Banner
University Health Plans

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March 2022 Provider Update

Changing Prior Authorization Process (eviCore)

We want to let you know that prior authorization processes will be changing for some of your patients. Banner Health has contracted with eviCore healthcare to provide services for members enrolled in Banner - University Family Care/AHCCCS Complete Care and Banner – University Family Care/ALTCS along with those in Banner Medicare Plans: Prime, Plus and Dual.

Effective Apr. 1, 2022, providers of members on these plans will require prior authorization from eviCore for select services for dates of service beginning Apr. 1, 2022. We encourage you to review the details below to submit requests in a timely manner prior to the deadline. As a reminder, services performed without authorization may not be reimbursed for the services listed below, and you may not seek reimbursement from members. Please see a full list of CPT codes requiring prior authorization at https://www.evicore.com/resources.

Choose the **health plan**, **solution resources tab**, **program** and **CPT list**.

Authorization is required for:

- Advanced Imaging
- Nuclear Medicine
- Cardiac Imaging
- Medical Oncology
- Radiation Therapy
- MSK-Therapies (PT/OT)
- MSK-Pain/Joint/Surgery

Services performed in conjunction with an inpatient stay, 23-hour observation or emergency room visit are not subject to authorization requirements.

To request authorization:
• Log onto www.evicore.com **(preferred)**
• Call: 888-444-9261
• Fax: 888-863-3210

For urgent requests: If services are required in less than 48 hours due to medically urgent conditions, please submit a request online at www.evicore.com and indicate that the procedure is NOT routine/standard. Providers can also call the toll-free number at 888-444-9261. Be sure to tell the representative that the request is for medically urgent care.

We recommend that ordering physicians request authorization and pass the approval information to the rendering facilities at the time of scheduling. Authorizations contain approval numbers and one or more CPT codes specific to the services authorized. If the service requested is different than what was initially authorized, the rendering facility must contact eviCore to make revisions and authorization prior to claim submission.

Have questions about requesting authorizations? Attend one of our online training sessions – detailed information below.

eviCore healthcare's Clinical Guidelines and request forms are available at: www.evicore.com. Please call the Client and Provider Services department at 800-646-0418 (option 4) if you have any questions or need more information.

Prior Authorization (eviCore) – Orientation Session Invitation

Banner Health Providers: Beginning Apr. 1, eviCore healthcare will provide utilization management for Banner - University Family Care/AHCCCS Complete Care and Banner – University Family Care/ALTCS members and Banner Medicare Advantage plans Prime, Plus and Dual. The programs will begin accepting authorization requests on Apr. 1, 2022, and forward.

In the coming weeks, eviCore healthcare will be leading orientation sessions designed to assist you and your staff with the new utilization management programs. You will be able to attend the web orientation session that works best for you and your schedule. You can review the provider resource site for supporting documentation to assist with the utilization management process at https://www.evicore.com/resources/healthplan/banner-health. The website will be updated with more information before Apr. 1, 2022.

During these sessions we will discuss in detail the prior authorization requirements for Radiology, Cardiology, Medical Oncology, Radiation Therapy, MSK – Pain/Spine/Joint/PT/OT services and how to navigate the eviCore website at www.evicore.com. Time and participation permitting, the training sessions will be followed by a question-and-answer session. We encourage you to attend one of these informative sessions to ensure your understanding of the prior authorization process for these services.

Registration

All online orientation sessions require advance registration. Each online orientation session is free of charge and will last approximately one hour. Please choose from the following session program specific training webinars:

Session Names: Banner Health Radiology/Cardiology Provider Orientation
Banner Health Radiation Therapy Provider Orientation
Banner Health Medical Oncology Provider Orientation
Banner Health Physical and Occupation Therapy Provider Orientation
Banner Health MSK-Pain/Joint/Spine Provider Orientation

How To Register

Please read the following instructions to register for and participate in a session:

1. Please go to evicore.webex.com
2. Select **Webex Training** below the **Sign in** button.

3. Click the **Upcoming** Tab. Choose Program name from list above- **See above program specific session name**
4. Click **Register** next to the session you wish to attend.
5. Enter the registration information.

After you have registered for a training session, you will receive an e-mail containing the toll-free phone number and meeting number, password, and a link to the web portion of the session. **Please keep the registration e-mail so you will have the link to the Web conference and the call-in number for the session in which you will be participating.**

If you are unable to participate in a session, you can view the presentation on the Banner Health Resources page located on eviCore.com or by using this URL https://www.evicore.com/resources/healthplan/banner-health.

If you have any questions regarding the eviCore web portal, please contact the Web Support team via email at portal.support@evicore.com or via phone at 800-646-0418 (Option 2). For any Client or Provider inquiries not associated with this training, please email ClientServices@evicore.com.

Plan Materials Available on Website

Banner Medicare Advantage plan materials for 2022 are now available on our website at :https://www.bannerhealth.com/medicare/our-plans

On our website, you can find plan materials for:

- Banner Medicare Advantage Prime HMO
- Banner Medicare Advantage Plus PPO
- Banner Medicare Advantage Dual HMO D-SNP (formerly known as Banner-University Care Advantage)
- Banner Medicare Rx Prescription Drug Plans

Materials include the Annual Notice of Changes, Evidence of Coverage, Summary of Benefits, Drug Formulary, and Provider and Pharmacy Directories.

Please make note of these important plan materials.

Important Note:
Federal law prohibits Medicare providers from charging individuals in the Qualified Medicare Beneficiary (QMB) program for Medicare cost sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copayments for any Medicare-covered items and services.

Changing Primary Care Providers (PCP)

Members have the right to select a new PCP at any time. They can contact the Customer Care Call Center and a Representative will be able to assist with their request. Our Representatives will ask the member if they have already scheduled an appointment with the PCP of their choice, this is to ensure a provider is able to accommodate a member's timely

request for an appointment. A Representative will also verify if the PCP has the proper panels in place to make the requested change.

- If there is a closed panel – We will verify with the provider's office representative that it is acceptable to add a member to their respective panel.
- No panel listed for provider - We will notify the member. If a provider believes this is incorrect information, they can update their information by clicking on the following link https://www.banneruhp.com/materials-and-services/provider-data-update-form

How can you verify PCP assignments?
Providers can always verify a member's PCP assignment by visiting eServices, https://eservices.uph.org

For more information about eServices, contact your Care Transformation Specialist.

Customer Care
Banner – University Family Care ACC Phone: 800-582-8686
Banner – University Family Care ATLCS Phone: 833-318-4146
Banner Medicare Advantage Dual Phone: 877-874-3930

COVID Antiviral Update

Given the increasing supply of oral antivirals for Arizona, as well as the ability of pharmacy partners to meet demand with allotted supply, **ADHS has approved moving into Tier 3 of the Antiviral Prioritization Criteria**. (link: https://azdhs.gov/covid19/documents/antivirals/antivirals-prioritization-criteria.pdf)
Per the Vaccine and Antiviral Advisory Committee (VAPAC) meeting recommendations approved on January 7, 2022:
Tier 1 eligible patients include:

- Patients 70 years of age or older.
- OR who have major immune suppression (i.e., HIV, severe primary immunodeficiency, cancer and/or transplant patients, or patients on chronic steroids or other immunosuppressive drugs)

Tier 2 eligible patients include:

- Tier 1 and patients 50 years of age or older with one or more CDC high risk conditions for COVID-19 disease progression. **The CDC has updated their list of medical conditions associated with higher risk for severe COVID-19. Please visit their website for more information on current evidence for higher risk conditions: CDC High Risk Health Conditions.** https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

Tier 3 expands use for all eligible patients within the general population.
Oral antiviral medications have been shown to decrease severity of disease in high- risk patients to help avoid hospitalization or death due to severe COVID-19 and have also been shown to be effective against the Omicron variant.

Prioritization Criteria: https://azdhs.gov/covid19/documents/antivirals/antivirals-prioritization-criteria.pdf
Pharmacy locator (English): https://www.azdhs.gov/covid19/index.php#antivirals
Pharmacy locator (Spanish): https://www.azdhs.gov/covid19/es/index.php#antivirals

Eligible patients should be started on these antivirals as soon as possible after confirmed diagnosis of COVID-19 AND **within 5 days of symptom onset**. Prescribers are responsible for determining patient eligibility as outlined in the Emergency Use Authorizations (EUAs) and Health Care Provider Fact Sheets prior to issuing prescriptions for either of these products. There are many clinical considerations including potential drug interactions, reproductive concerns, and dosage adjustments associated with these therapies.

Health care providers and patients can call 211 or the Arizona Poison Control Systems COVID-19 Hotline (844-542-8201) for locations of pharmacies that were allocated federal supply of these medications nearest them, or visit the ADHS Antivirals for COVID-19 website (https://www.azdhs.gov/covid19/index.php#antivirals) and locate a map for treatment locations (https://www.azdhs.gov/covid19/index.php#find-treatment).
For additional questions, email the ADHS COVID-19 Therapeutics Team at therapies@azdhs.gov.

CY2022 Behavioral Health and Integrated Care Medical Record Review Audit Notification

During the pandemic, required audits of medical records were postponed for the last two years. These audits have been reinstated by AHCCCS for calendar year 2022 (CY2022). All health plans utilize a collaborative and transparent audit process in conjunction with the Arizona Association of Health Plans (AzAHP), which results in only one medical record review being completed by an assigned health plan and lessens provider burden. These audits are conducted under the AHCCCS ACC and RBHA contracts, which states that all health plans are required per AHCCCS Medical Policy Manual (AMPM) Chapter 900, Policy 910, Attachment 910A and Policy 940 to monitor contracted behavioral health outpatient clinics that conduct behavioral health intakes for members on an annual basis per contract fiscal year (Oct. 1 – Sept 30). If Banner University Health Plans is assigned to your organization for this specific audit, BUHP will contact you to coordinate the Remote Medical Record Review. You will receive an audit notification email with the following information:

- Start and end date of the audit (notification will be sent at least two weeks in advance of start date)
- Audit review period (will be one year back from the date the notification is sent)
- Sample and Over Sample List if applicable
- AHCCCS Audit Tools & Operational Definitions applicable to the Audit Sample
- Contact information of your assigned Quality Audit Analyst
- Instructions for providing EHR log on information to the assigned auditor or instructions for uploading medical records to a Banner One Drive account.
- Exit interview information

Please note that the CY2022 audit will be a baseline review and no formal corrective actions will be administered by the assigned health plan. Technical assistance during the exit interview will be provided in reference to any of the individual standards on the audit tool(s) that did not meet the minimum performance standard (MPS) of 85%. The audit will take approximately one week and will be conducted remotely. If you were contacted for an audit, please have your quality management department prepared by having allocated staff to assist with setting up remote chart access as well as a contact person available to answer questions during the audit. We

appreciate your readiness to work with us in advance so this process can go smoothly. The BUHP Quality Audit Team looks forward to working with you to complete this audit.

Cultural Competency: How can health care providers overcome language barriers?

Providers are expected to deliver high-quality health care while also maintaining the patient's rights and promoting health equity. When a provider and an individual experience a language barrier, it can lead to concerns with the quality of care they receive, further leading to potential unequal treatment and negative clinical outcomes. Additionally, these language barriers can lead to higher levels of dissatisfaction and potential concerns with patient safety. It is critical that providers develop and implement strategies to not only identify language barriers but also develop strategies to overcome the identified language barriers.

An individual's access to equitable health care including preferred language, can increase understanding and compliance with treatment plans leading to more positive clinical outcomes and increased satisfaction. We encourage providers to develop language plans and strategies with their staff to help overcome communication barriers.

As a reminder, per the AHCCCS Contractor Operations Manual, Chapter 400, Policy 405:

- Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may have limited English proficiency (LEP) and be eligible to receive language assistance for a particular type of service, benefit, or encountered as specified in 42 CFR 457.1207, 42 CFR 438.10.
- Individuals should have access to oral interpretation, translation, sign language, disability-related services, and provide auxiliary aids and alternative formats upon request, and at no cost.
- Translation and interpretation services need to be accurate, timely, and protect the privacy and independence of the individual with LEP.
- Translation and interpretation services shall be provided by a qualified interpreter/translator.
- Individuals are permitted to use an adult accompanying the individual with LEP for translation and/or interpretation 1) in an emergency when there is no qualified interpreter immediately available or 2) when the individual with LEP requests the accompanying adult to interpret or facilitate the communication, the accompanying adult agrees to provide the communication assistance, and reliance on the accompanying adult is reasonable under the circumstances. Individuals are not permitted to rely on a minor child for translation and/or interpretation except in an emergency when there is no qualified interpreter immediately available.
    - All written materials for individuals shall be translated into Spanish regardless of whether materials are vital.
- Written materials that are critical to obtain services (vital materials) shall be made available in the prevalent non-English language spoken for each LEP population as per 42 CFR 438.10(d)(3). Oral interpretation services shall not substitute for written translation of vital materials.
- Oral interpretation services are available at no cost, including sign language and all non-English languages.

- Providers shall utilize licensed interpreters for the Deaf and Hard of Hearing
- Providers shall provide auxiliary aids or licensed sign language interpreters that meet the needs of the individual upon request (including, but not limited to computer-aided transcriptions, written materials, assistive listening devices, closed/open captioning. Refer to the Arizona Commission for the Deaf and Hard of Hearing for complete listing and rules/regulations for the State of Arizona.

BUHP provides interpretive and translation services for its members, including written materials in alternative formats to meet member needs. If you have a member who needs the following services, please contact the Customer Care Center.

References:

- CMS brochure: *How Healthcare Providers Meet Patient Language Needs: Highlights of a Medscape Provider Survey* (link: https://go.cms.gov/3J5uJWE)
- Oman Medical Journal: *Implications of Language Barriers for Healthcare: A Systemic Review* (link: https://bit.ly/3vXXalW)
- AHCCCS Contractor Operations Manual, Cultural Competency Policy (link: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/405.pdf

Behavioral Health Best Practice Guidelines

Best practice guidelines provide research-based knowledge that is intended to work in collaboration with clinical guidelines and service delivery. Best practice guidelines enhance service delivery by ensuring member focused treatment while helping to bridge evidence-based clinical practice research with individualized treatment planning. B-UHP best practice guidelines support in identifying, collecting, evaluating and implementing practices that aid in service delivery that supports member-centered interventions and desired outcomes.

BUHP adopted the following best practice guidelines for our provider network to promote achievement of member's desired outcomes in their treatment. These can be found on our Banner University Health Plans provider website:www.banneruhp.com/resources/clinical-practice-guidelines.

1. American Psychiatric Association: Assessment of Adults
2. AACAP Practice Parameters: Reactive Attachment Disorder and Disinhibited Social Engagement Disorder
3. Veterans Administration (VA)/Department of Defense (DoD) Clinical Practice Guidelines for Major Depressive Disorder
4. American Psychological Association: Guidelines for PTSD
5. American Psychological Association: Guidelines for Depression for Youth and Adults
6. American Psychiatric Association: Psychopharmacologic treatment of Patients with Alcohol Use Disorder
7. American Psychiatric Association: Antipsychotic Use to Treat Agitation or Psychosis in Patients with Dementia

Behavioral Health Guidelines: https://www.banneruhp.com/resources/clinical-practice-guidelines.

Lab Monitoring Requirements

Monitoring members on psychotropic medications is important. BUHP has laboratory monitoring requirements for these members. A flyer that describes these requirements can be accessed through this link: (https://bit.ly/3t0cM6t) and a hard copy follows at the end of this newsletter for your reference.

For members on antipsychotic medications, there are minimum monitoring requirements that focus on screening for diabetes and other metabolic issues including completion of the following:

- Comprehensive metabolic panel, lipids, fasting glucose and CBC: On initiation and at least annually
- AIMS: On initiation and at least every 6 months
- Abdominal Girth: On initiative and at least every 6 months
- Weight/BMI: On initiative and at least every 6 months
- HR/BP: On initiative and at least every 6 months

Office of Individual and Family Affairs (OIFA)

Committee and Council Recruitment

Banner University Health Plans (BUHP) is committed to engaging members and their families in conversations regarding health policy, access to care, and system improvements. To demonstrate our continued commitment to a member-centric culture, we are always working toward increasing our member and family representation on the following BUHP committees and councils: Member and Family Advisory Council (MAC), Governance Committee, Neighborhood Community Advisory Council (CAC) and three of our BUHP Health Plan Committees: Cultural Competency Committee, Complete Care Oversight Committee, and Grievance and Appeals Committee. We are also looking to increase youth voices on the Neighborhood Community Advisory Councils (CAC).

Committee and Council participation is a way to further bring our members, peers, family members, providers and community partners together to discuss issues impacting care while collaboratively building local solutions. Additionally, this is also a way to ensure that member and family voices are heard at every level of BUHP's organization and leadership.

Below are links to our Committee and Council Application and Attachments:

Member Advocacy and Advisory Council Application: https://bit.ly/34vWyZe and https://bit.ly/3hXNwHz **Member Council Descriptions Attachment:** https://bit.ly/3pVDn2p and https://bit.ly/3pWJvHL **Library Resources Attachment:** https://bit.ly/36dwP8E.

You can also find this information on our website at www.bannerufc.com/acc. Just click on **Plan Information** then click on **Office of Individual and Family Affairs (OIFA)** and scroll down to **Join a Council**. You can download a committee application (PDF) from this page, have the interested individual fill out the form, save it and email it to the Office of Individual and Family Affairs at: OIFATeam@bannerhealth.com.

If you would like OIFA to speak at an agency Advisory Council regarding this opportunity or if you have additional questions on how to connect your BUHP members and family members to

one of our councils or committees, please contact BUHP OIFA through our general mailbox: OIFATeam@bannerhealth.com.

AHCCCS – Division of Health Care Management

Differential Adjusted Payment (DAP)

AHCCCS intends to offer a Differential Adjusted Payment (DAP) opportunity for providers who send their employment staff, or other staff that provide employment services, to an ACRE-approved (Association of Community Rehabilitation Educators) Job Developer training and receive the Certificate of Achievement. To receive a 2.0% DAP increase for employment staff training, providers must complete and return the AHCCCS attestation (link: https://bit.ly/3vWKUSo) by May 31, 2022. Qualified providers may receive an increased percentage to their current rate for employment services during the period of Oct. 1, 2022 – Sep. 30, 2023.

More detailed information can be found on the AHCCCS website (link: https://bit.ly/3CuJgsy).

Please note – Funding for DAP rate increases is subject to the appropriation of State funds and State budget constraints. Federal funding for DAP rate increases is contingent upon federal approval. All decisions or considerations included in this notice are therefore subject to the availability of funds and federal approval.

Electronic Visit Verification (EVV)

Banner University Health Plan would like to share a notice sent by AHCCCS regarding Electronic Visit Verification (EVV). If you have any questions or need additional support, please contact your Care Transformation Specialist.

AHCCCS intends to offer a Differential Adjusted Payment (DAP) opportunity for providers who are subject to EVV. HCBS providers that participate in EVV will qualify for a DAP increase of 1.0% if the provider has logged at least one visit in the EVV system for at least 80% of its members from Jan. 1, 2021 to Mar. 31, 2022. Qualified providers may receive an increased percentage to their current rate for services subject to EVV during the period of Oct. 1, 2022- to Sep. 30, 2023.

More detailed information can be found on the AHCCCS website (https://bit.ly/35S3gJE)

Please note – Funding for DAP rate increases is subject to the appropriation of State funds and State budget constraints. Federal funding for DAP rate increases is contingent upon federal approval. All decisions or considerations included in this notice are therefore subject to the availability of funds and federal approval.

AHCCCS has created a Constant Contact email notification list to communicate updates on recent developments for initiatives such as the EVV initiative. AHCCCS encourages anyone (members, families, advocates, service providers, etc.) interested in the EVV initiative, such as outreach and training information, to sign up to receive communication directly from AHCCCS. To subscribe, visit the sign-up site (link: https://bit.ly/37mJXsz).

Children's System of Care

Meet Me Where I am (MMWIA)

Meet Me Where I Am (**MMWIA**) is a designation for programs that provide intensive Support and Rehabilitation Services to children in the behavioral health system. These services align with the Arizona Vision - 12 Principles and are sometimes called Direct Support Services, Community-Based Support Services or Wraparound Services.

In 2007, the statewide MMWIA campaign was developed for three purposes:

- Increase the quality and quantity of support, rehabilitation, and case management services available to families across Arizona.
- Ensure the services provided meet the needs and preferences of the families.
- Provide intensive community-based services to help keep children living in their home environment or return to a community-based living arrangement.

MMWIA services are provided in the home, school and community for a frequency and duration that best meets the needs of the member and family. Providers utilize a foundation of Positive Behavioral Intervention Support (PBIS), formerly PBS, in their work with members. MMWIA services are intensive, flexible, and individualized; this sometimes requires multiple provider agencies to collaborate to meet the needs of a single member. MMWIA programs are designed to support children with complex needs who may fit into one or more of the following categories:

- Involved with multiple state agencies
- Have lost or are at risk of losing a placement
- Are living out of home
- Experience severe behavioral health symptoms
- Experience significant behavioral disruption
- Have caregivers with behavioral issues
- Have experienced severe trauma
- Have re-occurring crisis episodes
- Have severe difficulty with transitions
- Have difficulty dealing with loss
- Display behaviors that could result in justice involvement
- Are potential safety risks
- Have a developmental disability or co-occurring medical issues
- Are transitioning to the adult behavioral health system

If you are working with a member that would benefit from Support and Rehabilitation Services or MMWIA services and need to identify a provider, refer to the Children's Specialty Behavioral Health Provider Directory https://www.banneruhp.com/resources/child-and-family-support.

If you have questions about the MMWIA campaign or would like to learn more about developing a MMWIA program refer to the MMWIA website, MMWIA.com or contact our Customer Care Center and ask to speak with the Children's System of Care Program Coordinator.

Adolescent Substance Use Treatment

Adolescence is a critical period with specific health and developmental needs that require nurturing and support due to an increased potential for substance use disorders (SUDs) and/or mental health concerns. Substance use can have long-lasting effects on an adolescent's developing brain and may interfere with positive relationships and school performance. Identification of risk factors such as parental substance use, poverty, trauma, parental mental illness, and family discord can help providers connect youth with prevention services and

adequate supports early on. When working with youth using or misusing substances, consider the following principles:

1. Adolescent substance use needs to be identified and addressed as soon as possible.
2. Adolescents may benefit from substance use interventions even if they are not addicted to a drug.
3. Routine annual medical visits are an opportunity to screen for adolescent substance use.
    - Refer to the PCP Screening and Assessment Tools for Behavioral Health found on the B – UHP website for a list of screening tools.

4. Education and/or testing for diseases that are transmitted sexually as well as through the blood due to increased risk.
    - Substance use disorder treatment should be tailored to the unique needs of the adolescent and family.
        - Evidence-based treatment may include behavioral approaches, family-based approaches, addiction medications and recovery support services.
    - Treatment should address the needs of the whole person, rather than just focusing on the substance use.
5. Coordination between providers is extremely important, especially when comorbidities are present and drug interaction is a concern.
6. Families and the community are important aspects of treatment and the adolescent's sustained recovery.
7. Effectively treating substance use disorders in adolescents requires also identifying and addressing any other mental health conditions and/or trauma they may have.
8. It is important to monitor drug use during treatment, identify triggers associated with relapse, and adjust the treatment plan as needed.
9. Staying in treatment for an adequate period and continuity of care after SUD treatment completion are important to continued recovery.

Resources:

2. https://nida.nih.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/evidence-based-approaches-to-treating-adolescent-substance-use-disorders
3. https://ncsacw.samhsa.gov/files/working-with-adolescents.pdf
4. https://www.banneruhp.com/materials-and-services/behavioral-health

Provider Services & Support

Q2 Provider Satisfaction Provider Survey

We invite our Banner – University Family Care contracted providers to share your feedback with us by participating in our Q2 2022 Provider Satisfaction Survey. The survey will be available through March 31, 2022, via the link below: https://www.banneruhp.com/resources/notifications/02282022-2022-provider-survey.

Notify the Health Plan Data Department of any updates to the information below:

According to provider standards and responsibilities, providers must notify plan with any changes to:

3. Provider and Provider Group Adds

4. Provider or Group Location demographic updates (except terms)
5. Provider Panel Changes
6. Telephone numbers
7. Provider (Group) Term

This notification should occur within 30 days of any of the above changes. Please send all updates and changes via the online Provider Update Form located at https://www.banneruhp.com/materials-and-services/provider-data-update-form or you may email to BUHPDataTeam@bannerhealth.com.

Member Rosters
To access member enrollment information and obtain member rosters, please visit https://eservices.uph.org/. For more information about eServices, contact the Provider Experience Center.

Access to Timely Care
The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey asks patients to report on and evaluate their experiences with health care and their provider. One important component focuses on getting appointments and care quickly. AHCCCS also has a set of required appointment standards. Ensuring your office meets these standards increases the patients positive experience with your office and healthcare. Ease of getting needed care impacts overall health care quality for our members.

BUHP has made a commitment to meet appointment availability standards as set forth by AHCCCS, Medicare and community standards; Chart of standards follows the end of this newsletter.

In accordance with AHCCCS and Medicare standards, appointment standards/wait time audits are conducted regularly to ensure members have timely access to care. Should providers not meet appointment or wait time standards, a Corrective Action Plan will be issued.

Note: BUHP utilizes a contracted vendor (Contact One) to conduct appointment availability surveys on a quarterly basis. Please share the appointment standards below with your staff. You may designate a representative in your office to complete the quarterly appointment availability survey with Contact One to alleviate confusion. If you have any questions on implementing this in your office, please reach out to your Care Transformation Specialist or Consultant.

Provider Manuals: All Banner University Health Plans provider manuals can be accessed on the Health Plans website: https://www.banneruhp.com. A printed copy of the Provider Manual(s) will be made available at no charge upon request, please contact your Care Transformation Specialist or Consultant.

Compliance Corner

False Claims Act Overview 31 U.S.C. § § 3729-3733

The False Claims Act (FCA) is the primary weapon used to address fraud against government agencies. The civil law enforcement action allows for recovery of damages and penalties. A person or person(s) found guilty can also be criminally prosecuted and may be punishable by incarceration, federal and/or state program exclusion and/or monetary fines.

The FCA prohibits knowingly presenting a false claim or knowingly making a false record or statement material to a false claim. It also includes reverse false claims which include retaining overpayments that the entity is not entitled to keep and should return.

Damages/Penalties

- Three times the amount the government paid for the fraudulent claims
- Penalties of $12,537 to $25,076 per claim (these figures are adjusted for inflation)

Some examples of FCA violations include:

- Billing for services or supplies that were not provided Misrepresenting services actually provided such as assigning a code for a more complicated procedure (upcoding)Dividing a procedure or service typically billed as one procedure into multiple parts (unbundling) Duplicate billing for services rendered Falsely certifying that services were medically necessary
- Providing services outside the scope of licensure

The FCA includes a qui tam provision that allows private citizens, "whistleblowers," to file lawsuits on behalf of the government (the government can opt to pursue the case). The whistleblowers may be entitled to share in up to 30% of the settlement. The FCA also contains language that protects a whistleblower from any retaliation by their employer.

The State of Arizona has not adopted a separate False Claims Act or statutes that have qui tam or whistleblower provisions. However, Arizona has a Medicaid anti-fraud statute that focuses on the prevention of false and fraudulent claims to the Arizona Health Care Cost Containment System (AHCCCS) program.

Arizona Revised Statute § 36-2918 requires all contractors, subcontracted providers of care, and non-contracting providers to immediately notify the director of AHCCCS, in a written report, of any cases of suspected fraud or abuse. Violations of Arizona Revised Statute § 36-2918 are punishable by civil penalties of up to $2,000 per item or service claimed plus an assessment of up to twice the amount claimed for each item or service.

In fiscal year 2021, the United States Justice Department's False Claims Act settlements and judgments exceeded $5.6 Billion. Of this amount, over $5 Billion related to matters involving the health care industry. The Justice Department also stated that 598 qui tam cases were filed in 2021, with $237 million paid out to the individuals who exposed fraud and false claims by filing these actions.

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

24- hour hotline (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 via phone 520-874-2847or 520-548-7862.

Contact the Medicare Compliance Officer via phone 520-874-2553.

Banner Medicaid and Medicare Health Plans Customer Care Contact Information
B-UHP Customer Care
Banner - University Family Care/ACC 800-582-8686
Banner - University Family Care/ALTCS 833-318-4146
Banner - Medicare Advantage/Dual 877-874-3930

Banner Medicare Advantage Customer Care
Banner Medicare Advantage Prime HMO – 844-549-1857
Banner Medicare Advantage Plus PPO -1-844-549-1859
Banner Medicare RX PDP – 1-844-549-1859

AHCCCS Office of the Inspector General
Providers are required to report any suspected FWA directly to AHCCCS OIG:
Provider Fraud -602-417-4045 or 888-487-6686
Website -www.azahcccs.gov (select Fraud Prevention)
Mail:
Inspector General
701 E Jefferson St.
MD 4500
Phoenix, AZ 85034
Member Fraud 602-417-4193 or 888-487-6686

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

Banner University Health Plans
Banner – University Family Care

Minimum Laboratory Monitoring For Psychotropic Medications

ANTIPSYCHOTIC MEDICATIONS			
GENERIC	**BRAND**	**GENERIC**	**BRAND**
Aripiprazole	Abilify, Abilify Maintena, Aristada	Olanzapine	Zyprexa, Zyprexa Zydis
Asenapine	Saphris	Paliperidone	Invega, Invega Sustenna, Invega Trinza
Brexpiprazole	Rexulti	Perphenazine	Trilafon
Cariprazine	Vraylar	Pimozide	Orap
Chlorpromazine	Thorazine	Quetiapine	Seroquel, Seroquel XR
Clozapine	Clozaril, Fazaclo	Risperidone	Risperdal, Risperdal Consta, Risperdal M Tabs
Fluphenazine, Fluphenazine D	Prolixin, Prolixin D	Thioridazine	Mellaril
Haloperidol, Haloperidol D	Haldol, Haldol D	Thiothixene	Navane
Iloperidone	Fanapt	Trifluoperazine	Stelazine
Loxapine	Loxitane	Ziprasidone	Geodon
Lurasidone	Latuda		

MONITORING	ANTIPSYCHOTIC FREQUENCY OF MONITORING
AIMS (Abnormal Involuntary Movement Scale)	On initiation of any antipsychotic medication and at least every six months thereafter, or more frequently as clinically indicated.
ABDOMINAL GIRTH (≥18 years old)	For individuals at least 18 years old, on initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
WEIGHT & BODY MASS INDEX (BMI)	On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
HEART RATE & BLOOD PRESSSURE	On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
COMPREHENSIVE METABOLIC PANEL (CMP), LIPIDS, FASTING GLUCOSE AND COMPLETE BLOOD COUNT (CBC)	On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.

CLOZAPINE MONITORING	
MONITORING	**FREQUENCY OF MONITORING**
White Blood Cell Count (WBC) w/ Absolute Neutrophil Count (ANC)	Weekly for 1st 6 months (if values within normal limits), then every 2 wks. for 6 months, then monthly (if values within normal limits)
Comprehensive Metabolic Panel (CMP)	At least annually
Fasting Lipid Panel	At least annually

LITHIUM MONITORING	
MONITORING	**FREQUENCY OF MONITORING**
Lithium Level	Within one month of initiation of lithium or significant change in dose and at least every six months thereafter or more frequently as clinically indicated.
Thyroid Function	Within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated.
CBC w/ Platelet Count	On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
CMP	Renal function – within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated.

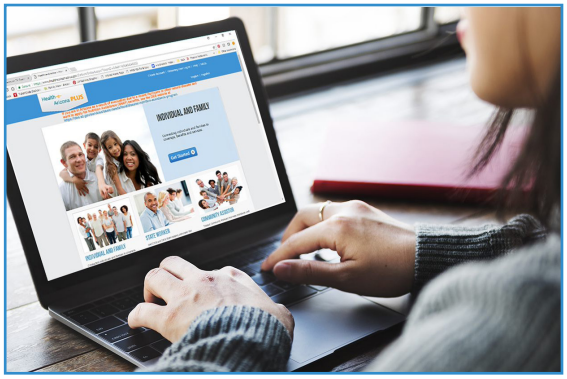
VALPROIC ACID MONITORING	
MONITORING	FREQUENCY OF MONITORING
Valproic Acid Level and CMP	Within one month of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
CBC with Platelet Count	On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.

CARBAMAZEPINE MONITORING	
MONITORING	**FREQUENCY OF MONITORING**
Carbamazepine Level, CMP and TSH	Within 1 month of initiation of carbamazepine or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
CBC w/ Platelet Count	On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.

AHCCCS
Arizona Health Care Cost Containment System
OFFICE OF INDIVIDUAL AND FAMILY AFFAIRS

How to Update Your Mailing Address

AHCCCS sometimes sends information to your mailing address. It is YOUR responsibility to notify AHCCCS when your address changes.



How To Update Your Address Via Phone Or Email

By Phone: (855) HEA-PLUS (432-7587)
By Mail: P.O. BOX 19009, Phoenix, AZ 85005

How To Update Your Address Online

(this is fastest!)

WHAT YOU NEED

Health-e-ArizonaPlus Username
Health-e-ArizonaPlus Password

FORGOT YOUR USERNAME OR PASSWORD?

To reset your username or password, select the links on the user login screen.

Reset Username: To retrieve your username, select the "Click here" link. Enter the following information:

- First Name and Last Name
- Date of Birth
- Answers to secret questions

Reset Password: To reset your password enter your username and select the link "If you have forgotten your password, click here." Then enter the correct answers to your secret questions.

WHAT TO DO

1. Go to www.healthearizonaplus.gov
2. Click "Report a Change"
3. On the "How to Report Changes" screen, click "Next"
3. Choose either:
   - "New Contact Information" if only your mailing address changed (example: changing from a street address to a P.O. Box) OR
   - "Household Move" if the entire household is moving
5. Choose "In Arizona"
6. Enter new mailing address

How Do You Get Letters If You Become Homeless?

AHCCCS recommends that you sign up for electronic notifications. For email, you will need access to the Internet and an email address. For a text message notifying you that you have a letter waiting for you on the HealthArizonaplus website, you'll need a telephone that can receive text messages. The local library usually has free internet access, and you can create a free email account at Yahoo.com or Gmail.com.

You can have your letters sent to a friend's address, but it is important that your friend add your name to their address at the United States Post Office. Otherwise, your mail may be returned and your benefits may be stopped.

You can also sign up for a PO Box or General Delivery Service with a United States Post Office (USPS). To sign up for General Delivery Services visit your local post office. You will need a valid ID. Your mail will be held there for 30 days. Every 30 days you must ask for an extension at the General Delivery location.

The Arizona Health Care Cost Containment System (AHCCCS) is committed to ensuring the availability of timely, quality health care. If you know of an AHCCCS member who is unable to access health services, or if you have a concern about the quality of care, please call your AHCCCS health care plan's Member Services number. If your concern is not resolved, please call AHCCCS Clinical Resolution Unit at 602-364-4558, or 1-800-867-5308.

AHCCCS Health Plan Contacts

AHCCCS ACUTE CARE/INTEGRATED HEALTH PLANS	
Arizona Complete Health - Complete Care Plan Customer Service 1-888-788-4408 www.azcompletehealth.com/completecare	**Mercy Care** Customer Service 1-800-624-3879 www.mercycareaz.org
Care 1st Health Plan Customer Service 1-866-560-4042 www.care1staz.com	**Molina Complete Care** Customer Service 1-800-424-5891 www.mccofaz.com
Banner – University Family Care Customer Service 1-800-582-8686 www.bannerufc.com/acc	**United Healthcare Community Plan** Customer Service 1-800-348-4058 www.uhccommunityplan.com
Health Choice Arizona Customer Services 1-800-322-8670 www.healthchoiceaz.com	**Mercy Care Department of Child Safety Comprehensive Health Plan** Customer Service 1-833-711-0776 mercycareaz.org/members/chp-members

AHCCCS CLINICAL RESOLUTION UNIT (JACOB'S LAW AHCCCS CLINICAL RESOLUTION UNIT (JACOB'S LAW – FOSTER/KINSHIP/ADOPTIVE)
602-364-4558 or 800-867-5808 DCS@azahcccs.gov

LONG TERM CARE HEALTH PLANS (PROGRAM CONTRACTORS)	
Banner – University Family Care LTC Customer Service 1-833-318-4146 www.bannerufc.com	**Mercy Care LTC** Customer Services 1-800-624-3879 www.mercycareaz.org
United Healthcare LTC Customer Service 1-800-293-3740 www.uhccommunityplan.com	**Department of Economic Security/ Division of Developmental Disabilities (DES/DDD)** Customer Service 1-844-770-9500 www.azdes.gov/ddd/

REGIONAL BEHAVIORAL HEALTH AUTHORITY (RBHA) HEALTH PLANS		
Arizona Complete Health - Complete Care Plan RBHA Customer Service 1-888-788-4408 www.azcompletehealth.com/completecare	**Mercy Care RBHA** Customer Service 1-800-564-5465 www.mercycareaz.org	**Health Choice Arizona RBHA** Customer Services 1-800-322-8670 www.healthchoiceaz.com

Banner
University Health Plans

Public Health Emergency (PHE)

What is the PHE and how does it affect members?	At the beginning of the COVID-19 pandemic, the federal government declared a PHE. During the PHE, Medicaid agencies are required to continue health care coverage for members, even if someone's eligibility changes, with limited exceptions. As a result, most AHCCCS and KidsCare members have kept and will continue to keep their health care coverage during the PHE, regardless of eligibility status.
How long will the PHE last?	Right now, the PHE has been extended until 4/16/22, but will be reviewed again for possible extension. The federal government can extend the PHE 90 days at a time and has done so multiple times since March 2020.
How many AHCCCS members will be impacted once the PHE ends?	There are roughly 500,000 members who are in the "COVID override" group in Arizona. These 500,000 members either 1) did not respond to a renewal request for information and were unable to be automatically renewed; or 2) are shown to be ineligible based on information provided by the member or via electronic sources. The first report we received from AHCCCS specific to Banner – University Health Plans included 35,000 members.
Is AHCCCS still processing renewals?	The process of annual renewals never stopped; AHCCCS has maintained the process of renewing eligibility during the PHE for Title XIX and Title XXI members. Many members are able to be renewed automatically based on federal hub information; however, if AHCCCS needs additional information in order to process a member's renewal they will send the member a request for information indicating the items needed to process their renewal.
What other coverage options do members have if they no longer qualify for AHCCCS after the PHE?	Members who are no longer eligible for Medicaid or the Children's Health Insurance Program following the end of the PHE may be eligible for coverage through the health insurance marketplace. Banner – University Health Plans partners with Banner Aetna for marketplace coverage. They serve Maricopa, Pinal and Pima counties.
How is AHCCCS working with their contracted health plans to provide information on members who need to take some type of action to continue coverage?	AHCCCS is providing contracted MCOs with member level data of enrolled members who may lose eligibility if they don't complete the AHCCCS renewal process. MCOs are partnering with providers and community stakeholders to conduct outreach and ensure members understand the importance of renewing their coverage.
What is critical for AHCCCS members to do today?	Ensuring accurate and current member contact information is up to date in Health-e-Arizona Plus (HEAplus) is critical to ensuring a member continues health care coverage. It is important that members respond to Requests for Information.
What is HEAplus and how do members access it?	HEAplus is a website: www.healthearizonaplus.gov.This portal offers the most accurate, credible, real-time eligibility determinations for public assistance programs. HEAplus is often able to verify much of the information needed for an eligibility decision through electronic data sources. Members can update their contact information and other critical information within the HEAplus portal. If you don't qualify for AHCCCS you will be automatically connected to the Federal Health Insurance Marketplace.
What are Community Assistors?	Today there are over 200 Community Assistors throughout the state using HEAplus to help Arizonans apply online for AHCCCS Health Insurance, Nutrition Assistance and TANF Cash Assistance. Community Assistors complete HEAplus applications during an interactive interview with the member. If members need to upload electronic sources assistors can help with this. Assistors can track the progress of the application and help members throughout the application process. If you are interested in becoming a Community Assistor, please visit https://www.azahcccs.gov/Resources/CommunityPartners/HEAplus.html