Banner
University Health Plans

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Provider Update

Nov. 15, 2022

In this issue:

2023 Banner Medicare Advantage Plan Materials

- Preview 2023 benefits for all Banner Medicare Advantage plans (pg. 2)

Sonora Quest Laboratories

- Sonora Quest Laboratories is the lab provider for all B – UHP and Banner Medicare Advantage plan members (pg. 3)

2022-23 Flu Season Has Begun

- Discuss flu shots with your patients (pg. 3)

HEDIS Season is Approaching Fast

- Medicare HEDIS review kicks off in Jan. 2023 (pg. 3)

DME Provider Update

- J&B Medical Supply Co Inc for adult brief supplies effective Sep. 1, 2022 (pg. 4)

Banner Children's December 2022 Free and Virtual Lecture Services

- Pediatric Infectious Disease specialist, Nurul Hariadi, MD, FAAP will be presenting on Dec. 7, 2022 (pg. 4)

Provider Manual Updates

- B – UHP Medicaid Provider Manual updates will be effective Dec. 11, 2022 (pg. 5)

Office of Individual and Family Affairs (OIFA)

- AHCCCS Medical Policy Manual (AMPM) updates effective Oct. 1, 2022 (pg. 6)
- Peer Support Employment Training Programs (pg. 6)

Adult Recovery Team

- Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services (pg. 7)

Stimulant Use Disorder

- Stimulant misuse and overdose trends and therapy recommendation (pg. 8)

Maternal & Child Health

- Respiratory Syncytial Virus (RSV) prior authorization no longer required effective Nov. 15, 2022 (pg. 9)
- EPSDT/Well-Child Visits Updated Behavioral Health Screening Requirements (pg. 10)
- Nutritional Assessment and Services for EPSDT-Aged Members (pg. 11)
- Well Women's Preventive Care Services (pg. 13)

Children's System of Care

- Required Documentation and Chart Elements for Specialty Providers (pg. 14)
- Identifying and Treating Eating Disorders (pg. 15)
- Correlation between Epilepsy and Behavioral Health (pg. 16)
- 504 Plan to Support Students with Diabetes (pg. 17)
- Child and Family Team (CFT) Initiatives (pg. 17)

Provider Services & Support

- 2023 Provider Satisfaction Survey (pg. 18)
- Trending Topics in Health Care Law: Physical Access to Health Care (pg. 18)
- Practitioner Rights (pg. 19)
- Model of Care Attestation (pg. 20)
- Skilled Nursing Facility (SNF) and Behavioral Health Residential Facility (BHRF) Audit Announcement (pg. 20)
- Claims Updates (pg. 20)

Compliance Corner

- Exclusions Program, Screening and Reporting Obligations (pg. 21)

Attachment

- CMS Hedis Fax Transmission Sheet sample

2023 Banner Medicare Advantage Plan Materials Now Available

The 2023 Banner Medicare Advantage Plan materials can be found by visiting the following pages:

For Banner Medicare Advantage Prime HMO plan materials, visit:
www.bannerhealth.com/medicare/advantage/our-plans/2023-open-enrollment/cy23-hmo-plan

For Banner Medicare Advantage Plus PPO plan materials, visit:
www.bannerhealth.com/medicare/advantage/our-plans/2023-open-enrollment/cy23-ppo-plan

For Banner Medicare Advantage Dual HMO D-SNP plan materials, visit:
www.bannerhealth.com/medicare/advantage/our-plans/2023-open-enrollment/cy23-dsnp-plan

Sonora Quest Laboratories

For Banner – University Health Plans, Sonora Quest Laboratories is the recommended lab.

For Banner Medicare Advantage HMO & PPO, Sonora Quest Laboratories is used exclusively for laboratory services for our members.

If you request lab work that cannot be done by Sonora Quest Laboratories, you must get Prior Authorization from Banner for the lab services to be performed at an out-of-network laboratory.

Sonora Quest Laboratories website: https://www.sonoraquest.com

For information on contracted health plans and patient service center locations, visit this link: https://sonoraquest.com/patient/knowledge-center (Information is updated on a monthly basis)

The 2022-23 Flu Season Has Begun

Have you spoken to your patients about the flu shot?

It's important to encourage patients to stay safe during the flu season – this includes getting the flu shot. Listen to their concerns and let patients know that the best way to prevent the flu is by getting the flu shot.

HEDIS Talk: HEDIS Season is Approaching Fast

HEDIS is the gold standard for measuring the quality of health care performance!

Healthcare Effectiveness Data and Information Set (HEDIS) is a National Committee for Quality Assurance (NCQA) tool used by health plans nationwide to measure performance on several important aspects of care and service.

While some information is collected *administratively* using medical, pharmacy and encounter claims, some data can only be taken directly from the member's medical record. This type of reporting is called *Hybrid* data collection.

Beginning January 2023, Banner will kick off our annual Medicare HEDIS Hybrid review for measurement year 2022. This means we will be looking back at services rendered from Jan. 1 – Dec. 31, 2022. The HEDIS Hybrid review will continue through May 2023.

What is a provider's role in HEDIS?

You and your office play an essential role in promoting the health of our members!

To make this HEDIS season go smoothly you can assist by doing the following:

- Respond to Fax requests promptly and completely.
- Utilize secure email if faxing is not available.

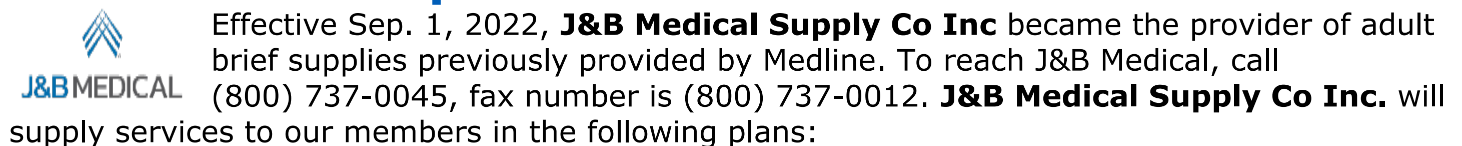
If your medical records requests are processed by a vendor, please emphasize the importance of responding quickly at no cost (Banner – University Health Plans cannot contact the vendor directly for medical records).

- Allow remote EHR access to your electronic medical record. This will greatly reduce the number of medical record requests to your office and will improve accuracy (preferred method of medical record abstraction).
- Ask questions! Contact the HEDIS Medicare Quality Team if you have questions or concerns. All contact information is available on the fax request (See attachment).
- Check out the fax transmission sheet example at the end of this newsletter to get an idea of what to expect. Please look for this early next year!

Please note: A patient's written authorization to release PHI is NOT required for HEDIS. According to HIPAA (Health Insurance Portability and Accountability) Privacy Rule (45 CFR 160, 164), health care providers can disclose protected health information (PHI) to health plans for several reasons including quality assurance/quality improvement activities, such as HEDIS data collection.

(see attachment)

DME Provider Update



Effective Sep. 1, 2022, **J&B Medical Supply Co Inc** became the provider of adult brief supplies previously provided by Medline. To reach J&B Medical, call (800) 737-0045, fax number is (800) 737-0012. **J&B Medical Supply Co Inc.** will supply services to our members in the following plans:

- Banner – University Family Care/ACC (B – UFC/ACC)
- Banner – University Family Care/ALTCS (B – UFC/ALTCS)
- Banner Medicare Advantage Dual HMO D-SNP (Banner Dual) (formerly known as Banner – University Care Advantage)

A list of alternate contracted suppliers is listed below. You may also use these suppliers for your patients who need adult briefs.
For a comprehensive list of all Durable Medical Equipment and Supply providers, please visit our provider directory at: https://www.banneruhp.com/find-a-provider

Using the **Advanced Search** option, select **Durable Medical Equipment** in the **Provider Type** field.

Additional questions can be directed to the Provider Experience Center by calling the number that corresponds to the member's health plan listed on page 22.

Banner Children's FREE and Virtual Lunch Lecture Series

Join us monthly for a free virtual lecture series happening the first Wednesday of each month. This educational lunchtime lecture hosts a different pediatric specialist to share informational content to providers. Each lecture offers 1 CME credit.

When: Wednesday, Dec. 7, 2022

Time: Noon - 1:00 p.m.

Speaker: Pediatric Infectious Disease, Nurul Hariadi, MD, FAAP

Topic: Refresher on Congenital & Perinatal Infection for Outpatient Setting

- Participants will be able to recognize history, symptoms, and signs that should prompt evaluation for congenital or perinatal infections
- Participants will be able to choose appropriate diagnostic tests for suspected congenital or perinatal infections

Participants will be able to determine when to refer or admit patients for congenital or perinatal infection and to appropriately monitor for sequelae

Add event to calendar: https://bit.ly/3GJLp4d

Join via Microsoft Teams: https://bit.ly/33ej6gq

Banner Health is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. Banner Health designates this virtual activity for a maximum of ***1 AMA PRA Category 1 Credit™****. Physician should claim only the credit commensurate with the extent of their participation in the activity.*

Nurul Hariadi, MD, and the series planners have reported no financial relationships.
CME credit is available to Banner Health staff, Banner Health Network and affiliated providers only.

AHCCCS Updates

Provider Manual Updates

Updates to the B – UHP Medicaid Provider Manual have been made and will be effective **Dec. 11, 2022.**

Reminder: These updates can be found on www.BannerUHP.com under the B – UFC/ACC and B – UFC/ALTCS Provider Manual.

Key updates and changes:

Revised the following sections:

- Practitioner Rights related to the initial credentialing and recredentialing as

been updated. (pg. 11)
- Section 4, Clinical Services has been updated.
  - EPSDT Oral Health Screenings – (pg. 65)
  - Dental Services – (pg. 67)
  - Well Women Preventive Care Services – (pg. 71)
  - Family Planning Services – (pg. 73)
  - Medical Record Review Requirements – (pg. 80)
  - Member's comprehensive record maintained by the PCP – (pg. 88, items 28 to 31)

The new Banner Medicare Advantage Provider Manual has also been posted and will be effective **Nov. 11, 2022.** The new manual includes all Medicare lines of business: Banner Medicare Advantage Prime HMO, Banner Medicare Advantage Plus PPO and Banner Medicare Advantage Dual HMO D-SNP.

Office of Individual and Family Affairs (OIFA)

AHCCCS Medical Policy Manual (AMPM) 963-Peer and Recovery Support Service Provision Requirements and 964-Credentialed Parent Peer-Family Support Requirements

AHCCCS Medical Policy Manual (AMPM) 963-Peer and Recovery Support Service Provision Requirements and 964-Credentialed Parent Peer-Family Support Requirements has recently been updated and these updates became effective Oct. 1, 2022.

B – UHP's Office of Individual and Family Affairs (OIFA) is required to monitor our provider agencies contracted to deliver peer support and family support services to ensure that these policies are being followed, including the quarterly deliverable submission using Attachment A in each policy: Peer/Recovery Support Specialist Involvement in Service Delivery (AMPM 963) and Credentialed Parent Peer/Family Support Partner Involvement in Service Delivery Report (AMPM 964).

Both AMPM 963 & 964 can be found here:
https://www.azahcccs.gov/shared/MedicalPolicyManual/

If you are an agency that delivers peer and family support services and have questions about the requirements of these two policies, you can contact B – UHP's Office of Individual and Family Affairs (OIFA) Team general email box: OIFATeam@bannerhealth.com.

Peer Support Employment Training Programs (PSETPs) Pause

AHCCCS OIFA recognizes more than 40 Peer Support Employment Training Programs (PSETPs) as compliant with AMPM 963. Since the Spring of 2022, AHCCCS OIFA has been contacted by 12 providers who have interest in developing their own PSETPS.

AHCCCS OIFA believes additional criteria are necessary to become a PSETP to ensure fidelity to the practice of peer support for agencies interested in training the PRSS workforce. To ensure AHCCCS OIFA has appropriate processes in place to recognize PSETPs who are best qualified to train the PRSS workforce, AHCCCS OIFA will be implementing a "pause" on reviewing and

recognizing new training programs from Oct. 31, 2022 to Jan. 31, 2023. AHCCCS OIFA will be considering additional criteria, including but not limited to:

- Providing peer support services and/or understand the role of PRSS
- Improving application process for operating a PSETP
- Limiting the number of trainings each provider can conduct per year
- Including the OIFA Alliance in review of curricula via secured file sharing

During this pause the OIFA Alliance (OIFAs at AHCCCS, ACC, ACC-RBHA, DES/DDD and DCS/CHP) will be collaborating to create a review and recognition process that is consistent and transparent.

Questions? You can contact B – UHP's Office of Individual and Family Affairs (OIFA) Team general email box: OIFATeam@bannerhealth.com

Adult Recovery Team (ART)

An Adult Recovery team is a group of individuals who follow the Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems, work in collaboration and are actively involved in a person's assessment, services planning and service delivery. At a minimum, the team consists of the person, his/her guardian (if applicable), advocates (if assigned), and a qualified behavioral health representative. The team may also include members of the enrolled person's family, physical health, mental health or social service providers, representatives or other agencies serving the person, professionals representing various areas of expertise related to the person's needs, designated representatives or other persons identified by the enrolled person.

Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services

The principles have been developed to provide a shared understanding of the key ingredients needed for an adult behavioral health system to promote recovery. System development efforts, programs, service provision and stakeholder collaboration must be guided by these principles. We must utilize these principles to guide our decision-making process and our interactions with each other.

Here is the link to the Nine Guiding Principles https://www.azahcccs.gov/AHCCCS/Downloads/ArnoldVSarn/9-guiding-principles-for-recovery-oriented-bhs.pdf

ART Requirements and Best Practice

- Complete ART when member is inpatient for psychiatric or at a Behavioral Health Residential Facility (BHRF).
  - Discuss member's treatment goals and needs.
  - Discuss member's progress or lack of progress.
  - Meet the member where they're at.

  - Discuss discharge planning. Discharge planning includes where member will discharge to and wrap around services.
  - Complete necessary referrals to ensure member continues treatment/services upon discharge.

- ART includes the member/guardian, qualified behavioral health representative, health home case manager, and natural supports.
  - Advocate and peer support if assigned.
  - B – UHP care manager and B – UHP discharge coordinator as needed.
- ART can be completed on an outpatient basis, annual assessment and upon member request.
- Complete necessary referrals in a timely manner.
- Best Practice is for place of service to schedule and facilitate ART.

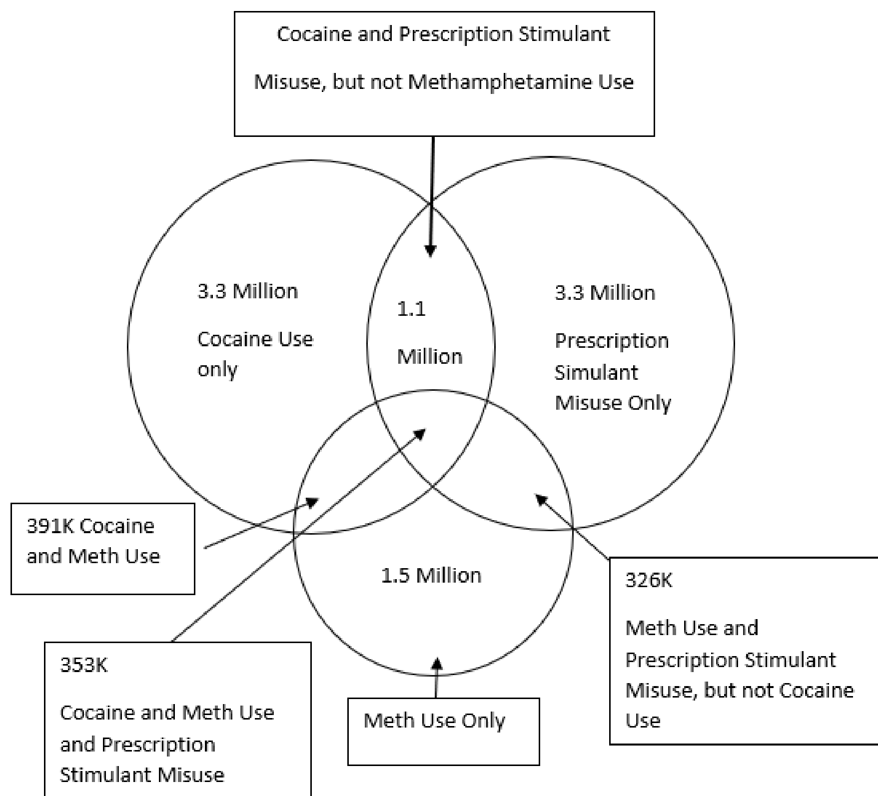
Stimulant Use Disorder

Stimulants produce effects such as increased alertness, wakefulness, or energy. Physical side effects can also occur and include rapid or irregular heartbeat or increased blood pressure and body temperature. Stimulant misuse and overdose is on the rise. There are currently no FDA-approved medications to treat stimulant use disorder and behavioral therapy is the most effective treatment.

Did you know?

- In 2020, a reported 10.3 million people misused Central Nervous System (CNS) Stimulants in the U.S.
- Approximately a third of those misusing CNS stimulants misused only prescription stimulants.
- Greater than 1 million individuals were misusing cocaine and prescription stimulants.

Past Year Central Nervous System (CNS) Stimulant Misuse: Among People Aged 12 or Older; 2020



Substance Abuse and Mental Health Services Administration (2021). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

The American Professional Society of ADHD and Related Disorders (APSARD), plans to release the first U.S. guidelines for diagnosing and treating ADHD in adults in 2023. Ensuring access to appropriate treatment options is critical for the successful management of stimulant use disorder.

Maternal & Child Health

Respiratory Syncytial Virus (RSV)

Removal of Prior Auth Requirement for Synagis

Based on regional surveillance data, Banner – University Family Care/ACC is pausing Prior Authorization requirements this season for Synagis® (palivizumab). Effective *November 15, 2022*, the Prior Authorization form for RSV prophylaxis to utilize Syangis is **not** required for the remainder of the 2022-23 RSV season.

Synagis® (palivizumab) is covered via medical or pharmacy benefit. Submit medical claims for Synagis using standard billing practices for "buy and bill" drug products. To submit claims via the pharmacy benefit, follow the instructions below:

1. Ordering Synagis for In Office Administration
    a. Please use Banner Family Pharmacy – Chandler
        i. Contact Information: (844) 747-6442
        ii. Please include provider's office shipping address and best contact information for member's legal guardians.
        iii. Banner Family Pharmacy will verify prescription and coverage.
        iv. Once verified, Banner Family Pharmacy will complete a welcome call with member's legal guardians.
        v. After welcome call, medication will be shipped to provided address for office.
2. Ordering Synagis from In Home Administration by Home Health Agency
    a. Contact Information
        1. Customer Care Center (800) 582-8686
3. The Health Plan's Maternal Child Health department has specialty Pediatric Nurse Care Managers available to assist you through any issues in the Synagis acquisition and administration process. Please send your questions (with the member's name, DOB and AHCCCS ID#) to: BUHPMaternalChildHealth@bannerhealth.com

Additionally – Parents or health care decision makers may call our Customer Care Center at (800) 582-8686 to request a Pediatric Nurse Care Manager at any time for assistance.

EPSDT/Well-Child Visits

Updated Behavioral Health Screening Requirements

Effective Oct. 1, 2022, NEW Behavioral Health screening requirements have been added to certain EPSDT/Well-Child visits. These additions are reflected in the updated AHCCCS Medical Policy Manual (AMPM) Policy 430 – *Early and Periodic Screening, Diagnostic and Treatment Services.*

Adolescent Suicide and Depression Screening

Primary Care Providers shall provide Adolescent Suicide and Depression screening at the annual EPSDT visits beginning at 10 years of age. The screening should utilize a standardized, norm-referenced screening tool specific for suicide and depression. These screenings are separately billable, and a copy is to be kept in the medical record. The AHCCCS *EPSDT Clinical Sample Templates* (forms for ages 9-12 years, 13-17 years and 18-21 years) have been updated to include the new screenings. Positive screening results require appropriate and timely referral for further evaluation and service provision. Banner – University Family Care/ACC has both Pediatric Nurse Care Managers and Children's Behavioral Health Care Managers available to assist with any care coordination needs.

Postpartum Depression Screenings for Birthing Parents

Postpartum Screening of the birthing parent shall be performed during the infant member's one- two-, four- and six-month EPSDT/Well-Child visits. A standardized, norm-reference screening tool shall be used. These screenings are separately billable, and a copy is to be kept in the

child's medical record. The AHCCCS *EPSDT Clinical Sample Templates* for these infant visits have been updated to include the new screenings. Positive screening results require referral to the appropriate care managers and services at the mother's health plan. Banner – University Health Plans has Maternal Child Care Managers available to assist the birth parent with appropriate postpartum depression support and referrals.

To make a referral to Banner – University Health Plans' Maternal Child Health team:
Contact Customer Care Center at (800) 585-8686 and ask to speak to a Maternal Child Care Manager or email us directly at buhpmaternalchildhealth@bannerhealth.com
EPSDT Clinical Sample Templates may be downloaded from: www.azahcccs.gov à Shared à Medical Policy Manual à 430 Attachment E.

Submitting EPSDT / Well-Child Visit Forms:

Secure email: BUHPEPSDTForms@BannerHealth.com
Secure Fax: (520) 874-7184
US Mail: Banner – University Health Plans
Attn: EPSDT
2701 E. Elvira Rd.
Tucson, AZ 85756

Nutritional Assessment and Services for EPSDT-Aged Members

Nutritional Assessments

Banner Medicaid Health Plans cover the assessment of nutritional status provided by the member's PCP as part of the EPSDT/Well-Child visit screenings, and additionally as determined medically necessary. Nutritional assessments of EPSDT-aged members by a Registered Dietician (when ordered by the member's PCP) are also covered. This includes EPSDT members who are identified as underweight or overweight.
Nutritional assessment is a separately billable service by the PCPs who care for EPSDT-aged members. Prior Authorization is not required for nutritional assessments provided by either a PCP or a Registered Dietician when ordered by a PCP.

Nutritional Therapy

For EPSDT-aged members, the Health Plan covers Enteral, Total Parenteral (TPN), or oral nutrition when determined medically necessary to provide either complete or supplemental daily dietary requirements.
Nutritional therapy is covered for WIC (Women, Infants and Children)-eligible children who qualify for nutritional therapy due to a medical condition.
Prior Authorization **is** required for Commercial Oral Nutritional Supplements, enteral nutrition or parenteral nutrition, with some exceptions. unless:

- The member is currently receiving enteral/parenteral nutrition for which PA has already been obtained.

- For the first 30 days with members who require oral supplemental nutritional feedings on a temporary basis due to an emergent hospitalization (i.e., post-hospitalization).

The PCP or Specialist must submit the *Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT Aged Members – Initial or Ongoing Requests)* [AHCCCS Policy

430, Attachment B], directly to the Banner – University Health Plans, to obtain the required Prior Authorization.

Commercial Oral Nutritional Supplements
Covered nutritional therapy for WIC (Women, Infants and Children)-eligible children who qualify due to a medical condition includes:

- Medically necessary formulas not provided through WIC (not based on brand preference).
- For infants (0 – 1 year) requiring formulas above the amount provided by WIC, an AHCCCS *Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT-Aged Members – Initial and Ongoing Requests)* form [AMPM 430, Attachment B] must be submitted with the PA request for the amount of formula exceeding what is provided by WIC.
- For children (under 5 years) requiring formulas not provided by WIC, an AHCCCS *Certificate of Medical Necessity for Commercial Oral Nutritional Supplements (EPSDT-Aged Members – Initial and Ongoing Requests)* form [AMPM 430, Attachment B] must be submitted with the PA request.

Medical necessity for commercial oral supplements for EPSDT-aged members must be determined on an individual basis by the PCP or Specialist. Extensive and detailed criteria for Commercial Oral Nutritional Supplements is outlined in *AMPM Policy 430 Early and Periodic Screening, Diagnostic, and Treatment Services*, Section III. E., Item #6, (pages 14 – 16) available at https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/400/430.pdf .

Supporting documentation must accompany the Certificate of Medical Necessity for Commercial Oral Nutritional Supplements. This documentation must demonstrate that the member meets all the required criteria and is outlined in the above referenced section of AMPM Policy 430.

- **Ongoing Requests**: Subsequent submissions for all nutritional therapies shall include a clinical note or other supporting documentation dated within three months of the original request that includes the member's overall response to the supplemental therapy and justification for continued supplement use. This shall include the member's tolerance to formula, recent hospitalizations, current height/weight percentiles, and BMI percentile if member is two years of age or older. Documentation demonstrating encouragement and assistance provided to the parent/guardian in weaning the member from supplemental nutritional feedings should be included, when appropriate.
- **Follow-up requirements** (all aged members): Members receiving nutritional therapy shall be physically assessed by the member's PCP, specialty provider or registered dietitian at least annually.
- **Metabolic Medical Foods**: The health plan covers metabolic medical foods used to treat inherited metabolic disorders (rare genetic conditions in which normal metabolic function is inhibited by a deficiency in a critical enzyme), such as metabolic formulas or modified low protein foods which are produced/manufactured specifically for persons with a qualifying metabolic disorder and are not generally used by persons without qualifying disorders. Qualifying conditions, specific requirements and limitations are detailed in AMPM Policy 310-GG, Section III., C.

Metabolic Medical Foods, available at
https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310GG.pdf

Well-Woman Preventive Care Services

Annual well-woman preventive care visits are a covered benefit for all women enrolled with AHCCCS. These visits provide regular preventive care and screening services to help promote essential healthy lifestyle habits, identify risk factors for disease and address existing medical or behavioral health concerns.

Well-Woman Preventive Care Visits Include (are not limited to):

- Physical (wellness) exam that assesses overall health
- Clinical breast exam
- Pelvic exam (as necessary per current recommendations and best standards of practice)
- Review and administration of immunizations, screenings and testing as appropriate for age and risk factors.
- Screening & counseling as part of the well-woman preventive care visit, focused on maintaining a healthy lifestyle & minimizing risks, addressing at a minimum:
    - Proper Nutrition
    - Physical Activity
    - Elevated BMI indicative of obesity
    - Tobacco/Substance Use, Abuse and/or Dependency
    - Depression Screening
    - Interpersonal & Domestic Violence Screening
      [This screening shall include counseling to elicit information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner, to address current and future safety and health concerns.]
    - Sexually Transmitted Infections
    - HIV testing, plus available counseling, and treatment if (+) results are received
- Family Planning Services & Supplies
    - Preconception Counseling w/ discussion about a wealthy lifestyle before & between pregnancies, which includes:
        - Reproductive history & sexual practices
        - Healthy weight, diet, nutrition, supplements & folic acid intake
        - Physical activity or exercise
        - Oral health care
        - Chronic disease management
        - Emotional wellness
        - Tobacco & drug use (prescription drugs, caffeine, alcohol, marijuana, etc.)
        - Recommended intervals between pregnancies
- Immunizations during Well Woman Preventive Care visits:
    - AHCCCS will cover the Human Papilloma Virus (HPV) vaccine for members, as specified in AMPM Policy 310 M.

- Adult immunizations shall be provided in accordance with AHCCCS AMPM Policy 310-M, Immunizations.
- Children (members under 19 years of age) shall be provided immunizations in accordance with AHCCCS AMPM Policy 310-M and Policy 430.
- Providers must coordinate with The Arizona Department of Health Services (ADHS) Vaccines for Children (VFC) Program in the delivery of immunization services if providing vaccinations to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) members less than 19 years of age.

Female members have direct access to preventive and well care services from a PCP or an OB/GYN within the B – UFC/ACC network without a referral.

Transportation as well as scheduling assistance for Well-Woman Preventive Care services through the B – UFC/ACC Customer Care Center at (800) 582-8686.

*Note: Genetic screening and testing is not covered except as specifically described in (AMPM Policy 310- II, Genetic Testing).

Children's System of Care

Required Documentation and Chart Elements for Specialty Providers

AHCCCS requires specific assessments and documentation for all children receiving behavioral health services. These assessments and documents are required elements for billing. **Specialty Providers contracted with B – UFC/ACC & B – UFC/ALTCS are required to meet AHCCCS requirements.**

These documentation requirements may be met in one of two ways:
- Coordination with a health home that facilitates/completes these requirements.
- The specialty provider facilitates/completes these requirements.

Minimum Requirements:

Comprehensive Behavioral Health Assessment that includes all elements in AHCCCS AMPM 320-O. • This is not a specialty SUD, ASD, or TAY assessment.	Updated at least annually or more often with life events or significant changes.
Service Plan • Goals and objectives, services and frequency linked to the Comprehensive Assessment • The Behavioral Health Provider and/or case manager oversees and facilitates the implementation of the plan.	Completed based on the decisions of the CFT. • Updated within 30 days of changes to comprehensive assessment, • Updated at least annually or more often to reflect the progress or lack of progress on goals and objectives.
Strengths, Needs, and Culture Discovery (SNCD)	Updated in conjunction with the annual comprehensive assessment or with life events or significant changes.

• Addresses Family/Living/Housing, Community Involvement, Educational/Vocational Training,	
Service Need Assessment (CALOCUS)	Completed within 45 days of enrollment and every 6 months, more often as needed.
Crisis Plan	Updated at least annually or when clinically indicated.
DUGless for AHCCCS reported Data, Social Determinants of Health Identifiers and Outcomes	Updated in the DUGless portal for new members and when their information is updated. (Reference the DUGless Portal Guide.
CFT Engagement and Documentation	The frequency of CFT meetings is individualized and scheduled in relation to the child and family's situation, preferences, and level of need.
Progress notes documenting services provided.	Progress notes should reflect the date, duration, description, and member's response to the service.

Questions? Contact us for support at: BUHPCSOC@bannerhealth.com

Identifying and Treating Eating Disorders

During the COVID-19 Pandemic, many behavioral health disorders worsened, including the **prevalence of eating disorders among adults and teens.** There are several commonly occurring comorbid disorders including anxiety, social anxiety, depression, post-traumatic stress disorder, etc. Genetics, personality traits (perfectionism, neuroticism, and impulsivity) and societal pressures are all often linked to a higher risk of developing an eating disorder. Eating disorders or relapse may be first noticed by a physician tracking weight and other health indicators. This fact lends itself to the importance for behavioral health and physical health providers to practice active integrated care.

Providers should be on the lookout for eating disorders. It can be difficult for someone dealing with an eating disorder to admit they have a problem and need treatment.

Behavioral symptoms may include:

- Dramatic weight fluctuations
- Preoccupation with weight, food, calories, fat grams, or dieting
- Complaints of constipation, cold intolerance, abdominal pain, lethargy, or excess energy
- Avoiding mealtime and eating in public
- Severely limiting and restricting food
- Dressing in layers to hide weight loss
- Refusing certain foods, denying hunger
- Expressing a need to "burn off" calories
- Repeatedly weighing oneself
- Patterns of binge eating and purging
- Rituals around food
- Excessively exercising
- Cooking meals for others without eating

Physical symptoms may include:

- Stomach cramps and GI symptoms
- Difficulty concentrating
- Atypical lab test results (anemia, low thyroid levels, low hormone levels, low potassium, low blood cell counts, slow heart rate)
- Dizziness, Fainting
- Feeling cold all the time
- Sleep irregularities
- Menstrual irregularities
- Calluses across the tops of the finger joints (a sign of inducing vomiting)
- Dry skin, thin nails, thinning hair
- Muscle weakness
- Impaired healing and immune system
- Poor immune system

There are several valid self-report screenings that may be utilized if there are questions around diagnosis or the suspicion of an eating disorder. These may be used to assist in diagnosing an eating disorder.

Best practices for treatment include a multi-disciplinary team approach and integrative health care to treat both the psychological and physical health needs. A team of mental health professionals and physical health professionals are likely to include a physician, dietician, therapist and psychiatrist. If you need assistance identifying an appropriate Eating Disorder Treatment provider for children or teens, contact BUFC Customer Service at (800) 582-8686 or refer to the Children's Specialty Behavioral Health Provider Directory. https://www.banneruhp.com/resources/child-and-family-support.

Resources

Spettigue, W., Obeid, N., Erbach, M. et al. The impact of COVID-19 on adolescents with eating disorders: a cohort study. J Eat Disord 9, 65 (2021). https://doi.org/10.1186/s40337-021-00419-3
Ptre, Alina, Seitz, Adriene. 6 Common Types of Eating Disorders (and Their Symptoms). May 18, 2022. https://www.healthline.com/nutrition/common-eating-disorders
Eating Disorder Treatment. Mayo Clinic July 14, 2017. https://www.mayoclinic.org/diseases-conditions/eating-disorders/in-depth/eating-disorder-treatment/art-20046234

Correlation between Epilepsy and Behavioral Health

The CDC reports there are more than 11,000 children in the state of Arizona with a diagnosis of Epilepsy. According to the Epilepsy Foundation website, between 25-50% of people diagnosed with epilepsy also have a behavioral health diagnosis which may include depression, anxiety, OCD, ADHD, personality disorders or psychosis. Interestingly, the relationship between Epilepsy and behavioral health is bi-directional; individuals diagnosed with Epilepsy are at a higher risk of having a behavioral health diagnosis and people with behavioral health diagnosis have a higher risk of developing epilepsy.

The Child and Family Team and behavioral health providers can have a positive impact on the health and well-being of children with co-morbid epilepsy and behavioral health disorders by

referring members to appropriate services and connecting members and families to specialty resources. Appropriate behavioral health treatment options could include, but are not limited to, cognitive behavioral therapy, psychiatric medication, skills training, family support and respite. Interventions should be tailored to help the member cope with the symptoms of the behavioral health diagnosis to improve functioning and manage social relationships.

The CDC provides in-depth information and resources for parents and caregivers, health care providers, schools and community members on their website https://www.cdc.gov/epilepsy/index.html.

The Epilepsy Foundation website has robust information about co-morbidity, behavioral health treatment options and parenting children during different stages of life https://www.epilepsy.com/parents-and-caregivers.

504 Plan to Support Students with Diabetes

Did you know that a Diabetes diagnosis can quality a child for a 504 Plan? Section 504 of the Rehabilitation Act of 1973 is a federal civil rights law that prohibits discrimination on the basis of disability. A 504 Plan identifies the actions a school will take to make sure the student with Diabetes is medically safe, has the same access to education as other children, and is treated fairly. It is a tool that can be used to make sure that students, parents/guardians and school staff understand their responsibilities and to minimize misunderstandings. School personnel and parents work together to make the plan. The Child and Family Team can play an important role in supporting the child and family during this process.

Each 504 plan should be individualized to meet the needs and abilities of the member. Potential 504 Accommodations for a child diagnosed with diabetes could include:

- Training staff to check blood glucose levels and administer insulin
- Training teachers, coaches and bus drivers to recognize signs of low/high blood sugar and respond appropriately.
- Educating staff members about the mood swings, frustration and aggression that can sometimes accompany highs and lows in blood sugar.
- Allowing the student to carry diabetes supplies and self-manage blood sugar.
- Ensuring full participation in sports, extracurricular activities and field trips.
- Permitting the student to eat meals and snacks and use the restroom when needed.

Are you working with a child who would benefit from a 504 plan? The parent or educational decision maker can contact the school directly to request a 504-determination meeting. In addition, the CFT can support the family in contacting Raising Special Kids at (800) 237-3007.

Child and Family Team (CFT) Initiatives

In collaboration with the other ACC Plans, B – UHP assisted in the development of the statewide CFT Facilitator Course. The CFT Facilitator Course consists of 5 initiatives that will be implemented at different times throughout the upcoming months. For a full description of the initiatives and timelines please refer to the Arizona Association of Health Plans (AzAHP) Workforce Development Alliance CFT Initiatives communication (https://bit.ly/3PtdoL8)

Initiative 3 is the CFT Supervisor Train the Trainer (TtT). The AzAHP Workforce Devel opment Alliance and associated health plans will collectively offer several TtT sessions that began in October 2022. These sessions are intended for previously trained CFT Champions who will be delivering the 5-hour CFT Supervisor Course in-house in their own agency. The CFT Supervisor Training course will be required for **all new** and **existing** leaders at the agency.

Supervisor TtT sessions will be approximately 3 hours long and will be delivered via virtual instructor-led training. The TtT sessions will serve as an opportunity to provide review of the content prepared and help CFT Champions to successfully deliver the CFT Supervisor course to leaders who supervise staff who facilitate CFT's.

Enrollment for CFT Supervisor TtT is now open in Relias. Complete registration for your identified CFT Champion(s). Please note that you may receive this communication from different health plans, but you are only required to register once. For any questions regarding CFT Initiatives reach out to, Jennifer Blau, Jennifer.Blau@bannerhealth.com or Sarah Donovan, Sarah.Donovan@bannerhealth.com.

Provider Services & Support

2023 Provider Satisfaction Survey

We encourage all providers contracted with Banner – University Health Plans to share your feedback by participating in our 2023 Provider Satisfaction Survey.

Available from October 20 to November 20, 2022
The purpose of this survey is to assess overall provider satisfaction and identify specific key focus areas of satisfaction with the following departments: Provider Experience/Customer Care Center, Provider Relations, Reimbursement Services, Provider Data Management, Medical Management, Contracting and Credentialing.

In addition, this survey will be used to better understand the needs of our members and the capabilities of our network. The results of the Provider Satisfaction Survey will help Banner identify key opportunities for improving the experience of our providers and our internal processes within the organization in order to make doing business with Banner easier.

2023 Provider Satisfaction Survey:
https://bannerhealth.formstack.com/forms/2023providersurvey

Trending Topics in Health care Law: Physical Access to Health care

Federal laws (such as the Americans with Disabilities Act, Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and Affordable Care Act) prohibit health programs or facilities from discriminating based on race, color, national origin, age, disability or sex. Covered health care facilities include, but are not limited to, hospitals, doctors' offices, pharmacies, dentists' offices, acupuncturists' offices, etc. According to the National Center on Birth Defects

and Developmental Disabilities, Centers for Disease Control and Prevention, approximately 64 million adults in the US live with a disability and 13.7% of them have mobility disabilities, including individuals who may use a wheelchair, a scooter, a walker, a cane or crutches or have problems getting around, walking, balancing or climbing stairs.

Providing accessible, non-discriminatory health care coverage and services for persons with disabilities is an essential part of the health care system. However, individuals with disabilities face discrimination in both health care coverage and services. Common limitations in health care that cause accessibility barriers for individuals with mobility disabilities include absence of a weight scale that accommodates wheelchairs or others who have difficulty stepping up, doorways and staircases in medical office buildings that are not wide enough to accommodate a wheelchair user, or steps and curbs that block a person with mobility impairment from entering a building or using a sidewalk.

Understanding the barriers to health care for individuals with disabilities is the first step toward removing them. There are several steps health care providers can take to promote full access for patients with disabilities. Examples may include obtaining accessible office equipment, such as height-adjustable exam tables, scales and X-ray machines, ensuring the office building complies with modern accessibility guidelines, such as having doorways wide enough for wheelchair access, appropriate ramps and elevators and accessible restrooms. For additional information please visit: https://adata.org/factsheet/accessible-health-care and https://www.ada.gov/medcare_mobility_ta/medcare_ta.htm

Disclaimer: This article is intended for educational purposes only. It is not intended to be legal advice. Providers should consult their legal counsel and/or compliance departments regarding specific questions regarding nondiscrimination laws.

Practitioner Rights

Every practitioner going through initial credentialing and recredentialing process has rights:

1. Review of information submitted to support credentialing application. In the verification process, if any discrepancies are found in the information provided by a practitioner, the credentialing specialist contacts the practitioner by phone or in writing to validate the correct information. The Credentialing Specialist must notify the practitioner if there is a substantial variation in information regarding actions on licenses, malpractice claims history and board certification. The practitioner may not review references or recommendations or other information that is peer review protected, and the credentialing department is not required to reveal the source of information if law prohibits disclosure.
2. Correct any erroneous information in their credentialing application by phone or in writing, prior to the Credentialing Committee meeting date. The practitioner is also notified by email or phone of the deadline for submitting the corrections. The notification includes the following:
    - Erroneous information must be corrected within seven business days
    - Submission of corrections must be in the correct format
    - Corrections must be submitted to the credentialing specialist
    - Receipt of the corrections is documented
3. Receives the status of their credentialing or recredentialing application

4. Receives notification of these rights

Model of Care – Annual Training and Attestation

IMPORTANT REMINDER

If you have not completed and submitted your required annual attestation for this year, please do so as you only have until Dec. 31, 2022, to remain compliant with this requirement.

Contracted providers, Subcontractors, and Non-participating providers with **Banner Medicare Advantage Dual** are required to complete the **Model of Care Annual Training and submit the Attestation**.

Instructions:

1. Review the training content located here: https://www.banneruhp.com/resources/provider-trainings
   - Select Model of Care Training to access the required training and attestation.
2. Complete the 2022 *Annual Attestation*: https://bannerhealth.formstack.com/forms/moc_attestations
3. When completing your online attestation, please ensure you are documenting each provider's individual NPI on the attestation form.

Skilled Nursing Facility (SNF) and Behavioral Health Residential Facility (BHRF) Audit Announcement

B – UHP is working with other health plans to visit the long-term care sites (LTCs). This is to ensure that our members continue to receive the quality care they need in a safe environment.

B – UHP has prioritized SNF audits due to the higher level of care our members receive in these settings. The audit will be onsite and will focus on a comprehensive review of resident medical records. The SNF audit will occur from November to December 2022. From January to March 2023, B – UHP will audit BHRFs. This will be a multi-tiered audit that will include medical record and staff qualification reviews as well as a health and safety check. Please respond to audit notices in a timely manner due to the timeframes noted above. It is helpful to have staff available to set up the audit, provide access to medical records, and answer questions.

Thank you for helping our members get the quality care they deserve.

Claims Updates

Provider Data Reminder

It is important that you keep your AHCCCS Provider Registration data current and complete.

Missing data in your Provider Registration Files can result in denial or recoupment of claims (i.e. ensuring you have all applicable optional COS for your provider type; ensuring that you have all applicable licenses updated, etc.).

AHCCCS provides several options to update/maintain registration data – visit the AHCCCS Provider Enrollment Portal (azahcccs.gov) – www.azahcccs.gov/PlansProviders/NewProviders/APEP.html

Email & Fax Options – fax and email address to specifically send paper-related documents (e.g. paper provider enrollment application, etc.) – Fax: (602) 256-1474; Email PRNotice@azahcccs.gov

Reminders of Upcoming AHCCCS Changes

Referring, Ordering, Prescribing, and Attending (ROPA) Providers Required to Register with AHCCCS – ROPA – www.azahcccs.gov/PlansProviders/NewProviders/ROPA.html

Participating Provider Reporting Requirements

Effective for dates of service on or after June 1, 2022, submitted on and after Jan. 1, 2023

Participating Provider Reporting Requirements will also apply to the following provider types and claim forms. To retain information related to the actual professional practitioner that is participating in or performing services with the clinic visit, this information must be reported on the claim.

Claim Form Types:

CMS 1500 claim form, Field 19 Field Title: Additional Claim Information and ADA claim form, Field 35 Field Title: Remarks

Provider Types: 05 – Clinic; 77 – Outpatient Behavioral Health Clinic; IC – Integrated Clinic

Denial Edit – "NPI Missing or Invalid" will append to the claim if the participating provider information is not entered or is in the incorrect format.

AHCCCS Fee Schedule Updates effective Oct.1, 2022 – Final changes and validation in progress, release of pended claims with dates of service Oct. 1 and after impacted by these changes began last week.

EVV – reminder that claims will be edited for correct application of EVV requirements effective Jan.1, 2023 dates of service and failures to correctly apply these requirements may result in denial of claims.

Compliance Corner

Exclusions Program, Screening and Reporting Obligations

Banner – University Health Plans and Banner Medicare Advantage Plans require its First Tier, Downstream and Related Entities (FDRs), Providers and Administrative Contractors to screen all employees and downstream entities prior to hire/contract and on a monthly basis. All Providers are required to notify the Banner Medicaid and Medicare Plans Compliance Department upon confirmation that an employee or contractor is excluded from any of the data bases listed below. They are also required to inform the Compliance Department if any of their subcontractors who

do business for Banner Medicaid and Medicare Plans has identified an excluded employee or contractor. It is the obligation of the Provider to notify the Compliance Department immediately upon discovery. The methods to notify the Compliance Department are listed below.

Office of Inspector General (OIG) Exclusions Program
The OIG has the authority to exclude both individuals and entities from Federally funded health care programs including Medicare and Medicaid. They could be excluded due to a number of reasons including a conviction for fraud. Any entity or individual who is excluded is prohibited from receiving payment from Federal healthcare programs for any items or services they provide, order, or prescribe.

The list of excluded individuals and entities maintained by the OIG is called the List of Excluded Individuals/Entities (LEIE). The online searchable data base can be located at: https://exclusions.oig.hhs.gov/

Any Provider who hires an individual or entity on the LEIE list may be subject to civil monetary penalties (CMP). In order to avoid this probability of receiving CMP, it is important to routinely check the list prior to hire or contract and then monthly thereafter. If the Provider uses a vendor to do this service, it would be wise to ensure appropriate contract language to protect the Provider in the event a CMP is imposed due to the failure of the vendor.

System for Award Management
The System for Award Management (SAM) contains a list of debarred individuals or entities by any Federal agency. The persons and entities listed as excluded are for a specified term as determined by the debarring agency and as indicated by the listing.

The link to check the SAM is:
https://sam.gov/search/?index=ex&sort=-relevance&page=1&pageSize=25&sfm%5BsimpleSearch%5D%5BkeywordRadio%5D=ALL&sfm%5Bstatus%5D%5Bis_active%5D=true
Both the OIG and the SAM should be utilized to check individuals and entities prior to hire or contract and monthly thereafter.

Both AHCCCS and CMS include exclusion screenings in their requirements. In addition, according to the B – UHP Contracts with Arizona Medicaid, notification must be provided to the Insurance Division Compliance Department if any individual or entity is determined excluded from any State Medicaid, not just Arizona.

In addition, for Medicare Advantage Plans, CMS made the first Preclusion List available to plans Jan. 1, 2019, and they are issued monthly thereafter.

The preclusion list is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

Plans are required to:

- To reject a pharmacy claim (or deny an enrollee's request for reimbursement)
- For a Part D drug that is prescribed by an individual on the Preclusion List.
- To deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

If you identify or suspect FWA or non-compliance issues, immediately notify the Banner Insurance Division Compliance Department:

24- hour hotline (confidential and anonymous reporting): (888) 747-7989

Email: BHPCompliance@BannerHealth.com

Secure Fax: (520) 874-7072

Compliance Department Mail:
Banner Medicaid and Medicare Health Plans Compliance Department
2701 E Elvira Rd
Tucson, AZ 85756

Contact the Medicaid Compliance Officer Terri Dorazio via phone (520) 874-2847 (office) or (520) 548-7862 (cell) or email Theresa.Dorazio@BannerHealth.com

Contact the Medicare Compliance Officer Adam Barker via phone (602) 747-8452 or email : BMAComplianceOfficer@BannerHealth.com

Customer Care Center Contact Information
B – UHP Customer Care Center
Banner – University Family Care/ACC (800) 582-8686
Banner – University Family Care/ALTCS (833) 318-4146
Banner – Medicare Advantage Dual HMO D-SNP (877) 874-3930

Banner Medicare Advantage Customer Care Center
Banner Medicare Advantage Prime HMO (844) 549-1857
Banner Medicare Advantage Plus PPO (844) 549-1859
Banner Medicare RX PDP (844) 549-1859

AHCCCS Office of the Inspector General
Providers are required to report any suspected FWA directly to AHCCCS OIG:

Provider Fraud

- In Arizona: (602)417-4045
- Toll Free Outside of Arizona Only: (888) ITS-NOT-OK or (888) 487-6686

Website: www.azahcccs.gov (select Fraud Prevention)

Mail:
Inspector General
801 E Jefferson St.
MD 4500
Phoenix, AZ 85034

Member Fraud

- In Arizona: (602) 417-4193
- Toll Free Outside of Arizona Only: (888) ITS-NOT-OK or (888) 487-6686

Medicare
Providers are required to report all suspected fraud, waste, and abuse to the Banner Medicare Health Plans Compliance Department or to Medicare
Phone: (800) HHS-TIPS or (800) 447-8477
FAX: (800) 223-8164
Mail:
US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

Banner
Medicare Advantage

Banner Medicare Advantage (D-SNP, PRIME HMO, PLUS PPO)
2701 E. Elvira Road, Tucson, Arizona 85756
520-874-5390 •Fax (520) 777-9878

CMS HEDIS FAX TRANSMISSION SHEET

Dear Office Manager:

Banner Medicare Advantage (D-SNP HMO, PRIME HMO, PLUS PPO) is conducting an audit as required by the Centers for Medicare and Medicaid Services (CMS). One or more members assigned to your care have been selected for the CMS HEDIS audit. Please refer to the next page for the requested records and members.

Please fax the requested records to Kathleen Shooshtari at Fax Number: **(520) 777-9878** or send by Secure Email: **kathleen.shooshtari@bannerhealth.com.**

Response is required within **10 business days** as per Banner Health Plans Provider Agreement.

If mailing the request, please address the envelope to:

Banner Medicare Advantage
Attention: Kathleen Shooshtari, Clinical Performance Improvement
2701 E. Elvira Road
Tucson, AZ 85756

Please return ALL requests. Please add a comment to the request sheet if:

- The member is not your patient
- You do not have the requested information

If your medical record requests are processed by a vendor, please let them know the importance of sending the records to us within the contracted time frame at no cost. We are not able to contact vendors directly.

- **ATTENTION SHARECARE PLEASE SEND RECORDS TO OUR ONLINE PORTAL: BUHP5-85756-7121**
- **ATTENTION CIOX PLEASE SEND RECORDS TO OUR ONLINE PORTAL: 1662791**

We are Banner Medicare Advantage, the health plan for these members. As per 45 CFR 164.501, the information requested is intended for Health Care Operations, and therefore, no health insurance release form is necessary. If you have any questions or concerns, please contact Kathleen Shooshtari at the number or email below.

Thank you very much for your cooperation,

Kathleen Shooshtari

Kathleen Shooshtari

HP Project Coordinator Sr.
Clinical Performance Improvement Department
Banner Medicare Advantage
Email: kathleen.shooshtari@bannerhealth.com
Phone: 520-874-5390
Fax: 520-777-9878

Banner
Medicare Advantage

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