of bill (see UB-92 Training Manual).

- Item 5 Federal Tax ID number - The number assigned to the provider by the federal government for tax reporting purposes.

- Item 6 Statement Covers Period - The beginning and ending service dates of the period included on this bill.

- Item 7 Covered Days – These were previously indicated on the UB-92 in Form Locator 7, but are now indicated on the UB-04 in Form Locators 39-41 a-d using value code "80".

- Item 8 Non-Covered Days – These were previously indicated on the UB-92 in Form Locator 8, but are now indicated on the UB-04 in Form Locators 39-41 a-d using value code "81".

- Item 8b Patient Name - Last name, first name and middle initial of the member.

- Item 9a-9d Patient Address - The address of the member that may be used for possible identification reasons.

- Item 10 Patient Birth date - The date of birth of the patient.

- Item 11 Patient Sex - The sex of the member that may be used to verify the member's eligibility.

- Item 12 Admission/Start of Care Date - The date the patient was admitted to the provider's facility.

- Item 13 Admission Hour – Enter the code which best indicates members' time of admission. See AHA Uniform Billing Manual for codes.

- Item 14 Type of Admission - A code indicating the priority of this admission (see UB-92 Training Manual).
- Item 15 Source of Admission – Enter the code that describes the admission source. (See AHA Uniform Billing Manual for codes.)
- Item 16 Discharge Hour – Enter the code which best indicates the time of discharge. (See AHA Uniform Billing Manual for codes.)
- Item 17 Patient Status - A code indicating patient status as of the ending service date of the period covered on this bill.
- Items 18-28 Condition Code – Enter the appropriate condition codes that apply. See AHA Uniform Billing Manual for codes.
- Outlier consideration may be considered by entering “61” in a condition code field.
 - To bill for multiple distinct/independent outpatient visits on the same day, facilities must enter “G0”
- Items 31-34 Occurrence Code and Date – Enter the appropriate code and date. If a member has exhausted their Medicare Part A Coverage the A3 Occurrence code is to be used with the date benefits were exhausted.
- Item 35-36 Occurrence Span Code and Date
- Items 39-41 Value Codes and Amounts - Enter the appropriate code(s) and the amount(s). See AHA Uniform Billing Manual for codes. The following codes are required on claims with Medicare or other insurance.

- | | |
|---------------------------------------|--|
| A1 Use for Medicare Part A Deductible | A2 Use for Medicare Part A Coinsurance |
| B1 Use for Medicare Part B Deductible | B2 Use for Medicare Part B Coinsurance |
| C1 Third Party Deductible | C2 Third Party Coinsurance |

The following codes are required on dialysis claims from free-standing and hospital based dialysis facilities when billing for administration of Erythropoietin (EPO):

- | | |
|----------------------------|---------------------------|
| 49 Hematocrit test results | 68 EPO units administered |
|----------------------------|---------------------------|

Situational Codes which should be reported as applicable include:

- | | |
|-------------------|-------------------|
| A8 Patient Weight | A9 Patient Height |
|-------------------|-------------------|

New Value Codes Include:

80 for the number of Covered Days. This is the number of days covered by CHS, as qualified by CHS.

- 81 for the number of Non-covered Days. – This is the number of Days of care not covered by CHS.
- Item 42 Revenue Code - A code that identifies a specific accommodation, ancillary service or billing calculation (see UB-92 Training Manual).
- Item 43 Revenue Description - A narrative description of the related revenue categories included on this bill.
- Item 44 HCPCS/Rates - The accommodation rate for inpatient bills and the CMS Common Procedure Coding System (HCPCS) applicable to ancillary service and outpatient bills.
- Item 45 Service Date - The date the indicated service was provided.
- Item 46 Units of Service - A quantitative measure of services rendered by revenue category to or for the member.
- Item 47 Total Charges - Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period.
- Item 48 Non-Covered Charges – Amount of charges for each Revenue Code and HCPCS when applicable that are non-covered.
- Item 50 Payer Identification - Name of each payer organization from which the provider might expect some payment for the bill.
- Item 54 Prior Payments - Payers and Patient - The amount the provider has received toward payment of this bill prior to the billing date by the indicated payer.
- Item 56 National Provider Identifier (NPI) – Provider NPI must be included in this box.
- Item 58 Insured's Name - The name of the individual in whose name the insurance is carried. Should be the same as patient's name.
- Item 59 Patient's Relationship to Insured - A code indicating the relationship of the patient to the identified insured. Should be self.
- Item 60 Certificate / Social Security Number / Health Insurance Claim / Identification Number - Insured's unique identification number assigned by the payer organization.
- Item 61 Insured Group Name - Name of the group or plan through which the insurance is provided to the insured.
- Item 63 Treatment Authorization Code - A number that designates that the treatment covered by this bill has been authorized by the payer (if applicable).

- Item 66 Principal Diagnosis Code - The ICD-9-CM codes describing the principal diagnosis. The ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently and which have an effect on the treatment received or the length of stay.
- Item 69 The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.
- Item 74 Principal Procedure Code and Dates – Enter the principal ICD-9 procedure code and the date the procedure was performed.
- Item 76 Attending Physician NPI - The name and NPI of the licensed physician who would normally be expected to certify and re-certify the medical necessity of the services rendered and/or who has primary responsibility for the member's care and treatment.

Signature and date, previously indicated on the UB-92 in Form Locator 85, are not on the UB-04. Each Provider is solely responsible for the truthfulness, accuracy, timeliness, and completeness of claims relating to reimbursement for services submitted to CHS.

Facility Responsibility:

1. Fill out each field completely.
2. Obtain the appropriate prior authorization and document PA number on claim.
3. Submit the claim initially within 30 days of date of service or discharge date. Hospitals agree to bill only for dates of service that have been prior authorized by CHS or in the case of emergency medical services, where notification was given to CHS within twelve (12) hours of the member registering for services. Hospitals agree not to bill CHS for the date of member's discharge.
4. Make sure the total billed charges match the itemization.
5. Attach all EOBs that relate to claim. Remember, **CHS IS PAYER OF LAST RESORT**.
6. Submit documentation to support claim as requested by CHS.

11.5 a. UB-04 INPATIENT DOCUMENTATION

1. History and physical on claims over \$5000.
2. Itemized statements or accounts on all UB-04 claims.
3. Claims must be split before submission if dates of service (DOS) span two AHCCCS (October 1 through September 30) fiscal years or two County (July 1 through June 30) fiscal years.
4. Consultation reports.
5. Discharge Summary.
6. Progress notes on interim billings.
7. ER reports.
8. Operative reports.
9. Specific additional information upon request by CHS.

11.5 b. UB-04 OUTPATIENT DOCUMENTATION

1. Physician's orders and/or progress notes from Physical Therapist.
2. Emergency Room reports. ALL DOCUMENTATION MUST BE LEGIBLE.
3. Referral forms signed by the PCP.

11.6 MEDICARE PATIENTS IN A SKILLED NURSING FACILITY SETTING

Medicare will cover 100% of cost for the first 20 days. CHS will pay the co-pay and/or deductible from day 21-100. At the end of this period CHS will cover 100% of the Contracted rates.

11.7 PRIOR PERIOD CLAIMS SUBMISSION

Claims for services provided during prior period coverage must be initially submitted within six (6) months from the date of enrollment with CHS. Resubmission of claims should be performed in the same manner as all other claims **but a final clean claim must be submitted within twelve (12) months of the date of enrollment with CHS.**

Prior Period Coverage (PPC) services do not require prior authorization, but are subject to Medical Review (refer to salmon section).

11.8 TIMELY CLAIM SUBMISSION REQUIREMENTS

CHS requires that all claims be submitted no later than six (6) months from date of service. INITIAL CLAIMS NOT SUBMITTED WITHIN SIX (6) MONTHS OF THE DATE OF SERVICE WILL BE DENIED. A CLEAN CLAIM NOT SUBMITTED WITHIN TWELVE (12) MONTHS OF THE DATE OF SERVICE WILL BE DENIED.

Please mail all claims to:

COCHISE HEALTH SYSTEMS
CLAIMS SECTION
PO BOX 4249
BISBEE AZ 85603-4249

11.9 RESUBMISSION OF CLAIMS

Providers may resubmit claims that have been denied or adjudicated by CHS but must be received by CHS within twelve (12) months of the date of service.

CHS will re-adjudicate claims resubmitted by the Provider only if the initial claim(s) had been filed within the described submission deadline.

All resubmitted claims should be submitted on the ORIGINAL CLAIM FORM marked resubmission with the correction(s) clearly indicated or with a letter explaining the reason for the returned claim. Do not submit a new claim for a resubmitted claim unless absolutely necessary. If you must, the Provider should indicate that the claim is being resubmitted, and include a copy of the initial claim, a copy of the letter from CHS requesting additional

information, supporting documentation, and a written explanation detailing the reason for resubmission.

11.10 THIRD-PARTY RESOURCES

CHS is, by law, the payer of last resort for ALTCS eligible members. Therefore providers must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing CHS for long term care services and for acute care services, as required by contract. However, if you have not received the EOB within four (4) months of service, you should bill CHS and indicate pending EOB. This will allow you twelve (12) months from date of service in which to submit a clean claim. Please attach a copy of the EOB to the submitted claim.

Providers are required to notify CHS and AHCCCS Administration if they become aware of a potential third party payer including an automobile liability insurance settlement in accordance with A.A.C. R9-22-1001.E

11.11 TECHNICAL ASSISTANCE

If providers need technical assistance related to the claims process, please contact the CHS Finance Section. In-service sessions can be scheduled to discuss areas of difficulty. The Member-Provider Relations Supervisor will also be able to provide you additional information.

11.12 TECHNICAL ASSISTANCE TO RECUPERATE SHARE OF COST OR ROOM AND BOARD

The nursing facility or any other alternate residential living setting is responsible for collecting the member's Share of Cost or Room and Board payments. When a CHS member/representative is overdue on the ALTCS assigned Share of Cost or room and board, CHS Case Management Section will assist in the collection of these costs. (For more information see policy CM070 in the policy section [pink] of this manual) Providers may not assess a late fee to share of cost collections.

If an HCBS member is assigned a Share of Cost (SOC), and collection of the SOC has not been subcontracted to a Provider, CHS will collect the SOC.

The Agency's assistance in share of cost collection does not waive the Contractor's responsibility to continue to pursue all appropriate methods of collection.

11.13 CLAIMS MEDICAL REVIEW

All claims are subject to medical review for determination of medical necessity.

11.14 REMITTANCE

For licensed skilled nursing facilities, alternative residential settings or other home and community based claims: A claim for an authorized service submitted by the Contractor shall be adjudicated within thirty (30) calendar days after receipt by the Agency. Any clean claim for an authorized service provided to a member that is not paid within thirty (30) calendar days after the claim is received accrues interest at the rate of one per cent per month from the date the

claim is submitted. The interest is prorated on a daily basis and must be paid by the Agency at the time the clean claim is paid (A.R.S. § 36-2943.D)

Hospital claims shall be paid in accordance with the applicable AHCCCS reimbursement methodologies. Please refer to AHCCCS Fee for Service Manual.

For all other contracted services, CHS will pay within sixty (60) calendar days from receipt of the clean claim that has payment due. Payment will be considered late after ninety (90) calendar days from receipt of a clean claim, and interest will be paid at ten (10) percent per annum on the amount due.

All Cochise County warrants for payment of billed services should include a remittance advice as shown in the sample included as the last page of your Provider Manual. Call the CHS Finance Section if you do not receive this remittance advice with the warrant. The remittance advice is necessary to identify exactly which claims are being paid with the warrant.

11.15 POST PAYMENT CLAIMS REVIEW

AHCCCS requires Program Contractors to perform Post Payment Claims Review for most claims. This will be conducted per Finance Policies FIN 030 and FIN 031 as well as Medical Post Payment Review Policy, UM008A and UM008A FM1. Any contractor not complying with medical documentation requests will be subject to having all payments held until compliance occurs.

XII. CLAIM DISPUTES / COMPLAINTS-ISSUES RESOLUTION PROCESS

12.1 RIGHTS AND RESPONSIBILITIES

All providers of services and items to Cochise Health Systems (CHS) members have the right to submit a claim dispute involving a payment or denial of a claim by CHS in accordance with Arizona Administrative Code, R9-34, Article 4 and Arizona Revised Statutes § 36-2903.01.B.4.

Complaints-issues related to contractual matters will be resolved as outlined in the County's Procurement Code and Provider Contracts.

All providers must comply with policies and procedures related to the claim dispute / complaints-issues resolution process in accordance with Federal and State laws, regulations and policies, including, but not limited to, 42 CFR Part 438 Subpart F.

All providers must ensure that member care is not compromised or impacted by the providers pursuing the claim dispute or complaints-issues resolution process. Refer to Policies GRV002 and CHS001 in the Policy Section (pink) of the manual.

12.2 CLAIM DISPUTES

a. Prior to submitting a claim dispute, a provider must take reasonable steps to (1) understand the underlying basis of a claim denial or adjudication, and (2) correct any defects in the initial claim submission and resubmit the claim.

b. CHS encourages providers to seek information/relief prior to initiating a claim dispute, if time allows.

The following steps are recommended:

STEP ONE: Carefully review the explanation of any denial or nonpayment contained on the remittance advice or medical review sheet. Check the claim submission to see if minor corrections or additional information is needed. If so, make corrections or additions and resubmit the claim. It may result in payment. All resubmitted claims should be submitted on the ORIGINAL CLAIM FORM, with a cover letter explaining the reason for the returned claim. Do not submit a new claim for a resubmitted claim unless absolutely necessary. In addition, please clearly mark the claim as a RESUBMISSION.

STEP TWO: Contact the CHS Finance Section to help clarify any denials or other actions relevant to the claim and to help with a possible resubmission of a claim with modifications. Allow the CHS Finance Section a reasonable amount of time (30 days) to respond to your request.

STEP THREE: If the provider still has a dispute with the resolution of the claim after CHS assistance, the provider may challenge the claim denial or adjudication by filing a formal written claim dispute with the CHS Grievance Manager in compliance with this policy and applicable Federal and State laws.

c. Prior to submitting a claim dispute regarding a claim not yet adjudicated, a provider is encouraged to contact the CHS Finance Section to determine whether the claim was received and processed by the CHS Finance Section.

d. The provider should indicate (1) the steps taken to locate any claim (claims tracer) or obtain any explanation; and (2) the date and person contacted.

e. The provider must institute in writing to the CHS Grievance Manager any claim dispute challenging a claim denial or adjudication. The Grievance Manager must receive the written claim dispute WITHIN TWELVE (12) MONTHS AFTER THE DATE OF SERVICE (FOR A HOSPITAL INPATIENT, FROM THE DATE OF DISCHARGE) FOR WHICH PAYMENT IS CLAIMED, TWELVE (12) MONTHS AFTER THE DATE THAT ELIGIBILITY IS POSTED OR WITHIN SIXTY (60) DAYS AFTER THE DATE OF THE DENIAL OF A TIMELY CLAIM SUBMISSION, WHICHEVER IS LATER.

f. The claim dispute shall specify in detail the factual and legal basis for the grievance and the relief requested, along with any documents (i.e. claim, claim denial form, remit, medical review sheet, medical records, correspondence, etc.) in support of the factual and legal basis of the claim dispute. Failure of a provider to detail the factual or legal basis may result in the denial of the claim dispute.

g. A provider shall, as requested by CHS Grievance Manager, supply additional information necessary to document and/or resolve the claim dispute. Failure of a provider to supply requested information in a timely manner may result in adjudication of the claim dispute based upon existing documentation alone.

h. CHS will make a final decision within thirty (30) days of receipt of the claim dispute and advise you of your appeal rights and procedures if you do not agree with the decision. You must let CHS know you wish to request a hearing WITHIN THIRTY (30) DAYS OF THE DATE YOU RECEIVE THE DECISION LETTER.

12.3 MEMBER COMPLAINTS TO PROVIDERS

CHS members should be advised to attempt to resolve any complaints through their Case Manager.

12.4 SUSPENSION OR DEBARMENT

The Agency will not employ, consult, subcontract or enter into any agreement for Title XIX services with any person or entity who is debarred, suspended or otherwise excluded from federal procurement activity. This prohibition extends to any entity which employs, consults, subcontracts with or otherwise reimburses for services any person substantially involved in the management of another entity which is debarred, suspended or otherwise excluded from federal procurement activity. Any contract or agreement found to have been made with a provider that has been suspended or debarred shall be null and void upon the Agency being notified of the suspension or debarment.

12.5 MEMBER/ENROLLEE RIGHTS

Contractor shall ensure that Members are treated with dignity and respect when providing services in accordance with 42 CFR 438.100.

12.6 PROVIDER-MEMBER COMMUNICATIONS

The Agency shall not prohibit or otherwise restrict a healthcare provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his/her patient with respect to the following (in accordance with [42 CFR 438.102]):

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered. [42 CFR 438.100(b)(2)]
- Any information the member needs in order 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 438.100(b)(2)(iv)]

XIII. CHS PROVIDER RELATIONS DEPARTMENT

The Cochise Health Systems Provider Relations Department is responsible for the development of a provider network that meets and exceeds the needs of our diverse population of members while also adhering to both state and federal regulations. In addition to network development, the Provider Relations Department is charged with provider monitoring to ensure compliance with contractual terms, credentialing and acts as CHS liaison between Providers and CHS.

The Member-Provider Relations Supervisor has been designated as the primary point of contact for providers who may require assistance. The Member-Provider Relations Supervisor is responsible for assisting the providers with information and will serve as a liaison with other operational sections within CHS.

Any questions or concerns related to your CHS contract(s) can be directed to the CHS Member-Provider Relations Supervisor at (520) 432-9600.

13.1 PROVIDER NETWORK DEVELOPMENT AND COORDINATION

CHS is responsible for providing covered services to over 900 members. This is accomplished through a comprehensive Network of contracted providers (yellow section of this manual). This Network is comprised of participating health care professionals, such as primary care physicians, specialist physicians, medical facilities, allied health professionals, and ancillary service providers under contract with CHS. The Network provides an integrated and coordinated health delivery system that affords us the greatest opportunity to provide a choice of caregivers for our members.

The Network is carefully developed to include health care professionals that meet certain criteria. Criteria which are considered include quality of care, availability, specialty, hospital privileges, geographic location, and the acceptance of financial considerations and CHS managed care principles. This ensures appropriate availability of providers based on the volume of members, members' needs, geographic location and projected growth.

A credentials file is created for all CHS contracted medical providers using information obtained through a contracted credentialing agency. The files are screened by the CHS Credentialing/Peer Review Committee and approved for inclusion in the Network by the CHS Credentialing Committee. The Credentialing Committee will re-credential all medical providers at least every three (3) years. CHS Network Providers are required by contract to coordinate member care within the CHS Provider Network. Referrals for CHS members shall be made by primary care physicians to CHS contracted providers with prior authorization obtained from CHS for particular services as defined in the primary care physician contracts. The Specialist Network has been developed with physicians having office hours in Cochise, Graham and Greenlee Counties. Appointments must be made during those in-county office hours unless medically contraindicated.

Referrals outside of the contracted Network are only permitted with CHS prior authorization and are based on continuity of care and provider availability. A current list of the CHS Provider Network is mailed to contracted providers on a quarterly basis and is available on the CHS website. Questions concerning the CHS Network should be directed to the attention of the CHS Member-Provider Relations Supervisor.

The CHS Organizational Credentialing Committee will meet as often as necessary to credential organizational providers. The purpose of this committee is to review and approve initial organizational credentialing files and re-credential files for the CHS Network. The committee will review the provider's state or business license and verify any other applicable state or federal requirements. The committee will also review the accreditation certification if applicable or ADHS survey results.

13.2 MEMBER/PROVIDER COUNCIL

To promote a collaborative effort to enhance the service delivery system in local community while maintaining a member focus, CHS has established a Provider/Member Council that participates in providing input on policy and programs. This council meets quarterly beginning in October of each contract year. Please call 520-432-9600, and talk to Patsy Lebron if you are interested in attending.

13.3 CHS CONTRACTED PROVIDER NETWORK (yellow section)

In this section, providers should insert the most current CHS Contracted Provider Network listing. This listing is published and mailed on a quarterly basis by CHS. Providers may also visit our website for a current listing of the CHS Network at <http://www.cochise.az.gov>

As is indicated in your contract, providers agree to refer members to contracted providers in accordance with the CHS referral policy. The Specialist Network has been developed with Physicians having office hours in Cochise, Graham and Greenlee Counties. Appointments must be made during those in-county office hours unless medically contraindicated. Providers may only refer members to non-contracted providers if the member requires medical services not available through a contracted provider AND if CHS has prior authorized the referral.

If a particular specialty is not listed in the provider listing, contact the CHS Prior Authorization Section for assistance at (520) 432-7485 or (800) 285-7485.

Material Changes

A material change to the network is defined as one which affects, or can reasonably be foreseen to affect, CHS' ability to meet the performance and network standards, it also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered. A material change in the network requires 30 days advance written notice to affected members.

XIV. GLOSSARY OF TERMS

A.A.C. – Arizona Administrative Code.

Abuse (Of Member) - Intentional infliction of physical, emotional or mental harm, caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault as defined by A.R.S. § 46-451.

Abuse (By Provider) - Provider practices that are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost to the AHCCCS program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the AHCCCS program as defined by 42 CFR 455.2.

Action – by CHS means: a. The denial or limited authorization of a requested service, including the type or level of service; b. The reduction, suspension, or termination of a previously authorized service; c. The denial, in whole or in part, of payment for a service; d. The failure of a contractor to provide services in a timely manner; e. The failure to act within the timeframes

required for standard and expedited resolution of appeals and standard disposition of grievances; or f. The denial of a rural enrollee's request to obtain services outside the Program Contractor's network under 42 CFR 438.52(b)(2)(ii), when the contractor is the only Program Contractor in the rural area.

ACOM – AHCCCS Contractor Operations Manual available on the AHCCCS website at www.azahcccs.gov

Acute Care Services - All medical services provided to a member, including but not limited to, physician services, inpatient hospitalization, prescription medications, DME, emergency room services, emergent and medically necessary transportation, lab, and x-ray.

ADHS – Arizona Department of Health Services, the state agency mandated to serve the public health needs of all Arizona residents.

Administration – The Arizona Health Care Cost Containment System Administration, its agents, employees, and designated representatives, as defined in 9 A.A.C. 22, Article 1.

Agent – Any person who has been delegated the authority to obligate or act on behalf of another person or entity.

AHCCCS - Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible person defined by A.R.S. § 36-2902, et seq.

AHCCCS Benefits - AHCCCS covered medical services.

AHCCCS Eligibility – Indigent Eligibility categories funded by Title XIX, by State and counties; eligibility determinations are done by state according to AHCCCS standards.

ALTCS - Arizona Long Term Care System, a program under AHCCCSA that delivers long term, acute, behavioral health care and case management services to eligible members, as authorized by A.R.S. § 36-2932.

Ambulatory Care – Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other health care providers.

AMPM – AHCCCS Medical Policy Manual available on the AHCCCS website at www.azahcccs.gov

Anniversary Date – The month the member is entitled to make an annual enrollment choice. The anniversary date is 12 months from the date enrolled with the Program Contractor and annually thereafter. In some cases, the anniversary date will change based on the last date the member changed Program Contractors or the last date the member was given an opportunity to change.

Annual Enrollment Choice (AEC) – The opportunity for a person to change contractors every 12 months, effective their anniversary date.

Appeal – means a request for review of an action (see definition of "action" above).

Appeal Resolution – The written determination by CHS concerning an appeal.

A.R.S. – Arizona Revised Statutes.

Assisted Living Facility – Residential care institution that provide supervisory care services, personal care services or directed care services on a continuing basis. All ALTCS approved residential settings in this category are required to meet ADHS licensing criteria. Of these facilities, ALTCS has approved four as covered settings.

At Risk – Refers to the period of time that a member is enrolled with a contractor during which time the Contractor is responsible to provide AHCCCS covered services under capitation.

Authorization - An administrative procedure whereby CHS QM/UM section gives approval of medical services rendered to members, such as outpatient procedures, hospitalization, referrals to a physician specialist, etc.

BBA – Balanced Budget Act of 1997.

Billed Charges - Charges billed by a provider rendering service to a CHS member.

Board Certified - A physician who has successfully completed a required residency in an approved training program who has passed the examination for board certification in his/her specialty.

Board Eligible - A physician who has successfully completed a required residency in an approved training program but has not taken the examination for board certification in his or her specialty.

Capitation Payment - Refers to a predetermined periodic payment, based upon the number of assigned members that is made to a contracted provider by CHS for providing Covered Services for a specific period.

Case Manager - A CHS social worker or nurse who develops appropriate member service plans in conjunction with the Primary Care Physician and who may authorize some services.

Children's Care Program (CCP) - The program for children defined by A.R.S. 36.2905.03.B, C and D.

Chiropractic Services - Treatment, provided by a licensed chiropractor who meets uniform minimum Medicare standards, by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray. Any such services are expressly limited to dual eligible Qualified Medicare Beneficiaries.

Claim Disputes – a dispute involving a payment of a claim, denial of a claim, imposition of a sanction or reinsurance.

Clean Claim – A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity, as defined by A.R.S. § 36-2904.

CMS - Centers for Medicare and Medicaid Services, an organization within the U.S. Department of Health and Human Services, which administers the Medicare, Medicaid and State Children's Health Insurance Program.

Concurrent Review - A member medical care evaluation study performed while a member is still hospitalized.

Convicted – A judgment of conviction has been entered by a federal, state or local court, regardless of whether an appeal from that judgment is pending.

Co-Payment - A monetary amount specified by the Director that the member pays directly to a contractor or provider at the time covered services are rendered as defined in 9 A.A.C. 22, Article 1.

Cost Avoidance – The process of identifying and utilizing all sources of first or third-party benefits before services are rendered by the Program Contractor or before payment is made by the Program Contractor. (This assumes the Program Contractor can avoid costs by not paying until the first or third party has paid what it covers first, or having the first or third party render the service so that the Program Contractor is only liable for coinsurance and/or deductibles.)

Covered Services – The health and medical services to be delivered by the Program Contractor as defined in 9 A.A.C. 28, Article 2 and 9 A.A.C. 31, Article 2, and the AMPM. {42 CFR 438.210(a) (4)}

Credentialing - Is the process of verifying all aspects of the doctor's professional life by the Peer Review Committee.

CRS - Children's Rehabilitative Services, as defined in 9 A.A.C. 22, Article 1. The Program for children with CRS-covered conditions is administered by the Arizona Department of Health Services (ADHS) for children who meet CRS eligibility for criteria. The Program Contractor shall refer children to the CRS program who are potentially eligible for services related to CRS covered conditions, as specified in 9 A.A.C. 28, Article 2 and A.R.S. § 36, Chapter 2, Article 3.

CRS Eligible – An individual who has completed the CRS application process, as delineated in the *CRS Policy and Procedure Manual*, and has met all applicable criteria to be eligible to receive CRS related services.

CRS Recipient – A CRS recipient is a CRS eligible individual who has completed the initial medical visit at an approved CRS Clinic, which allows the individual to participate in the CRS program.

CYE – Contract Year Ending, corresponds to federal fiscal year (Oct. 1 through Sept. 30). For example, Contract Year Ending 2002 is 10/1/01 – 9/30/02.

Days – Calendar days unless otherwise specified as defined in 9 A.A.C. 22, Article 1.

DES/DDD - Department of Economic Security/Division of Developmental Disabilities.

Discharge Planning - A process that begins on admission to determine the length of stay according to medical need and the identification of the need and planning for provision for a member's health care requirements after discharges from the hospital.

Disenrollment - The discontinuance of a member's ability to receive covered services through a Contractor.

DME – Durable medical equipment, is an item or appliance that can withstand repeated use, is designed to serve a medical purpose, and are not generally useful to a person in the absence of a medical condition, illness or injury, as defined in 9 A.A.C. 22, Article 1.

Dual Eligible – A member who is eligible for both Medicare and Medicaid.

Elective - Refers to medical procedures, which can be scheduled weeks or months in advance.

Emergency Dental Services - Those services and operational procedures required to eliminate acute infection, prevent pupal death and related imminent tooth loss, treat injuries to teeth or supportive structures, or provide palliative therapy for pericoronitis associated with impacted teeth.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including sever pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part. {42 CFR 438.114(a)}

Emergency Medical Service – Covered inpatient and outpatient services provided after the sudden onset of an emergency medical condition as defined above. These services must be furnished by a qualified provider, and must be necessary to evaluate or stabilize the emergency medical condition. {42 CFR 438.114(a)}

Encounter - A record of a health care related service rendered by a provider or providers registered with AHCCCSA to a member who is enrolled with a contractor on the date of service.

Enrollee (also called Member) – A Medicaid recipient who is currently enrolled with a contractor. [42 CFR 438.10(a)]

Enrollment - The process by which an eligible person becomes a member of a contractor's plan, as defined in 9 A.A.C. 28, Article 4.

EPD – Elderly and Physically Disabled.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment services for eligible persons or members less than 21 years of age, as defined in 9 A.A.C. 22, Article 2.

FFS - Fee-For-Service, a method of payment to registered providers on an amount-per-service basis.

Filed – means the date received by CHS, as established by a date stamp on the request or other record of receipt.

First Party Liability – The resources available from any insurance or other coverage obtained directly or indirectly by a members or eligible person that provides benefits directly to the member or eligible person and is liable to pay all or part of the expenses for medical services incurred by the Contractor or member.

Grievance – an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights.

Grievance System – A system that includes a process for enrollee grievances, enrollee appeals, provider claim disputes, and access to the state fair hearing process.

HCBS - Home and Community Based Services, as defined in A.R.S § 36-2931 and 36-2939.

Hospital - A health care institution which is:

- A. Licensed by the Department of Health Services pursuant to A.R.S. Title 36, Chapter 4, Article 2, as a hospital, and
- B. Certified as a provider under Title XVIII of the Social Security Act, as amended, or is currently determined to meet the requirements of such certification.

Inpatient - A patient admitted to an overnight medical facility such as a hospital.

Length of Stay - Total number of days for which a patient is hospitalized, either totally or in a particular unit or level of care; abbreviated as LOS.

Medicaid - A federal/state program authorized by Title XIX of the Social Security Act, as amended.

Medical Director - Refers to a physician who is designated by CHS to have overall responsibility for the direction of CHS's medical delivery system.

Medical Management (MM) – Is an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care (from prevention to end of life care).

Medically Necessary - Refers to those covered services required to preserve and maintain the health status of a member, according to the Primary Care Physician concurring with AHCCCS standards, and subject to review and concurrence by the CHS Medical Director.

Medically Necessary Dentures - Partial or full dentures and services that are determined to be the primary treatment of choice or an essential part of an overall treatment plan designed to

alleviate a medical condition as determined by the primary care physician in consultation with a dentist.

Medicare - A federal program authorized by Title XVIII of the Social Security Act, as amended.

Out-of-Area Care - Emergency Acute Care Services Only received by a CHS member when they are outside of CHS network area.

Out-of-State Care - Emergency Acute Care Service Only received by a CHS member when they are outside of the State of Arizona.

Outpatient - A person who goes to a licensed health care institution or a facility for care and services, but who does not occupy an inpatient bed.

Peer Review - Review of quality of care issues related to contracted physicians by a Committee of their peers.

Pharmaceutical Services - Medically necessary drugs prescribed by a primary care physician, a practitioner, or other physician or dentist upon referral by a primary care physician and dispensed in accordance with Arizona law.

Physician Services - Services provided within the scope of practice of medicine or osteopathy as defined by State law or under the personal supervision of a physician, in the case of services provided by a Physician's Assistant, or in collaboration with a physician in the case of service provided by Nurse Practitioner.

Preventive Health Care - Those health care activities aimed at protection against, and/or early detection and minimization of disease or disability.

Primary Care Physician (PCP) - A CHS contracted and credentialed physician such as a family practitioner, pediatrician, internist, general practitioner or obstetrician.

Prior Period Coverage (PPC) – The period between the member's effective date of eligibility, excluding any prior quarter coverage, and the date of enrollment with CHS (as defined in 9 A.A.C. 28. Article 1.)

Retrospective Review - Review of a service that has been rendered to a member to determine medical necessity of service rendered.

Share of Cost - Refers to the portion for the cost of care or provision of services that must be assumed by the Cochise Health Systems member as determined by the ALTCS eligibility process based on income, expenses and living arrangements.

Specialist - A CHS contracted and credentialed Board eligible or Certified Physician who declares himself or herself as such and practices a specific medical specialty.

SSI - Supplemental Security Income under Title XVI of the Social Security Act, as amended.

TANF - Temporary Assistance to Needy Families, as amended by the Welfare Reform Act.

Third-Party Recoveries - A general term applied to health care benefit payments. It derives from the fact that under normal market transactions, there are only two parties, the consumer and the supplier, but under a benefit plan, a third party (e.g., government, an insurance company, and employer, etc.) is ultimately responsible to pay the costs of services provided to covered person prior to payment from an AHCCCS plan.

Title XIX – Means Medicaid as defined in 42 U.S.C. 7.19.

Utilization Management - System of review conducted by professional health personnel, of the appropriateness, quality of, and need for health care services rendered to members covered by Medicare or other third-party payers, including AHCCCS.

Working Day – means a Monday, Tuesday, Wednesday, Thursday, or Friday unless: a. A legal holiday falls on one of those days; or b. A legal holiday falls on a Saturday or Sunday and CHS is closed for business the prior Friday or following Monday.

Accessing the Codes and AHCCCS Manuals, referenced in this Manual:

You will need access to the Internet and Acrobat Reader to look at these files. To obtain Acrobat Reader, in a search engine, such as, Yahoo, MSN, Dogpile, type in the word “Acrobat” and this will take you to another location that will allow you to download this program. If you are using a public computer, such as the one at the public Libraries, they should have this program already installed on those computers. You may wish to print just the portion of the file that you need. These are very lengthy documents.

Arizona Administrative Code: This link will take you to the Table of Contents. Find the chapter that you are looking for and left click on that chapter. This site is very user friendly, meaning that searching the Table of Contents to find the code that you need is relatively simple.

www.sosaz.com/public_services/Table_of_Contents.htm

Code of Federal Regulations: www.access.gpo.gov .This link will take you to the homepage for the Government Printing Office, scroll down to Quick Links, left click on Code of Federal Regulations and this will take you to the CFR Homepage. There are several search engines on this page, the most helpful of which is: Search or browse your choice of CFR titles and/or volumes. Healthcare issues are generally covered in Title 42. From this point, you should be able to locate the chapter that you need to reference.

To access the Arizona Health Care Cost Containment System (AHCCCS) Website, in the address bar type in www.ahcccs.state.az.us and for access to the policy manual, from the homepage, left click on Regulations, this will be on the left side of the homepage then click on AHCCCS Medical Policy Manual. If you click on Publications, this link will take you to the AHCCCS Fee for Service Schedules.