Arizona Priority Care Provider Manual

Revision date: 08/2017

One Goal. One Priority. Your Healthcare.

Arizona Priority Care

One Goal. One Priority. Your Healthcare.

e

Arizona Priority Care
One Goal. One Priority. Your Healthcare.

SECTION 1: AZPC & PROVIDER RESPONSIBILITIES

1.1 MISSION STATEMENT

Mission:
To facilitate quality care and provide service through our network of partner physicians, our clinical innovations, and our operational excellence
Vision:
To be recognized as the network of choice to members, providers and health plan partners and to be an employer of choice in our community
Values:
Integrity
Quality
Service Excellence
Teamwork

1.2 ARIZONA PRIORITY CARE PRODUCT

Arizona Priority Care is a physician led organization that provides fully integrated care and services to health plans and employer groups in Arizona. We manage the full spectrum of health care services for our members leveraging best in class technology to promote wellness and patient empowerment and to achieve the highest levels of satisfaction.

Arizona Priority Care is attractive to enrollees for many reasons, including:
Quality care
An affordable price
Comprehensive provider network
Ease of use
Patient prioritized services
Additional services offered through Arizona Priority Care's Programs

1.3 USING THE PROVIDER MANUAL

Purpose:

The Arizona Priority Care Provider Manual is designed specifically for Arizona Priority Care providers. This manual provides specific information needed for the care and treatment of Arizona Priority Care members.

1.4 PROVIDER RESPONSIBILITIES – EXPECTATIONS OF PROVIDERS

Arizona Priority Care expects contracted providers to:

- Understand that Arizona Priority Care does not deny patient care, but simply makes payment decisions based on the patient's coverage
- Act in the best interest of the patients
- Communicate fully with patients regarding their illness, as well as diagnostic treatment options, medication treatments and therapeutic options available to them regardless of benefit coverage
- Allow patients to participate in their health care decisions
- Provide continuity of care for patients by ensuring that there is an appropriate confidential exchange of medical information between all providers involved
- Refer patients for specialty care or second opinions within the Arizona Priority Care provider network, and obtain written approval from the Prior Authorization Department
- Providers are required, to assist Arizona Priority Care patients in obtaining prior authorization, as necessary, to facilitate claim payment. Services not requiring prior authorization are listed in the "Services That Do Not Require Authorization"
- Participate in Arizona Priority Care's utilization management and quality improvement initiatives, including allowing Arizona Priority Care reasonable access to patient medical records
- Recognize that there are multiple, well-accepted means of diagnosis and treatment for many given conditions
- Inform the Medical Director when the Arizona Priority Care procedures or actions are perceived as threatening the health or well-being of the patient
- Communicate with patients and Arizona Priority Care in a way that assumes that all parties are acting in good faith with the goal of providing good care for the patient

- Recognize that Arizona Priority Care is obligated to develop policies and procedures on benefit administration and to administer these in a fair and consistent manner even though this occasionally results in denial of payment for individual patients
- Understand that Arizona Priority Care's goal is to improve access and quality of health care
- Complete a successful credentialing program prior to contact with Arizona Priority Care patients
- Complete training programs offered by CMS or Arizona Priority Care to fulfill any
- CMS training compliance requirements.

1.5 ARIZONA PRIORITY CARE RESPONSIBILITIES

Participating Providers can expect Arizona Priority Care to:

- Assist the provider in meeting the expectations for Arizona Priority Care participation;
- Pay claims fairly and efficiently;
- Provide due process to the provider when complaints or grievances are lodged against him or her;
- Support the provider in practice by identifying opportunities to improve care when information is
  available on a practice basis or an individual patient basis;
- Maintain an appeals process that can respond quickly and appropriately to patients and providers;
- Educate and encourage patients to be seen for appropriate preventive services;
- Inform providers of quality or other initiatives that may affect them or the patients; and
- Work in all of our operational areas to improve service to providers and patients.

Utilization Management decision making is based only on appropriateness of care, service, and existence coverage. Arizona Priority Care does not specifically reward practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for Utilization Management decision makers do not encourage decisions that result in under-utilization.

1.6 ARIZONA PRIORITY CARE SERVICES AREA

The Provider Network:

Arizona Priority Care has a comprehensive network within Maricopa and Pinal Counties that includes physicians, clinics, hospitals, skilled nursing facilities, home health, and other allied and ancillary health care professionals.

Arizona Priority Care ensures the integrity of the network through quality initiatives such as credentialing, utilization review and ongoing quality programs.

Arizona Priority Care Provider Directory:
The most up-to-date listing of participating providers is located in the Provider Section on Arizona Priority Care's website or by contacting the Provider Service Department at (480) 499-8720.

SECTION 2: STAFF AND SERVICES

Hours of Operation
Arizona Priority Care is open Monday through Friday, 8:00 a.m. - 5:00 p.m.

Arizona Priority Care Office/Mailing Address
585 N. Juniper Drive, Suite 200
Chandler, Arizona 85226

Internet Address
www.azprioritycare.com

Contact and Service Function	Telephone and Fax Numbers
Patient Services	**Phone: 480-499-8750 or 855-711-2912** **Fax: 480-499-8759**
Provider & Claim Services	**Phone: 480-499-8720 Option 1 or** **855-706-8388 Option 1** **Fax: 480-499-8744 or 855-706-8389** **(no claims will be accepted via fax)**
Credentialing and Compliance	**Phone: 480-499-8700 ext. 8152** **Fax: 480-803-8203**
Clinical Services	**Phone: 480-499-8700 ext. 8315 or 855-711-2916** **Fax: 480-499-8779**
Prior Authorization/Direct Referral	**Phone: 480-499-8730 Option 1 or** **800-706-8388 Option 2** **Fax: 480-499-8798 or 855-711-2914**
Quality Phone	**480-499-8700 ext. 8290**

SECTION 3: PATIENT RELATED INFORMATION

3.1 INTRODUCTION TO PATIENT SERVICE REPRESENTATIVES

Patient and Provider Service Representatives are available Monday through Friday, 8:00 a.m. - 5:00 p.m. to assist Arizona Priority Care members with any questions or concerns.

Providers who encounter patients, who have questions regarding benefits, should instruct the patient to call the health plan member service phone number found on their ID card.

As a provider, you may not always be aware of your patient's individual plan benefits. Arizona Priority Care and/or you, the provider, may have to bear the financial responsibility if a benefit or cost is misrepresented. For this reason, providers should refrain from quoting patient benefits. However, providers may call the health plan phone number found on the patient ID card to verify patient eligibility and inquire about patient benefits.

Arizona Priority Care Patient Service Representatives can be reached at (480) 499-8750 or (855) 711-2912 to assist.

3.2. ELIGIBILITY

Individual enrollment for participation in health plan programs is determined by the specific Health Plan. Patients inquiring if they are eligible to enroll in or participate in specific programs should be referred to the health plan and not Arizona Priority Care. Arizona Priority Care will assist with the transfer of calls to the contracted health plan(s) if you are unable to contact them directly.

Arizona Priority Care obtains its eligibility data from the contracted health plan. The most current eligibility data can be obtained by contacting the health plan directly.

3.3 DISENROLLMENT/TERMINATION OF COVERAGE

Disenrollment

A patient may discontinue coverage from the health plan and Arizona Priority Care only during specific election periods, as specified by CMS or the health plan as appropriate. Disenrollment requests must be submitted in writing to the health plan, or may be received directly from CMS by the health plan. The patient must continue to receive all services from Arizona Priority Care participating providers until the disenrollment date.

Coverage Termination

The health plan can terminate a patient's coverage under the following circumstances:

- Change in residence making the individual ineligible
- Loss of entitlement to Medicare Part A and/or B
- Death
- Failure to pay required monthly premiums
- Fraudulent information recorded on the health plan enrollment application

Should coverage be terminated for any of the reasons above, a patient will receive advance notice from the health plan. Patients have recourse through the health plan grievance program and/or CMS (as applicable) if they are terminated and disagree with the health plan's position. Please have patients call their health plan with coverage termination questions.

3.4 PROVIDER RESPONSIBILITIES FOR VERIFICATION OF COVERAGE

- The provider shall request the patient's ID card before services are provided, and verify that all demographic and insurance information is correct in order to assure correct registration, billing, and reporting processes.
- The provider or designee shall contact the contracted health plan anytime verification of eligibility or verification of Primary Care Physician designation is necessary. Arizona Priority Care Patient Service Representatives can assist with verification but the Health Plan maintains the most current information.
- The provider's office shall contact the health plan Patient Services Department anytime the provider or designee becomes aware of incorrect patient information.

3.5 PATIENT ID CARD AND PATIENT RIGHTS AND RESPONSIBILITIES

Patients will receive their health plan identification card which they must use when obtaining medical services and prescriptions. Arizona Priority Care will be identified as the patients' Medical Group on the back of the ID card.

Patient Rights:

To Choose:

Patients have the right to choose a PCP from among Arizona Priority Care's network of physicians.

To Information:

Patients have the right to their health plan information relating to:
Covered and excluded health care benefits
Available primary and specialty care providers
Preventive care information
Illness and treatment options
The process to file a complaint, appeal or grievance
Policies and procedures relevant to their care

To Privacy and Confidentiality

Patients have rights to privacy/confidentiality of all communications/records of their care.

To Participate in Their Care

Patients have the right to be active in decisions about their treatment. Patients have the right to a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage. Patients have the right to obtain information about the risks and benefits of treatment. Patients have the right to refuse care.

To Present a Complaint, Appeal or Grievance

Patients have the right to voice concerns about their care and to receive a prompt and fair review of their concerns.

To be Treated with Respect and Dignity

Patients have the right to be treated with respect and dignity regardless of their race, age, gender, sexual orientation or creed.

To Make Recommendations

Patients have the right to make recommendations regarding the organization's patient rights and responsibilities policy.

Patient Responsibilities:

To Know their Patient Benefits and Requirements

Patients have a responsibility to:

- Understand their health plan benefits and limitations
- Follow the required procedures
- Present their ID card each time they receive services
- Know how to use the plan's provider network
- Ask questions about things they don't understand
- Provide accurate and complete information

To Participate in their Care

Patients have a responsibility to participate in their care by:

- Asking questions to understand their health problems
- Developing mutually agreed-upon treatment goals, to the degree possible, and following the agreed-upon treatment plan and instructions for care
- Making healthy lifestyle choices to maintain their health and prevent illness

To Keep their Appointments

Patients have a responsibility to:

- Keep their appointments or to give early notice if they must cancel
- To Show Consideration and Respect

Patients have a responsibility to show consideration and respect to the health plan, medical group staff and health care providers

3.6 PATIENT GRIEVANCE AND APPEAL PROCESS

Grievances:
In an effort to maintain patient satisfaction, regulatory and quality standards, Arizona Priority Care participating providers are required to follow the established process for prompt response of patient grievances.

Arizona Priority Care is not delegated to handle any patient generated grievance or appeal. These should be directed to the patient's health plan for resolution as indicated on the health plan's website.

Providers should direct any patient complaints related to Arizona Priority Care service issues, benefits, or claims status to the health plan's Appeals and Grievances department.

Patients have grievance rights available to them as specified in this section. A grievance means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of Arizona Priority Care's operations, activities, or behavior. Other areas of dissatisfaction include, but are not limited to:

- ACCESS—Difficulty in obtaining a timely appointment, reaching medical personnel during and after normal business hours, and in-office wait time.
- CUSTOMER SERVICE/ART OF CARING—Any communication perceived by the member as being rude or uncaring, lack of cultural sensitivity, abuse and neglect. This includes communication difficulties.
- QUALITY OF CARE—Any issue perceived by the member to affect quality of care (misdiagnosis, delay in diagnosis, medical complication, care not coordinated which resulted in delay of treatment, treatment plan not appropriate).
- OFFICE SITE/FACILITY—Any concerns about the cleanliness or physical barriers to receiving care (structure of the buildings, parking, exam rooms, bathrooms, etc.).

Appeals

Patients are entitled to a reconsideration of a pre-service request or denied claim. If the reconsideration outcome does not meet the patient's desired result(s) in whole or part, the matter is turned over to MAXIMUS Federal Services, a Medicare independent contractor.

Important Note:

If an Arizona Priority Care patient gives any indication of finding the provider's assessment unsatisfactory or unacceptable, please call Arizona Priority Care's Patient Service Representative at (480) 499-8750 or (855) 711-2912 or Health Net Appeals & Grievances at (800) 289-2818 as soon as possible, preferably that same day, to advise of the potential appealable issue. If Arizona Priority Care issues a notice of denial-of-coverage letter to the patient, it will include the appropriate appeal rights as defined by CMS. CMS considers this letter (or a corresponding claims denial) an "organizational determination."

Please be advised an indication of "no-need" or any other direct or indirect denial of a patient requested medical service, implied or stated, constitutes an "organizational determination" regarding the Health Plan's coverage to patients, and is subject to appeal.

Please reference the following grids for an overview of the Grievance and Appeals Process and a sample of Patient Rights-Grievance and Appeals information. These grids explain the differences between a grievance and an appeal, and outline the responsibilities of the provider, patient and Arizona Priority Care.

Grievance and Appeals

Definitions of what constitute a grievance and appeal can be referenced in the Grievance and Appeals grid below.

Grievance and Appeals

Patient Responsibilities	Provider Responsibilities	Health Plan and Arizona Priority Care's Responsibilities (as delegated)
1. Know patient rights and responsibilities. 2. File appeal within 60 calendar days of the adverse benefit determination. 3. Submit standard or expedited appeal requests in "writing" to the Health Plan 4. Provide authorized representative signature for all appeal requests on behalf of the patient	1. Notify patients of their appeal rights when request for services are denied. 2. If appropriate, support patient appeals. 3. Provide medical record information for "time sensitive" appeal requests, when applicable. (i.e. expedited appeal requests, required within 24 hours)	1. Process standard appeals/grievances within specified timeframes (AZPC 5 calendar days; Health Plan-30 calendar days from receipt). 2. Process expedited appeals/grievances within the Health Plan or CMS (as applicable) required time frames. 3. Pay or provide for service if decisions are overturned, and notify patient within required time frame.

For questions or concerns regarding this process, please call Arizona Priority Care's Quality Department at (480) 499-8700 ext. 8290.

3.7 END STAGE RENAL DISEASE (ESRD) CARE COORDINATION

3.7a ESRD Definition

ESRD is defined as a stage of kidney impairment that appears irreversible, permanent, and requires a regular course of dialysis or kidney transplantation to maintain life. A Medicare patient will be assigned ESRD status by the Medicare ESRD system as a result of their provider certifying the ESRD status of the patient and completing a CMS FORM (CMS 2728-U3). An individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of Medicare Advantage eligibility.

The following items identify the process for submitting ESRD annotation to CMS:

- Physician completes CMS form 2728-U4, Chronic Renal Disease Medical Evidence Report
- CMS form 2728 is sent to the appropriate ESRD network office by the renal provider
- ESRD network offices are listed in the ESRD Program Instruction Manual that is given to each renal provider by CMS
- ESRD network verifies the data on form 2728 and forwards the form to the ESRD support section at CMS
- CMS annotates the ESRD Database if patient is already entitled to Medicare (due to age)
- If the patient is waiting for entitlement to Medicare (due to ESRD), CMS does not annotate the database until Social Security Administration (SSA) informs CMS of entitlement

3.8 HOSPICE CARE COORDINATION

Coverage for Hospice care for Advance Practice Provider (APP) patients will be provided in accordance with Medicare guidelines.

A patient is eligible for Hospice care only after their attending physician and the Hospice Medical Director concur that the patient is terminally ill and has a life expectancy of six (6)

months or less. Patients who are appropriate for Hospice care and support services will be referred to a Medicare certified Hospice program for Hospice care.

Coverage Guidelines

All other services non-related to the terminal illness will be considered for coverage if the patient remains enrolled in the Health Plan as is assigned to the Arizona Priority Care medical group.

A Medicare Advantage patient has the right to discontinue their Hospice care election at any time and has the right to change Hospice programs one time per benefit period. Once the patient discontinues hospice care, he/she will resort back to Medicare Advantage on the first of the following month.

3.9 EMERGENCY SERVICES

Emergent or Urgently Needed Care outside the Service Area

If the patient is hospitalized at a facility outside the health plan service area, the patient is asked to notify the health plan, Arizona Priority Care and/or their PCP. Arizona Priority Care encourages the patient's PCP to be involved in the management of the patient's care, which may include arrangements for a transfer to a participating facility once the patient is stable and the condition warrants extended hospitalization.

3.10 ADVANCE DIRECTIVES

Overview

As capable adults, patients have the right to accept or refuse medical treatment, including life-sustaining treatment. In addition, a patient may appoint someone else to make health care decisions on their behalf should they become mentally or physically unable to do so. To comply with these rights, Arizona Priority Care educates staff and providers concerning

Advanced Directives. An Advance Directive is a document by which a person's wishes and decisions for future health care can be placed in writing and communicated to their family and health care providers. They can also designate a Health Care Agent who will make health care decisions on their behalf when it is determined that they are no longer capable of making these decisions for themselves. Two types of Advance Directives that are commonly used are:

- **Living Will**
- **Power of Attorney for Health Care**

As applicable, providers and facilities shall prominently document in each Arizona Priority Care patient's medical record whether he or she has executed an Advance Directive, and comply with any federal and state law requirements regarding advance directives.

Living Will

A Living Will is a written statement by the patient of his/her choices regarding the type of life-sustaining care they would want if they had a life-threatening condition and were no longer able to communicate their wishes.

Power of Attorney for Health Care

The Power of Attorney for Health Care (POA-Health Care) form allows a patient to appoint another person or persons to make health care decisions on their behalf should they become unable to make these decisions for themselves. The person (or persons) appointed is called their Health Care Agent. This form does not give the Health Care Agent any authority to make financial or other business decisions on behalf of the patient.

If a patient has an Advance Directive, they are encouraged to provide copies to their health care providers, family, and their Health Care Agent, if they have designated one.

SECTION 4: BENEFIT INFORMATION

4.1 BENEFIT INFORMATION

The Health Plan administers different plan options for Arizona Priority Care members, all with variations in benefits. Patients of the Arizona Priority Care plans must receive primary care from their primary care physician or other participating provider, except for urgent and emergency situations. Please contact our Patient Service Representatives with questions concerning benefits available for each plan.

Patient Service Representatives can be reached Monday through Friday, 8:00 a.m. - 5:00 p.m. at (480) 499-8750 or (855) 711-2912.

4.2 COORDINATION OF BENEFITS

Definition:

A coordination of benefits (COB) provision is an insurance contract provision intended to avoid claim payment delays and duplication of benefits when a person is covered by two or more insurance plans.

There is no coordination of benefits on a beneficiary-specific basis that would relieve an Arizona Priority Care patient with employer/union group health plan coverage of his or her cost sharing obligation under a Medicare Advantage HMO plan. As a result, the patient remains liable for payment of the MA HMO plan's cost sharing regardless of whether the MA HMO plan is primary or secondary.

Coordination of Benefit Rules: Who Pays First?

- If the patient is age 65 or older and has coverage under an employer group health plan with twenty (20) or more employees, either through his/her current employment or the employment of a spouse, that coverage pays before Arizona Priority Care.

- If the patient is age sixty-five (65) or older and has coverage under an employer group health plan with less than twenty (20) employees either through his/her own current employment or the employment of a spouse, such coverage pays after Arizona Priority Care.

- If the patient is under age sixty-five (65) and entitled to Medicare (Arizona Priority Care) due to a disability (other than End Stage Renal Disease) and has group health coverage under an employer with 2-99 employees, either through his/her own employment or the employment of a family member, Arizona Priority Care would be the primary payer. The employee group health coverage will be primary if the employer has 100 or more employees.

- If automobile medical or no fault liability insurance is available to the patient, then benefits under that plan would be primary.

- If the patient is eligible for coverage solely on the basis of End Stage Renal Disease (ESRD) and is covered under an employer group health plan, Arizona Priority Care pays secondary for the first thirty (30) months with the employer plan paying primary.

- Arizona Priority Care may exercise the same rights to recover from a primary plan, entity, or individual that the Secretary of DHHS exercises under the MSP regulations as they apply to MA Plans.

- Medicaid never pays first for services covered by Medicare.

4.3 NON-COVERAGE SPECIFICS

Arizona Priority Care Limitations and Exclusions

Any service not provided or arranged for by an Arizona Priority Care or health plan participating providers or not approved in advance by Arizona Priority Care when prior authorization is required, are not covered by Arizona Priority Care. Urgently needed care outside of the service area, emergency services anywhere, or renal dialysis services provided when temporarily outside the service area are covered benefits.

Benefits are subject to change and verification of benefits should be directed to the contracted health plan's Member Services department as indicated on the Patient's health plan ID card. Copies of patient's Evidence of Coverage are available at the health plan web sites.

SECTION 5: PHARMACY

5.1 INTRODUCTION TO PHARMACY DEPARTMENT SERVICES

Arizona Priority Care does not have delegated responsibility for addressing any Pharmacy Benefits provided by the health plan.

Please contact the health plan directly for any information related to retail pharmacy services.

5.2 PRESCRIPTION DRUG FORMULARY

The formulary is a list of medications identified by the health plan's interdisciplinary Pharmacy and Therapeutics (P&T) Subcommittee.

Arizona Priority Care strongly encourages the use of generic drugs and preferred brand formulary drugs for patients. The health plan's P&T Subcommittee will monitor and contact practitioners who prescribe non-formulary drugs to request consideration of formulary alternatives.

Here are three (3) general rules about drugs that Medicare drug plans will not cover under Part D:

1. The health plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

2. The health plan cannot cover a drug purchased outside the United States and its territories.

3. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

   Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as: Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

- Drugs covered under Part D that may be self-administered in a hospital outpatient setting such as emergency room, observation unit, and surgery center or pain clinic if not required for the medical condition being treated. You will need to bring all of your medications with you.

  Generic equivalents may be dispensed by the pharmacy if allowed by the provider or by law. All brand drugs that have a generic equivalent may be subject to an ancillary charge:

- If you or the patient chooses a brand name medication and there is a generic equivalent available, the patient will be required to pay the difference in cost between the brand name medication and the generic equivalent in addition to the co-payment/co-insurance. In some cases, the brand name drug may not be covered because the generic equivalent is on the formulary.

- If there is a medical reason that a patient cannot use a generic equivalent, the practitioner will need to indicate on the prescription that a brand name drug is medically necessary. The ancillary charge may be overridden at the pharmacy level.

5.2a Restrictions/Limitations

Some covered drugs may have additional requirements or limits on coverage. More detailed information about these restrictions/limitations, such as criteria for coverage, can be found on the Health Plan websites.

5.3 Part B Medications Require Authorization

Some injectable medications require prior authorization. These are covered under the Patient's medical benefit and are not considered a part of the patient's Pharmacy or Part D benefit. Please see the health plan website for Drugs and Medications in this

category. Failure to obtain prior authorization will result in denial of the claim and may not be treated as patient responsibility. Providers/practitioners are subject to plan guidelines and under certain circumstances, or contractual obligation, the services may be denied as provider/practitioner responsibility.

SECTION 6: PRIMARY CARE PHYSICIAN

6.1 PRIMARY CARE PHYSICIAN (PCP) MODEL OF CARE

The PCP has the primary responsibility for coordinating the overall health care for Arizona Priority Care members. The PCP is responsible for the coordination of the patient's care to assist in improving quality and ensuring appropriate utilization of health care services. PCPs are expected to provide appropriate care within their areas of expertise. The patient shall choose a PCP from a list provided by the health plan and Arizona Priority Care.

6.2 PRIMARY CARE PHYSICIAN CRITERIA

The Primary Care Physician will be a credentialed Medicare Certified Practitioner (Medical Doctor, Doctor of Osteopathy, Physician Assistant or Advance Practice Nurse) in one of the following disciplines:

Family Practice, General Practice, General Medicine, Internal Medicine, Geriatrics, Women's Health, and practicing in the Arizona Priority Care service area.

The PCP is responsible for coordination of overall healthcare services including:

- Routine health maintenance checks.
- Preventive care screening services.
- Discussion of treatment options including risks, benefits, consequences of treatment and non-treatment, and consideration of patient's desire to execute or follow an advance directive (including option of no treatment).

- Immunizations and counseling regarding health maintenance.
- Evaluation and treatment of acute illness.
- Evaluation and treatment as appropriate for specific chronic illnesses.
- Coordination of acute and chronic disease care.
- Referrals to consulting practitioners when services or consultations are necessary outside the scope of the PCP's area of expertise (in and out of network).
- Routine review and monitoring of the continuity and coordination of care furnished to patients.
- Coordination of patient care with skilled nursing facilities, home health, hospice and hospital care services.
- Active participation in patient care with care managers, disease state management programs and other care management activities.
- Allowing the patient to participate in decisions regarding their health care and treatment options.

6.2a PCPs will be classified in any Patient Listing as:

- Open Status: Practitioner available to see new patients as follows: Emergency Appointment-same day as request; Urgent Appointment-within 24 hours of request; Routine Appointment-within 7 business days of request.

- Closed Status: Practitioner available to see only *established patients as follows:
  - Emergency Appointment-same day as request; Urgent Appointment-within 24 hours of request; Routine Appointment-within 7 business days of request.

*Established patients are defined as patients that have received non-urgent care services from the practitioner within the past 3 years.

6.3 Panel Closure Request Process

All requests to close a PCP panel must meet contractual guidelines which includes closing of panels to new enrollees under all health plans. Please submit your request for panel closure to AZPC utilizing the PCP Panel Closure Request Form located on the AZPC website under: Providers\Forms\PCP Panel Closure Request Form.

Once received by the AZPC Network Contracting Department, it will be reviewed to confirm that the request meets contractual requirements and a confirmation letter will be sent to your office advising of the effective date of the panel closure. Unless your request to close your panel has been approved and communicated to your office, you are contractually obligated to continue accepting new AZPC enrollees.

6.4 CLINICAL SOCIAL ASSESSMENT (CSA)

A Health Risk Assessment (HRA) is provided by the designated health plan. Arizona Priority Care conducts a group-level version of the HRA which is the Clinical Social Assessment (CSA). These results will help determine whether a patient is at risk for catastrophic illness or extensive health care services. All CSA's are forwarded to the patient's PCP who is responsible for developing a treatment plan. The treatment plan will assist with assuring incorporation of all necessary services including, if available, case management.

6.5 NOTICE OF PRIMARY CARE PHYSICIAN PRACTICE CHANGE

The Provider Network Strategy & Contracting Department must be notified of any practice changes. It is the practitioner's responsibility to submit written documentation to the department for notification of any such changes. The Provider/Practitioner Notification Form (available online) is to be utilized for notification to the Provider Network Strategy & Contracting Department.

6.5a Primary Care Physician Status Changes

Continuity of care and a stable network of providers are necessary to assure timely access and appropriate care for patients.

PCPs are required to notify the Network Strategy & Contracting Department in writing at a minimum of 60 days in advance regarding the following status changes:

- ☐ Change of Address
- ☐ Tax identification number change
- ☐ Death
- ☐ Change in licensure, hospital privilege status or DEA certification
- ☐ Change from Open status to Closed status;
- ☐ Change from Closed status to Open status;
- ☐ Retirement, leave of absence, resignation, termination or any change in practitioner practice which impairs the provider to carry out their responsibilities;
- ☐ Practitioners who have previously terminated status as Primary Care Physicians and wish to reactivate this status shall be required to request a status change in writing to Arizona Priority Care Provider Network Management Department.

Upon receipt of request for change in status, the request shall be reviewed by designated Arizona Priority Care Network Strategy & Contracting Department staff. The Medical Director will then make the final determination whether the practitioner or contracted facility can continue to meet the Arizona Priority Care access standards for patients.

All providers/practitioners or their designee should notify Arizona Priority Care of the above when applicable/appropriate.

6.5b Transfer of Patient Care

In the event of a change in practice status, practitioners are required to assist Arizona Priority Care with transition of patient care.

It is the contracted facility or practitioner's responsibility to assure effective communication with patients regarding the transfer of the patient's care to another practitioner.

Activities associated with transition of patient care include:

- ☐ Identify and communicate with the practitioner who will be designated as the patient's PCP. Accepting practitioner must meet criteria for a PCP status as previously outlined.

- ☐ Effective date of anticipated transfer of care.
- ☐ Identification of patients in high-risk categories (chronic disease states, patients utilizing care management services).
- ☐ Assist patients in transferring medical record and treatment plan information to accepting practitioner.

In the event the practitioner cannot assist in the transfer of care, Arizona Priority Care is required to identify a suitable practitioner for patients who have not indicated a preference.

- ☐ Arizona Priority Care, through review of its panel of participating practitioners, will assist patients in transition of their care to an appropriate practitioner.
- ☐ Arizona Priority Care and/or health plan will be responsible to notify patients and other parties in regard to any practitioner status changes.
- ☐ If you require assistance with this process, please contact the Provider Services department at (480) 499-8720 or (855) 706-8388.

6.5c Non-Compliant Patients and Termination of physician-patient relationship

The following steps must be followed:

1. Document all areas of non-compliance, for example, verbal abuse, missed appointments or failure to follow treatment plan, in addition to all verbal discussions with patient pertaining to these concerns.
2. Notify patient and AZPC in writing of the potential dismissal of care due to continued non-compliance and give the patient 30 days to become compliant to avoid dismissal. NOTE: Expedited termination requests may be processed for serious threats or verbal abuse by patient.
3. If the patient fails to become compliant, notify the patient via certified mail that a decision has been made to terminate the relationship within 30 days. That notice must also include the reason for the termination, availability of current PCP for urgent or emergency care within the 30 day period, and notice to the patient of his/her right to transfer records to the new PCP.

A copy of the letter must be sent to AZPC, together with all documentation of non-compliance and/or incident(s) leading up to the decision to terminate relationship, to facilitate transition to a new PCP.

If a patient fails to cooperate with the care plan established by the physician or misses appointments, submit written documentation to the Arizona Priority Care Quality department via confidential fax at (480) 403-8216, or by mail at:

Arizona Priority Care
Attn: Quality Department
585 N. Juniper Drive, Suite 200
Chandler, Arizona 85226

6.6 REPORTING

6.6a Arizona Priority Care Responsibilities

☐ Arizona Priority Care will provide PCP enrollment reports.
The PCP Report is a current listing of all patients assigned to each PCP.

6.6b Practitioner Responsibilities

☐ The PCP and other treating practitioners will review information provided by Arizona Priority Care in order to maximize the patient's health status and evaluate the continuity and coordination of care furnished to enrollees.

☐ Patient's compliance with prescribed treatments or regimens, based on record review and administrative data.

☐ Identify and avoid duplication in diagnostic or laboratory testing.

☐ Identify and coordinate opportunities for health improvement or chronic management programs.

☐ Identify and coordinate community resources and social services.

- ☐ Identify and coordinate patient's eligibility and appropriateness for participation in case management or disease state management programs (high risk, chronic disease, frequent hospitalizations, and increased utilization of ambulatory services).
- ☐ Coordinate care with our Care Manager for those patients receiving these or related services (See Clinical Services Programs).
- ☐ Develop a treatment plan based on identified needs in the health risk appraisal and office assessment.
- ☐ Notification in a timely manner of all abnormal critical test results. The timeliness of the notification is based upon the medical indication and urgency of follow-up care, or the need for a change in the treatment plan.
- ☐ Notification may be communicated via letter, telephone, or verbally during a follow-up appointment, and will be documented in the patient's medical record.
- ☐ Practitioner will ensure appropriate and confidential exchange of patient information among treating health care professionals.
- ☐ Practitioner is responsible to ensure that patients/patients are informed of specific health care needs that require follow-up care. Patients must receive training as appropriate in self-care and other measures they may take to promote their own health.
- ☐ Practitioner is responsible for obtaining prior written authorization from Arizona Priority Care for all out of network services.
- ☐ Practitioner is responsible to provide information regarding treatment options in a culturally competent manner, including the option of no treatment.
- ☐ Practitioner is responsible to ensure that individuals with disabilities have effective communications throughout the health care network in order to make decisions regarding treatment options.
- ☐ Practitioner will involve the patient in the development of the treatment plan, and assist the patient by coordinating the services and prior authorization to Arizona Priority Care practitioners as appropriate.

6.7 IDENTIFICATION OF PATIENTS

6.7a Arizona Priority Care Responsibilities

☐ Patients enrolled in Arizona Priority Care will be provided with a patient identification card by the health plan. Health plan or Arizona Priority Care will provide confirmation of patient eligibility upon request but remember the Health Plan has the most current eligibility information. Call the contracted health plan or Arizona Priority Care's Patient Service Representatives at (480) 499-8750 or (855) 711-2912 to verify patient eligibility.

SECTION 7: PROVIDER RIGHTS AND RESPONSIBILITIES

7.1 PROVIDER RESPONSIBILITIES FOR VERIFICATION OF ELIGIBILITY

- The provider shall request the patient's ID card before services are provided and verify that all demographic and insurance information is correct in order to ensure correct registration and reduce the possibility of confusion in the billing and reporting processes.
- The provider or designee shall contact the health plan or Arizona Priority Care's Patient Service Representative at (480) 499-8750 or (855) 711-2912 any time verification of eligibility or verification of Primary Care Physician designation is necessary.
- The provider's office shall contact the health plan and Arizona Priority Care's Patient Service Representative any time the practitioner or designee becomes aware of incorrect patient information.

7.2 PROHIBITION OF INTERFERENCE – ADVICE TO PATIENTS

Arizona Priority Care advocates and upholds the provider relationship and does not prohibit or otherwise restrict a health care professional, acting within their lawful scope of practice, from providing advice to an individual who is a patient and enrolled in any health plan product administered by Arizona Priority Care. Specifically, Arizona Priority Care will not interfere with the communications between the provider and patient regarding:

- The patient's health status, medical care, or treatment options (including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options, including no treatment as an option).
- The risks, benefits, and consequences of treatment or non-treatment.
- The opportunity for an individual to refuse treatment and to express preferences about future treatment decisions.

Arizona Priority Care shall not penalize a provider because the provider, in good faith, reports to the State or Federal authorities any act or practice by Arizona Priority Care that, in the opinion of the provider, jeopardizes patient health or welfare.

7.3 NOTIFICATION PROCESS TO PROVIDERS

1. Notices, amendments, addendums, consents, approvals, requests or other communication required or permitted to be given pursuant to the terms and provisions of the Provider Agreement shall be in writing, and shall be personally delivered, sent by United States mail, or other nationally recognized mail service, and postage prepaid.

- Requests for changes in any fee or reimbursement schedule
- Addition of affiliated health plan
- Changes regarding contract provisions
- Changes in State, Federal or other regulatory agency requirements in which the provider will be required to comply
- Terminations of contractual relationships

- Prior authorization requirements
- Referral guidelines
- Billing Requirements/Terms for Payments
- Quality improvement initiatives and performance criteria
- Data reporting requirements
- Provider Manual changes

2. Arizona Priority Care will provide written notice as specified in the Provider Agreement regarding changes in #1 of the above requirements. All notices must be received by provider prior to effective date. This will be accomplished as applicable through:

- certified mail or
- hand delivery or
- direct mailing or
- fax or
- e-mail or
- provider manual updates

Provider Newsletter/Bulletins:

A provider newsletter/bulletin via mail, fax, email, or posted on www.azprioritycare.com. The Newsletter/Bulletin is a supplement to the Arizona Priority Care Provider Manual and will offer further clarification of current issues and regulations.

7.4 PROVIDER CONTRACTING

7.4a Contracting and Subcontracting Entities

Where Provider provides services through subcontracts with other individuals or entities, Provider shall require those individuals or entities to comply with Provider's obligations under the Provider Agreement, and as required by applicable state and federal statutes and regulations.

7.4b Termination

Consistent with all applicable regulatory requirements, Arizona Priority Care reserves the right to terminate any provider in accordance with the Provider Agreement for failure to be compliant with any of the following:

1. Arizona Priority Care participation standards.
2. Persistent non-compliance to Arizona Priority Care's policies and/or procedures.
3. Breach of the Provider Agreement without remedy of such breach after 30 day notification.
4. Upon receipt of written notice that provider can no longer meet the obligations required under their agreement. These include, but are not limited to suspension, revocation, or expiration of any license or certificate, which is required to perform required obligations under this Provider Agreement.
5. Upon notification of bankruptcy or insolvency.
6. Notification of any sanction, remedial actions or revocation of Medicare participation, or that of applicable State or Federal agency.
7. In the event that in the judgment of the Arizona Priority Care or the Health Plan, continuation of the agreement would jeopardize the health and welfare of patients; or with or without cause accompanied by appropriate written notice as designated within the Provider Agreement.

In the event of termination, Arizona Priority Care will:

1. Notify the health plan, provider or contracting entity of termination, including effective date and when applicable:

    - Reasons for termination
    - Right to appeal decision
    - Obligations of the provider in the termination process

2. Notify the health plan and Arizona Priority Care patients and coordinate transfer of patient care to other Arizona Priority Care providers within thirty (30) days.

3. Notify as applicable, the health plan and any State, Federal or regulatory agencies.

Termination of providers will be consistent with Arizona Priority Care policies and procedures and any applicable State or Federal laws.

7.5 CONTINUITY OF CARE

In the event a contractual agreement is terminated for reasons other than provider's misconduct, the provider shall be entitled to receive payment for services furnished to patients, through for the duration of the continuity of care period required by State and Federal regulations, and as specified below.

Patients may continue to seek care from the inactive provider, consistent with any State, Federal, and Health Plan requirements. Arizona Priority Care recognizes that inactive providers are not obligated to continue services except as required by any State or Federal Law. Providers continuing care must agree to meet the continuous care standards utilized by Arizona Priority Care.

During the continuation period, the provider agrees to accept payment rates set forth in the physician services agreement and abide by the terms of the contractual agreement, including, but not limited to, the Hold Harmless Clause and the Health Plan's and Arizona Priority Care's Utilization Review and Quality Assurance Procedures. In accordance with state regulations, Arizona Priority Care's obligation to provide compensation for authorized services furnished to a patient shall only apply if Arizona Priority Care or the Health Plan is a participating provider, participating hospital, or participating agency.

The period in which care may be continued:

1. In the case of a provider specializing in Family Practice, Internal Medicine, General Practice, Geriatric Medicine, a period that shall not exceed:
   - For a patient of a plan with no open enrollment period: until the end of the current plan year; or

- For a patient of a plan with an open enrollment period: until the end of the plan year for which the Plan represented that the physician was, or would be, a participating practitioner.

2. In the case of a provider from whom a patient is undergoing a course of treatment who is not a PCP, a period that shall not exceed
   - Except as provided below, the remainder of the course of treatment or thirty (30) days after provider's participation terminates, whichever is shorter or
   - If the course of treatment is maternity care and the patient is in the second or third trimester of pregnancy at the time participation terminates, until the completion of postpartum care for the woman and infant.

Coordination of continued care will be evaluated on a case-by-case basis. Any questions regarding any of the stipulations described above may be directed to Arizona Priority Care's Clinical Services Department at (480) 499-8700 ext. 8268.

7.6 CREDENTIALING PROCESS

The purpose of the Arizona Priority Care Credentialing Program is to ensure that the Arizona Priority Care network is comprised of appropriately credentialed providers and facilities. Arizona Priority Care's Credentialing Program is designed to comply with the standards of the National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), State and Federal agencies, and Health Plan policies as a delegated entity.

The credentialing process includes the systematic collection, verification and evaluation of information about a provider's education, experience, qualifications, licensure and quality of care. Unless there are clear and convincing reasons to depart from these guidelines, the Health Plan Credentialing Committees and staff will adhere to these guidelines.

Arizona Priority Care providers must receive credentialing approval for inclusion in the Provider Directory. Arizona Priority Care retains the discretion to list providers consistent with policy.

Arizona Priority Care providers must be recredentialed in order to qualify for continued network participation. This process occurs in increments of up to every three years. The recredentialing process includes, but is not limited to, a review of performance data such as utilization review, quality information and patient satisfaction.

Information acquired through the credentialing/recredentialing process is considered confidential. Arizona Priority Care is responsible for ensuring that all credentialing and peer review information remains confidential unless otherwise provided by law. The release of any provider information obtained during the credentialing/recredentialing process is prohibited without written, signed and dated consent provided by the provider.

Providers have a right to review the documentation received by Arizona Priority Care as a part of the credentialing process with the exception of letters of reference and peer review protected information. Providers also have the right to correct any erroneous information that varies substantially from information they have provided on the credentialing application and, upon request, to be informed of the status of their credentialing or recredentialing application. Arizona Priority Care will notify providers of their credentialing status within 60 days of the decision.

Arizona Priority Care reserves the discretionary authority to deny network participation to applicants, except as otherwise dictated by law. In selecting providers, Arizona Priority Care does not discriminate in terms of participation, reimbursement, or indemnification against any health care professional that is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification. Further, Arizona Priority Care does not discriminate against race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed, types of patients seen or professionals who serve high-risk populations. Providers applying for participation in the Arizona Priority Care network shall be responsible for maintaining the participation requirements that are outlined in this Provider Manual and their Provider Agreements. If the provider does not maintain these requirements, Arizona Priority Care maintains the authority to deny, suspend or discontinue their participation in the network, except as otherwise required by law.

7.7 PAYABLE PROVIDERS

It is an Arizona Priority Care requirement that providers within the network complete the credentialing process and receive credentialing approval by the Credentialing Committee, prior to payment of claims. Arizona Priority Care reserves the right to withhold payment to providers that are not successfully credentialed or who do not have Arizona Priority Care approval as a "Participating Professional." Payment of claims for services rendered to Arizona Priority Care patients prior to credentialing approval date will not be made except as required by law for urgent and emergent care, or at the discretion of Arizona Priority Care on an exception basis.

7.7a Medicare and Medicaid Exclusions / Eligibility / Medicare Opt-Out

Providers who have Medicare/Medicaid sanction(s) and continue to treat patients will be considered non-payable. Providers with sanctions, limitations on licensure and/or other restrictions will be reviewed prior to the payment of claims.

Per the Centers for Medicare/Medicaid Services (CMS) and the Office of Inspector General (OIG), Arizona Priority Care will pay a provider with a Medicare/Medicaid sanction for emergent or urgent services only, on a one-time-only basis. However, Arizona Priority Care will not pay a sanctioned provider for emergency services if the provider is employed or contracted to routinely provide emergency services. In addition, if Arizona Priority Care does pay for the services of a sanctioned provider, Arizona Priority Care will notify the patient that the provider was sanctioned and that Arizona Priority Care will not pay if the patient goes to that provider again.

Providers who have opted out of Medicare are non-payable for the 2-year period that follows such decision. The only exception to that rule is for emergency and urgently needed services where a private contract has not been entered into with a beneficiary who receives such services. Arizona Priority Care will pay for emergency or urgently needed services furnished by a provider to an enrollee in the Arizona Priority Care plan that has not signed a private contract with a beneficiary, but will not otherwise pay for services provided by opt-out providers.

7.7b Mental Health Providers

To be considered a Mental Health payable provider, or an Alcohol and Other Drug Abuse (AODA) payable provider, the health plan requirements for participation must be met. Arizona Priority Care may or may not delegate the responsibility for the contracting or credentialing of Mental Health Providers and will follow Health Plan requirements for credentialing of these providers as delegated.

7.8 ISSUE IDENTIFICATION AND CORRECTIVE ACTION

7.8a Purpose, Policy & Delegation of Decision-Making Authority

To provide a fair and efficient means to identify, investigate, and resolve problems arising from the care or conduct of a provider or office staff that may adversely affect patient care or the operations of Arizona Priority Care.

Policy:

An investigation or corrective action may be requested when a provider or his/her office staff engages in or exhibits acts, statements, demeanor, or professional conduct, either within or outside of the workplace, reasonably likely to be detrimental to patient safety or the delivery of quality patient care or reasonably likely to result in the imposition of sanctions by any governmental authority (local, state or federal).

Delegation of Decision-Making Authority:

The Arizona Priority Care Executive Committee delegates decision-making authority to the Credentialing Committee of Arizona Priority Care. The Arizona Priority Care Credentialing Committee sub-delegates the corrective action procedure to the Quality Improvement Committee.

7.8b Provider Grievance Process

Arizona Priority Care encourages feedback and input from all contracted providers related to any medical, administrative, or Arizona Priority Care matters.

Arizona Priority Care has a process for dispute resolution for provider grievances. A grievance is a written dissatisfaction from a provider regarding any aspect of Arizona Priority Care operations.

If a provider has a grievance regarding any aspect of the Arizona Priority Care operations, the provider may contact the Provider Relations Director, Director of Contracting, or the Medical Director, to discuss the matter. Documentation of issues will be forwarded to individual provider files.

- ☐ Arizona Priority Care will use provider grievances to identify improvement opportunities.
- ☐ Examples of grievances include delayed payment by Arizona Priority Care, request for exception to policy, or consideration of change in process or procedure.

If the grievance cannot be resolved by the department director within a reasonable time to the provider's satisfaction or not more than sixty (60) days, the provider may submit a written grievance to the Arizona Priority Care's Chief Medical Officer (CMO) or Medical Director.

Written grievances should be mailed to:

Arizona Priority Care
Attention: CMO or Medical Director
585 N. Juniper Drive Suite 200
Chandler, AZ 85226

7.9 ACCESS STANDARDS

All Arizona Priority Care participating providers will ensure sufficient staffing and coverage of health care services to provide timely services for both new and established

Arizona Priority Care patients, with a Prior Authorization, have direct access to all participating Arizona Priority Care providers, including specialists for initial evaluations. Female enrollees have direct access to participating Arizona Priority Care women's health specialists for routine and preventive care services without prior authorizations.

Arizona Priority Care has set standards for appointment access availability for patients. All Arizona Priority Care participating providers are expected to comply with the standards described below.

SERVICE	ACCESS STANDARD
Primary Care	Within 24 hours of a request for urgent care appointment. Within 7 calendar days of a request for a non-urgent appointment. Within 30 calendar days of initial request for a routine health assessment (asymptomatic), or preventive health appointment.
Specialist	Within 14 calendar days of request for a non-urgent appointment.
Urgent Care	24 hours
Life threatening emergency	Immediate

*All standards are based on calendar days.

All providers are required to:

1. Follow appointment wait time standards:
   - Wait times for scheduled appointments should not be fifteen (15) minutes beyond scheduled appointment time.

- When care is unavoidably delayed, patients must be notified of the delay and given the opportunity to reschedule their appointment.
- Attempts will be made to reschedule the appointment as medically appropriate and as close to the original date as possible.

2. Provide or arrange for services 24 hours per day, 7 days per week.
   - All providers should have an appropriate after-hours phone message available for patients calling in after normal business hours. We recommend provider's answering machines include their name and office hours and the name and phone number of a hospital or emergency services provider where a patient can obtain after-hour care or emergency care.
   - Suggested language for providers to use in their voice mail systems:

   "You have reached the after-hours message system for [Name of Clinic]. If you feel you are experiencing a life threatening emergency and cannot wait for the provider to call you back, please hang up and dial 911 or go to the nearest emergency department. Our office hours are [Office Hours]. If you have an urgent matter that cannot wait until our office reopens and you need to speak with the provider on call, please hold and you will be transferred to our answering service. You can expect a return call within 4 hours."

3. Have accessibility for handicapped patients as defined by the Americans with Disabilities Act (ADA), the Civil Rights Act, and any state or federal requirements to meet these needs.
4. Ensure that interpreter services are available for patients with language & hearing impairments.
5. Utilize Arizona Priority Care network participating providers. Ensure there is a process in place for communication between network providers.
6. Arizona Priority Care must ensure that patients have reasonable access to the care and services they require.

Arizona Priority Care has established geographic access standards that meet CMS Time/Distance Guidelines

Arizona Priority Care will monitor and evaluate providers' access and availability on an annual visit. The following evaluation methods will be used:

- Telephone surveys
- Site visits and routine Provider Relations staff visit feedback;
- Patient satisfaction surveys;
- Compilation of patient complaint data; and
- Provider feedback

The provider is expected to meet all appointment scheduling, wait time and office hour standards. Providers will be notified in writing of non-compliance with Arizona Priority Care appointment access standards. Providers will be given a specified period of time to correct any non-compliance issues, and/or recruit additional providers.

7.10 MEDICAL RECORD DOCUMENTATION AUDIT AND SITE REVIEW

The Medical Record Documentation Audit is a clinical review of the contents of the medical records within a provider's office. The medical records review is conducted at the same time as the site review. This function may be delegated to Arizona Priority Care or conducted by the health plan. When delegated, the Quality Department staff will contact the provider's office to inform them of the audit and will work with the identified contact person to set up an appointment for the audit. Prior to the visit, Quality Department will provide written confirmation of the scheduled audit date and time. A copy of the audit tools will be enclosed to assist with the efficiency of the audit process. Notification regarding the audit will be communicated to the facility at least seventy-two (72) hours prior to the scheduled visit. After the audit is completed, a written report will be furnished to the Provider's office within fourteen (14) business days indicating the results. A corrective action plan may be required if the score is below the minimum standard as established by Arizona Priority Care.

7.11 NOTIFICATION OF PROVIDER CHANGES

In the event of any provider additions/deletions/changes, please complete the Provider/Practitioner Notification Form, found in the forms section of the manual or on our website at www.azprioritycare.com

Arizona Priority Care
One Goal. One Priority. Your Healthcare.

If you are adding a provider we will review your request consistent with our contracting policy. If a decision is made to add the provider, a credentialing application form will be mailed to you under separate cover. Please remember that providers are not payable by Arizona Priority Care until the credentialing process is completed and approval has been granted.

7.12 FRAUD, WASTE, AND ABUSE REQUIREMENTS

(See Section 13 of the Provider Manual)

SECTION 8: CLINICAL SERVICES

8.1 FUNCTION OF CLINICAL SERVICES

The Clinical Services department performs Utilization Management and Case Management services under the direction of the Arizona Priority Care Medical Directors. It is the expectation that Arizona Priority Care providers review, cooperate, and participate with the process outlined below.

8.1a Overview of Utilization Management

Utilization Management performs the following services:

- ☐ Admission Notifications
- ☐ Concurrent Hospital Review
- ☐ Discharge Planning
- ☐ Retrospective Review
- ☐ Case Management
- ☐ Utilization Review
- ☐ Prior Authorizations

8.2 ADMISSION NOTIFICATION

- ☐ Notification is required for all hospital admissions within 24 hours, or the next business day. Hospitals should contact Arizona Priority Care Clinical Services at (480) 499-8700 Ext. 8315.

- ☐ Questions related to coverage or benefits should be directed to the Health Plan's toll free number located on the patient's health care card.

8.3 CONCURRENT HOSPITAL REVIEW

- ☐ Concurrent hospital review is performed for inpatient hospital admissions.
- ☐ Review is performed to determine medical necessity of the admission.

Inquiries regarding inpatient hospitalizations should be directed to the Clinical Services Department at (480) 499-8700 ext. 8315.

8.4 DISCHARGE PLANNING

Discharge planning involves the assessment of a patient's need for medically appropriate treatment after hospitalization. The Clinical Services department will work with Hospital staff and the attending physician to monitor and assist in this process.

1. Working in coordination with hospital staff, the attending physician, the patient and/or family/caregivers, the Clinical Services department is able to identify those cases with chronic conditions for which alternative treatment settings might be available within the community.
2. Clinical Services department staff will review the patient's treatment plan with hospital staff in order to establish the post discharge treatment plan.
3. Clinical Services department staff will monitor all post discharge services for patient progress.
4. Questions or concerns regarding the discharge planning process should be directed to the Arizona Priority Care VP of Clinical Services at (480) 499-8700 ext. 8295.
5. Questions or concerns regarding benefit issues should be directed to the patient's Health Plan.

Utilization information is collected on a retrospective basis through chart review, peer review and claims review. Retrospective review is used to assess specific services or patterns of care for appropriateness, underutilization, over utilization, efficiency, and outcomes.

8.5 UTILIZATION CASE MANAGEMENT

The Inter-Disciplinary Care Team (ICT) manages patient's health care benefits to ensure the best quality of care. The ICT is responsible for the following:

☐ Identifying appropriate alternatives to hospitalization yet achieving cost-effective quality of care.

☐ Discharge planning of hospitalized patients begins upon receipt of information of the impending admission or upon the initial review of the patient's hospital record.

☐ The acquisition of needed medical supplies and equipment, as well as home health services (skilled nursing care, physical therapy, speech therapy, and occupational therapy), is directed through contracted providers (whenever possible) and negotiates discounts with non-contracted providers.

☐ Manages concurrent reviews of admissions in and out of network, referrals to out of network facilities for Mental Health, transitional care, and other medical and surgical procedures. Works directly with hospital staff to facilitate transfers to lesser level of care as appropriate.

☐ Manages continued stay review, skilled nursing facility stays, and referral to hospice in accordance with Arizona Priority Care policy.

Upon initiation of home health services ordered by the attending provider, the ICT will maintain communication with the home health nurse. The ICT will coordinate care with Arizona Priority Care Prior Authorization/Precertification team and the home health

agency as needed until the patient is discharged from care and resumes care from the attending provider.

Arizona Priority Care will follow the Health Plan and Centers for Medicare/Medicaid Services (CMS)'s national coverage decisions as well as specific written medical review determinations of the local CMS carrier. Determinations of medical necessity and appropriateness may be based upon the following additional sets of criteria:

1. Milliman Care Guidelines
2. Health Plan medical policies
3. Arizona Priority Care Medical Policy and Procedure Manual
4. CMS Local Coverage Decisions and National Coverage Decisions Criteria are reviewed periodically to ensure consistency with current community standards

8.6 PRIOR AUTHORIZATION

Participating providers have responsibility for making decisions regarding care. However, in order to monitor the medical necessity services, prior authorizations for certain services are required before services are rendered. The prior authorization process determines both benefit application and medical necessity.

Providers are required to assist Arizona Priority Care patients in obtaining prior authorization. Failure to obtain necessary prior authorization may result in a denial of services. Changes are periodically made to the prior authorization list established by the Health Plan; therefore, it is recommended that providers contact the Prior Authorization/Precertification Department at (480) 499-8730 to obtain the most updated information.

Criteria used for the determination of medical necessity are available to all providers by contacting Arizona Priority Care at (480) 499-8700 or contact the Medical Director. Our Medical Directors are available upon request to discuss these decisions by calling (480) 499-8730 or (855) 711-2914.

SECTION 9: QUALITY MANAGEMENT PROGRAM

9.1 OVERVIEW OF QUALITY MANAGEMENT

Continuous Quality Improvement (CQI) will be achieved at all levels of the organization to assist in attaining Arizona Priority Care's Mission, Vision and Values. Arizona Priority Care is committed to providing patients a comprehensive provider network, which delivers the highest quality of care possible in the most cost-effective manner.

The Quality Management Program is designed to objectively, systematically and continuously monitor, evaluate and improve the delivery of health care and related services provided to patients.

9.2 CONFIDENTIALITY

- ☐ The provider and medical group staff and business associates agree to safeguard all individually identifiable health information and to protect the confidentiality and integrity of all health care information exchanged between the provider and Arizona Priority Care. Both provider and Arizona Priority Care agree to comply with all applicable requirements of State and Federal law regarding health information, including, but not limited to, the HIPAA administrative simplification laws concerning privacy, security, and electronic transactions, and Health Information Technology for Economic and Clinical Health Act (HITECH).
- ☐ All committee discussions are considered confidential. No clinical information will be disclosed outside of the Committee without the express consent of the patient or their designated representative.
- ☐ The breach of a patient's confidentiality by an employee of Arizona Priority Care constitutes grounds for disciplinary action, up to and including termination of employment.

☐ All information reviewed by the Quality Improvement (QI) staff and committee structure is protected by the Federal Health Care Quality Improvement Act of 1986 (42 U.S.C.11101 et seq.) and state statutes to ensure the confidentiality of this information.

☐ All patient and provider information (written, oral or electronic) is considered confidential, except where disclosure is mandated by law or regulatory requirement.

9.3 CONFLICT OF INTEREST

To ensure quality issues are reviewed without bias and that actions are in the best interests of patients, Arizona Priority Care mandates the following policies:

☐ All committee members are required to sign the Conflict of Interest Attestation prior to participation on a committee. To avoid actual or perceived conflicts of interest, Arizona Priority Care requires all committee members to provide appropriate disclosure.

☐ Any committee member who has an interest in any recommendation of a committee shall make a prompt and full disclosure of his or her interest to the committee before it makes such recommendation. Such disclosure shall include any relevant and material facts known to such member about the recommendation in question, which might reasonably be construed as adverse to Arizona Priority Care's interests. This includes, but is not limited to, situations in which a committee member has a personal, financial, or substantial interest in any recommendation of the committee.

☐ If the committee determines that a conflict of interest exists, it shall require the disclosing member to excuse him or herself from voting on the issue at hand.

9.4 QUALITY IMPROVEMENT COMMITTEE AUTHORITY

A. The Quality Improvement Committee (QIC) authority is granted by Arizona Priority Care's Executive Committee. Arizona Priority Care's Executive Committee also grants the QIC authority to carry out the responsibilities to meet the objectives stated in this program.

B. The QIC shall have the authority to direct the investigation of identified and suspected problems and to direct the responsible parties to implement action.

C. The QIC shall have the authority to request reports on QI activities and problems from departmental heads, quality management personnel, and others as needed.

D. The QIC shall have the authority to direct Arizona Priority Care's Medical Staff, departments/committees, and/or QI Teams to complete monitoring and evaluation on specific topics as appropriate. QIC will analyze and evaluate the results of these QI activities and reports directly to the Executive Committee.

E. If the QIC determines that inappropriate care or substandard services have been provided, or services which should have been furnished have not been provided, the QIC Chairman and/or the head of the QI Department or designee are responsible for communicating concerns identified and working with the provider to develop a Corrective Action Plan (CAP).

F. The QIC has the authority to implement sanctions against providers. Sanction activities used may include, but are not limited to:

1. Letter of information
2. Letter requesting provider response
3. Severity Level Determination
4. 100% review of all cases
5. Second opinion for all surgical cases

The QIC may refer a provider to credentialing for consideration of:

1. Suspension
2. Termination
3. Panel closure to new members
4. Action regarding Severity Level Determinations of Level 2-C and 3

All information gathered and documented for purposes of prioritizing problems and taking remedial action will be kept confidential.

9.4a Data Collection

Arizona Priority Care data collected on the approved indicators will be from in-house data systems or from the on-site review of medical records. The following are some of the data sources used; however, this is not an all-inclusive list:

- ☐ Medical Record Reviews (Inpatient, Skilled Nursing Facility (SNF), Hospice, Home Health)
- ☐ Inpatient Concurrent Data
- ☐ Ambulatory Care Utilization Data
- ☐ Diagnostic Utilization
- ☐ Outcome Studies Analysis
- ☐ HEDIS® Data/STAR Measures
- ☐ Quality Indicator Analysis
- ☐ Clinical Guideline Performance Studies
- ☐ Claims Data
- ☐ Patient Satisfaction Surveys
- ☐ Provider Satisfaction Surveys
- ☐ Preventive Care Services
- ☐ Health Risk Assessment and Screening Monitors
- ☐ Peer Case Reviews
- ☐ Focused Reviews
- ☐ Possible Avoidable Hospital Days Review

9.4b Quality Indicators

Indicators are developed by Arizona Priority Care's Medical Directors, Quality department staff and the Quality Improvement Committee. They are based upon the identification of care or services provided which represent a high volume or high risk to Arizona Priority

Care and its patients, or present potential areas for significant quality improvement. These areas for improvement may be identified through the following:

☐ Claims data.

☐ Demographic and epidemiological studies performed.

☐ Recommendations from patients, providers, other departments within Arizona Priority Care, the Medical Director, the Quality Improvement staff, and the Quality Improvement Committee structure.

☐ In accordance with standards developed by NCQA, CMS, OCI and other regulatory agencies.

Prior to the actual initiation of a study, the indicators require approval by the Quality Improvement Committee.

Each indicator is evaluated as to the time required to collect sufficient data. The area that is collecting the data, the Quality Management department, network peer physicians, and the Medical Director perform this evaluation.

Each indicator has a defined numerator and denominator in an effort to establish consistent, credible, and reliable statistics for reporting.

Each indicator has a defined source of data collection.

A database will be maintained for each indicator to assist in the collection of data and trend identification.

Each quality indicator will be reviewed by members of the provider network for input prior to implementation.

Providers will receive education regarding the quality indicator program, and results of the program will be shared on a regular basis. All individual provider information will be treated confidentially.

Indicators will be evaluated at least annually to determine their effectiveness and validity. Arizona Priority Care is obligated to disclose to the Health Plan and other regulatory agencies, quality and performance indicators for enrollee satisfaction, and health outcomes. Providers may be asked to assist Arizona Priority Care staff in meeting these requirements.

9.5 PRACTICE GUIDELINES

9.5a Overview

Acute and chronic health care evidence based guidelines will be adopted by Arizona Priority Care after approval by the QIC and Executive Committee.

1. Guidelines will be reviewed at least every two years and updated as appropriate.
2. Guidelines will be distributed to all practitioners.

Guidelines are reviewed and updated biannually. Providers are notified of implementation or changes in practice guidelines through the provider newsletter, mailings, electronic communications, and/or provider in-service sessions.

9.6 HEDIS® CAHPS® Measures

1. Arizona Priority Care will ensure that the healthcare service provided include appropriate preventive health care measures consistent with professionally recognized standards of practice.
2. Arizona Priority Care will adopt the Preventive Health Care Service guidelines based on national evidence based guidelines and will distribute them to the Providers.
3. Arizona Priority Care will provide the resources to obtain educational materials for Providers. Preventive Health Care Services (including services for the detection of asymptomatic diseases) shall include, under a physician's supervision:
    a. Colorectal Cancer Screening (50-75)

b. Mammogram screening (50-74 years)
c. Osteoporosis Testing (women 67 years & older)
d. Comprehensive Diabetes Care
e. Cholesterol Screening
f. Care of Older Adults Screening
g. Appropriate Monitoring for Patients Taking Long Term Medication(s)
h. Annual Flu Vaccine
i. Improving/Maintaining Physical/Mental Health
j. Improving Bladder Control
k. Fall Risk Assessment
l. BMI Screening

HEDIS® and STAR data will be reviewed to determine Arizona Priority Care/Provider compliance. Data will be analyzed to determine barriers and, when appropriate, corrective action in meeting compliance.

HEDIS® (Healthcare Effectiveness Data and Information Set) and STARs data is collected annually per NCQA's (National Committee for Quality Assurance) HEDIS® Technical Specifications. Quality Management and Information Systems staff assumes responsibility for the coordination and collection of HEDIS® and STARs data. Aggregate HEDIS®, STARs and CAHPS® results are reviewed by the QI Committee, Quality Management staff and other department staff as appropriately identified.

The QI Committee is provided with Quality Improvement Activity reports from various departments, and there is a discussion regarding identification of areas for improvement. Results are also reported to the QI Committee. The aggregate results of the HEDIS® Effectiveness of Care measures and the HEDIS® CAHPS® patient satisfaction measures are shared with providers via electronic communication and/or by provider mailings.

Some HEDIS® Effectiveness of Care measures require medical record review to provide accurate reporting of performance levels. For this reason, Arizona Priority Care staff may request to review medical records at the provider site or request that providers perform the medical record review. In event of the latter, Quality Management staff would provide any necessary training and data collection tools to facility staff designated to perform the medical record review.

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a standardized survey that is performed annually by an NCQA (National Committee for Quality Assurance) certified vendor according to the HEDIS® survey protocol. It is designed to capture consumer and patient perspectives on health care quality.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

9.7 Clinical Practice Guidelines

1. Arizona Priority Care will collaborate with its Providers to measure at least two (2) meaningful clinical issues relevant to membership for assessment and evaluation, one of which may be an issue related to preventive health.
2. Goals and/or benchmarks will be established.
3. The population will be identified from the affected population and data will be collected.

SECTION 10: PROVIDER BILLING AND REPORTING

10.1 PAYMENT ISSUES

10.1a Federal Funds

Payments received from Health Plans by Arizona Priority Care to provide services for patients are, in whole or part, from Federal funds. Therefore, providers and their subcontractors are subject to certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans With Disabilities Act and the Medicare Modernization Act of 2003.

10.1b Medicare Risk Adjustment

Risk Adjustment is the payment model that Centers for Medicare/Medicaid Services (CMS) uses for contracted Medicare Part C plans. The Risk Adjustment model places emphasis on the ***health status*** of the patient.

As a delegated participant in Medicare Part C plans, Arizona Priority Care is required to submit claim data to CMS on a routine basis. That data is used by CMS prospectively and data collected in the current year, is used to predict the CMS payment to Arizona Priority Care for the following year. CMS uses the diagnosis codes submitted for each individual patient in their formula to determine the payment.

Risk Adjustment data is collected from claims submitted, including hospital inpatient stays, hospital outpatient services, and physician encounters. Demographic variables are also components of risk adjustment payment calculation (e.g. patient age, gender, Medicaid eligibility, disabled status, reason for original entitlement to Medicare, community based or long-term based).

The payment is then risk adjusted according to the health status of the patient. Risk Adjustment factors are based on assignment to disease groups, also known as Hierarchical Condition Categories (HCCs). HCCs are determined by the diagnosis code submitted on the claim by the provider.

The level of Medicare payment is directly linked to diagnosis. It is imperative that providers document and submit all diagnosis codes at the highest level of specificity and that each diagnosis is validated with a status and plan in the medical record. Medical records must be signed and dated pursuant to CMS requirements.

Arizona Priority Care has special programs and forms designed to assist PCPs with comprehensive documentation of patient chronic conditions to meet these requirements.

10.2 BILLING/CLAIM SUBMISSION REQUIREMENTS

Claims should be submitted electronically, consistent with the requirements set forth in 45 CFR Parts 160 and 162, (the HIPAA requirements for standard transactions), or on paper, using industry standard CMS forms. Claims must be submitted utilizing valid and current Procedural Terminology (CPT), HCPCS Level II (National HCPCS), and/or revenue codes. CPT and Level II HCPCS modifiers are also required for claim adjudication and accurate reimbursement. ICD-9 CM codes must be submitted at the highest level of specificity. Incomplete or unacceptable claims will be returned with a letter of explanation. All returned claims must be resubmitted with the necessary information for adjudication. Claims received with incorrect coding will be returned or denied. Providers should bill based on the services provided consistent with standard billing guidelines unless otherwise communicated by Arizona Priority Care. The Explanation of Payment, or HIPAA 835, will include the reason for denial.

Filing a Claim

Arizona Priority Care strongly encourages the electronic filing of claims whenever possible. When submitting claims, it is important to accurately provide all required information as described in Claim Submission Requirements. Claims submitted with missing data may result in a delay in processing or a denial of the claim. Arizona Priority Care requires that all facility claims be submitted on a UB-04 claim form. Professional fees must be submitted

on a CMS 1500 claim form. Claims must be billed with a Maximum allowable amount and not the contracted rate or scheduled allowable.

Participating providers receive an Explanation of Benefits (EOB) each time a claim is processed.

When Arizona Priority Care is the primary payer, claims must be submitted as set forth in the Provider Participation Agreement (PPA) between Arizona Priority Care and the provider. ***Claims submitted more than 120 days after the date of service are denied***.

When Arizona Priority Care is the secondary payer, claims must be submitted as set forth in the Provider Participation Agreement (PPA). A copy of the primary carrier's EOB must be attached to the claim form.

If payment is denied based on a provider's failure to comply with timely filing requirements, the claim is treated as non-reimbursable and cannot be billed to the member.

Electronic Claim Submission

Arizona Priority Care has contracted with a clearinghouse to accept institutional and/or professional electronic claim transactions from the providers. Claims are received on a daily basis. The providers should request from the patient their current insurance card to assure that the claims are submitted with correct identification data.

Claims submitted with missing data elements or inaccurate data will be rejected or denied as billing errors in the claim adjudication process. More detailed information can be found in the Arizona Priority Care Claims Processing and Reimbursement Manual, located in Section 10 of the Provider Manual.

Paper Claim Submission

Providers may submit paper claims by completing a CMS 1500 form or UB-04 form, as appropriate. The following information must be indicated on the claim, in the box indicated, in order for Arizona Priority Care to accept and process the claim.

If all the information outlined below is not present and correct on the claim form, it will be returned to the provider as an unclean claim for the required information.

Paper claims should not be submitted by FAX. If we receive a requested FAX that is not readable, we will need to request that the provider resubmit a hard copy via mail, adding to the processing time for the claim.

Acceptable proof of timely filing includes:

- Computer-generated billing ledger showing Arizona Priority Care was billed within Arizona Priority Care's timely filing limits
- EOB from another insurance carrier dated within Arizona Priority Care's timely filing limits
- Denial letter from another insurance carrier, printed on its letterhead and dated within Arizona Priority Care's timely filing limits
- Electronic data interchange (EDI) rejection report from clearinghouse which indicates claim was forwarded to Arizona Priority Care (showing date received versus date of service) that reflects the claim was submitted within Arizona Priority Care's timely filing limits

Unacceptable proof of timely filing includes:

- Screen-print of claim invoice
- Copy of original claim
- Denial letter from another insurance carrier without a date and not on letterhead
- Record of billing stored in an Excel spreadsheet

Paper Claims Submission Address:
Arizona Priority Care
Attn: Claims
585 N. Juniper Drive, Suite 200
Chandler, Arizona 85226

10.2a Billing Reduced Services Modifiers

Providers submitting claims with reduction modifiers must submit full charges to facilitate correct payment. Payment will be reduced appropriately upon receipt of the claim.

10.2b Timely Payment

Arizona Priority Care will reimburse providers within thirty (30) days of receipt of a clean claim. A "clean claim" has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made. Claims that require additional information or are subject to coordination of benefits will be adjudicated promptly upon receipt of requested information.

10.2c Coordination of Benefits Claims Filing Limit

Coordination of Benefits claims should be submitted as soon as possible, but no later than Sixty (60) days from the date of receipt of the primary carrier Explanation of Benefits/Payment. Refer to your Arizona Priority Care contract for your claim filing limit.

10.2d Provider Payment Inquiries

Questions concerning claim status, claim payment, or adjustments should be directed to the Claims Department at (480) 499-8720 or (855) 706-8388.

Arizona Priority Care prefers overpayment recovery through an electronic recoupment process. Questions regarding recoveries or recoupments resulting in a negative balance should be directed to the Claims Department at (480) 499-8720 or
(855) 706-8388.

SECTION 11: CLAIMS AND PROVIDER REIMBURSEMENT

11.1 Claim Payment Overview

Arizona Priority Care will process all claims according to Medicare payment rules and specialty society guidelines, unless specified otherwise in a provider contract. If a billing or claims payment policy for a particular service is not addressed in this Claims and Provider Reimbursement Policy Section, follow procedures that are considered standard rules of the Centers for Medicare and Medicaid Services (CMS). This information is available at the CMS website **www.cms.gov**

The Claims Department processes all medical claims received from participating providers, unless a contractual arrangement exists to delegate claims payment to a participating entity. All claims are entered into the data processing system where an on-line claims history is maintained for at least twenty-four (24) months. Claims are adjudicated according to the provider's contractual agreement, the member's benefits and according to Medicare guidelines. You may direct any questions regarding claims to:

Provider Services at 480-499-8720 or 855-706-8388.

Arizona Priority Care will reimburse participating providers for prior authorized, medically necessary, contracted services rendered to a member eligible for care at the time of service. Verification of member eligibility is recommended prior to the rendering of service. Verification of eligibility however, is not a guarantee of payment. Services requiring prior authorization must be authorized before services are rendered to ensure proper reimbursement. Arizona Priority Care will not pay for unauthorized services that are not medically necessary.

Arizona Priority Care processes claims daily based upon First In First Out order and Arizona Priority Care has 30-60 days to process provider claims based upon Medicare guidelines. Arizona Priority Care cannot pull a check or an EOB for a provider to pick up.

Arizona Priority Care evaluates all medical billing information and coding for accuracy and appropriateness. This practice is designed to detect coding patterns such as unbundling, integral procedures, and mutually exclusive procedures.

In addition, Arizona Priority Care's claims payment system will adjudicate claims based on CMS (Centers for Medicare & Medicaid Services) and NCCI (National Correct Coding Init tive) edits. Arizona Priority Care considers coding edits that are based on industry sources, including but not limited to CPT guidelines from the American Medical Association, specialty organizations, and CMS. In coding scenarios where there are conflicts between sources, Arizona Priority Care will apply edits that Arizona Priority Care determines are most appropriate.

Arizona Priority Care assigns a value. This information is general in nature and describes general requirements only. Additional reimbursement requirements and specific reimbursement rates are set forth in and are governed by the Provider Participation Agreement (PPA) between Arizona Priority Care and the participating provider.

CMS 1500: Required Information	Box
Insured's ID# (including 2-digit suffix)	1a
Patient's name	2
Insured's name	4
Insured's address	7
Other insurance (for internal routing purposes only)	9 & 10
Is patient's condition related to (injury on job, auto or accident)	10a, b, c
Insured's policy, group number	11
Insured's date of birth; sex	11a
Patient or authorized person's signature (or Signature on File)	12
Referring physician's name	17
Referring physician's provider ID#	17a
Referring physician's NPI	17b
Diagnosis code(s) (accurate to the 4th or 5th digit)	21
Prior authorization number (if applicable)	23
Dates of service	24a
Place of service (from the Place of Service Code list)	24b
CPT/HCPCS code	24d
NDC	24e
Diagnosis pointer	
Charges	24f
Days or units	24g
Rendering provider ID	24j
Federal tax ID#	25
Accept assignment?	27
Total Charge	28
Signature of physician (or Signature on File)	31
Service facility location	32
NPI #	32a
Provider name, full address, and National Provider ID Number (6 or 10 digits; a.k.a. pin number), and site number (if applicable)	33

UB04: Required Information	Box
Facility name and full address	1
Type of bill	4
Federal tax ID#	5
Statement covers period	6
Patient's name	12
Revenue code	42
CPT or HCPCS/Rates (if applicable)	44
Total charges	47
Indication of dual payers (so that claims are appropriately routed through the Coordination of Benefits workflow)	50
National Provider ID number (6 or 10 digits)	51
Member ID#	60
Principle diagnosis code	67
ICD-9 Procedure Code	80/81

11.2 Balance Billing

Balance billing is the practice of a participating provider billing a member for the difference between the contracting amount and billed charges for covered services. When participating providers contract with Arizona Priority Care, they agree to accept Arizona Priority Care's contracting rate as payment in full. Billing members for any covered service is a breach of contract, as well as a violation of the Provider Participation Agreement (PPA) and state and federal (A.R.S. 20-1072) statutes. In some instances, balance billing of members can result in civil penalties of three times the amount of charges levied by the Arizona Department of Insurance (ADOI). Participating providers can only seek reimbursement from Arizona Priority Care members for copayments, coinsurance or deductibles.

11.3 Clean Claim Submission Guidelines

A "clean claim" is defined as a claim that can be processed as submitted without requiring additional information from the submitting physician, practitioner or facility. Submitted claims that do not meet the clean claims requirements may be pended for additional information or denied if the information submitted is invalid. Upon receipt of notice from Arizona Priority Care that additional information is required to complete adjudication of the claim; providers must submit only the missing information along with a copy of the notification letter. Providers should not submit a corrected claim in lieu of the additional information.

Upon receipt of a claim, if Arizona Priority Care determines that additional information is necessary to process the claim, the following steps are followed:

- The claim is pended and on the next business day, a notification letter requesting additional information is mailed to the provider
- If the requested information is not received within 30 days from the claim pended date, the claim remains pended and a second notification letter is mailed to the provider
- If the requested information is not received within 60 days from the claim pended date, the claim is denied
- For inpatient claims, if the requested information is not received within 45 days from the claim pended date, the claim is denied

If Arizona Priority Care obtains the requested additional information within 60 days (or 45 days for inpatient claims) from the initial claim pended date and the information demonstrates the claim should be denied, the claim is denied immediately. Providers should not initiate a new claim after receiving the notification letter requesting additional information. For reference, the notification letter includes the pended claim number that was previously submitted. Once Arizona Priority Care receives the additional information as requested, the original claim is processed. All requested information must be received at the address indicated in the letter. If payment is denied based on a provider's failure to comply with clean claim requirements, the claim is treated as non-reimbursable and cannot be billed to the member.

Further, claims for Medicare Advantage (MA) members must comply with the clean claim requirements for fee-for-service (FFS) Medicare (42 CFR 422.500). Refer to the Clean Claim Requirements for specific guidelines.

11.4 Corrected Claims Submission

Adjustments/Corrected Claims/Resubmissions
Informal Administrative requests for reconsideration — The provider requests reconsideration of a claim denied for administrative purposes (e.g., filing limit, coding edits, unclean claim, missing information, etc.).

Review the Explanation of Benefits to determine why the claim was denied or why only partial payment was made.

To ensure the Claims Department has adequate information to process claim adjustments and corrected claims in an accurate and timely manner, Arizona Priority Care requires that requests be submitted via the Claims Reconsideration Request Form.

The following maybe required for claims reconsideration:

- Letter requesting reconsideration
- Submission of a Corrected Claim
- Additional Documentation, Operative Reports, or office chart notes, as applicable. If additional documentation is requested by Arizona Priority Care, the documentation must be provided within 30 calendar days of the request. If received beyond this timeframe the denial will be upheld and the request will be closed.
- Proof of timely filing if appealing a claim that was denied for being submitted beyond the filing limit. (A computer printout from a provider's own office system is not acceptable proof of timely filing of claims.)

If the claim denial is the result of incorrect coding, the provider will receive notification to submit a corrected claim. Please note that Arizona Priority Care may not modify claims to add appropriate modifiers or change any information on the claims for received for processing. All corrections to claims are the responsibility of the provider.

Adjustments (review of a claims processing error) — The provider may request that Arizona Priority Care reconsider a denied claim or the amount paid based on the original claim submission. An adjustment should be requested if the claim was not paid for all reimbursable services or has been denied inappropriately for reasons such as member eligibility, duplicate services, retroactive referrals and authorizations, and retroactive contract change. For these requests, please attach any additional information to a copy of the original claim and submit it to the address shown below, or call 480-499-8720 or 855-706-8388 or Fax the information to 480-499-8799.

Arizona Priority Care
Attn: Claims - Reconsideration
585 N Juniper Drive, Suite 200
Chandler, AZ 85226

Adjustments may not be requested for services denied due to the application of CMS edits and payment rules.

Corrected Claims (review of a claims billing error) — The provider requests that Arizona Priority Care reconsider a claim based on incorrect, new, or missing data that was not submitted with the original claim.

Clinical documentation should not be submitted with corrected claims unless the claim involves a specialized service or circumstance.

The process for submitting adjustments, corrected claims, and resubmissions is the same, as outlined above.

If submitting a request for a corrected claim, also attach a copy of the corrected claim form (CMS 1500 or UB-04).

Submit to:
Arizona Priority Care
Attn: Claims Department
585 N Juniper Drive, Suite 200
Chandler, AZ 85226

Adjustments and corrected claims **may not** be submitted electronically.

Resubmission of claims that have not yet been paid **may** be submitted electronically. Arizona Priority Care's timely filing limit (from date of service) applies.

Arizona Priority Care must receive corrected claims within 365 calendar days of the Explanation of Benefits (EOB) issue date or payment may be denied. If payment is denied, the claim is treated as a non-reimbursable service and cannot be billed to the member.

Corrected claims must be appropriately marked as such and submitted to the appropriate claims mailing address.

Emdeon (*There may be a charge to the Provider*)
1-877-469-3263
https://www.emdeon.com
Payor ID: 27154

For additional information, contact Provider/Claim Services at 480-499-8720 Option 1, then Option 3 or 4

The benefits of electronic claim submission include:

- Reduction and elimination of costs associated with printing and mailing paper claims
- Improvement of data integrity through the use of clearinghouse edits
- Faster receipt of claims by Arizona Priority Care, resulting in reduced processing time and quicker payment
- Confirmation of receipt of claims by the clearinghouse
- Availability of reports when electronic claims are rejected and ability to track electronic claims, resulting in greater accountability

11.5 Electronic Data Interchange (EDI) Claims Submission Reports

For successful electronic data interchange (EDI) claim submission, participating providers must utilize the electronic reporting made available by their vendor or clearinghouse. There may be several levels of electronic reporting:

- Confirmation/rejection reports from EDI vendor
- Confirmation/rejection reports from EDI clearinghouse
- Confirmation/rejection reports from Arizona Priority Care

Providers are encouraged to contact their vendor/clearinghouse to see how these reports can be accessed or viewed. All electronic claims that have been rejected must be corrected and resubmitted. Rejected claims may be resubmitted electronically.

Providers may also check the status of paper and electronic claims online at Arizona Priority Care's On-Line Provider Portal.

For questions regarding electronic claims submission, contact the Arizona Priority Care EDI Claims Department at 480-499-8720 or 855-706-8388.

11.6 Fee-for-Service Reimbursement

Arizona Priority Care contracts with participating providers to provide covered services to members and reimburses them through a fee-for-service (FFS) arrangement. Arizona Priority Care's primary fee schedule is based on the CMS Resource-Based Relative Value Scale (RBRVS) (Medicare allowable). When there is no Medicare allowable,

11.7 Overpayment Recovery Procedures

Arizona Priority Care makes every attempt to identify a claim overpayment and issues a notice requesting reimbursement of an overpayment (Overpayment Refund Request) from the provider within 30 days of the overpayment being identified. If a provider receives an Overpayment Refund Request from Arizona Priority Care, the provider must follow the

instructions outlined in the letter for returning the overpayment or disputing the request. Included with the Overpayment Refund Request is a self-addressed envelope for the provider to use when returning the overpayment. In the event that the Provider does not respond to the Over payment refund request within thirty (30) days of the request, the provider will be notified of Arizona Priority Care's intent to institute an automatic system offset to recover outstanding funds due. An automatic system offset, where applicable, will be processed once the appropriate notification period has passed.

In the event that a provider independently identifies an overpayment from Arizona Priority Care (such as a credit balance), the provider must take the following steps:

- Send a check made payable to the appropriate entity (Arizona Priority Care)
- Include a copy of the remittance advice (RA) that accompanied the overpayment to expedite Arizona Priority Care's adjustment of the provider's account. If the RA is not available, the following information must be provided: Arizona Priority Care member name, date of service, payment amount, Arizona Priority Care member identification (ID) number, vendor name, provider tax identification (ID) number, provider number, vendor number, and reason for the overpayment refund. If the RA is not available, it takes longer for Arizona Priority Care to process the overpayment refund.
- Send the overpayment refund and applicable details to the Arizona Priority Care Claims Department.
- If a provider is contacted by a third-party overpayment recovery vendor acting on behalf of Arizona Priority Care, the provider must follow the overpayment refund instructions provided by the vendor.
- If a provider believes he or she has received an Arizona Priority Care check in error and the provider has not cashed the check, return the check to the Arizona Priority Care Claims Department with the applicable RA and a cover letter indicating why the check is being returned.

Encounters are records of member visits submitted by the physician or other clinician to Arizona Priority Care.

Encounters are submitted for all services rendered to patients when the provider is compensated by Capitation.

Encounters are not bills. These records show utilization of services rendered under a capitated agreement.

Encounters must be submitted to Arizona Priority Care within 60 days of the date services were rendered.

Encounters may be submitted electronically or by mail to Arizona Priority Care Claims Department. Encounters for Medicare Advantage (MA) HMO must be in the Centers for Medicare and Medicaid Services (CMS) National Standard Format. CMS mandates that all encounters are submitted in a timely manner. Future reimbursement rates will be determined by utilization, which is demonstrated by encounter data.

Encounters data is to be submitted in the same format as a fee for service claim. Submit encounters to the Arizona Priority Care Claims Submission address on the most current CMS-1500, UB-04, or other appropriate standard form:

- Provider identification (ID) number
- National Provider Identifier (NPI)
- Current tax ID number
- Current Medicare provider identification number (UPIN), if applicable
- Member's name, address, telephone number, gender, and date of birth
- Arizona Priority Care membership number or reference and group number
- Current CPT Code for each procedure performed and modifiers, if appropriate (include a copy of the operative report if a "by report" procedure code is being submitted)
- Centers for Medicare and Medicaid Services (CMS) coding for place of service and type of service
- Revenue code for departmental revenue
- Diagnosis code number (ICD-9). Indicate appropriate symptoms or diagnoses for tests performed and submit up to four diagnosis codes. Bill to highest level of specificity
- ICD-9 procedure and DRG codes for UB-04 claims

- Referral provider (indicate ordering provider on UB-04)
- Prior Authorization number if applicable
- Billing provider's name and remit address
- Date of service
- Current coordination of benefits (COB) information or other insurance information such as motor vehicle, workers' compensation or other third-party liability
- Name of the chemotherapeutic agent, drug or medication and HCPCS code used for chemotherapy services, or injectables, Arizona Priority Care participating providers are required to submit encounters for all services that are provided to Arizona Priority Care members. Arizona Priority Care reserves the right to process an EOB to serve as a report of the encounters submitted with appropriate documentation that the report is for encounter data and not claims payment.

11.8 Professional Claim Editing

Arizona Priority Care employs a software based solution for professional claim edit policy management. Using Virtual Examiner's services, Arizona Priority Care has the ability to apply advanced contextual processing for application of Arizona Priority Care edit logic.

The process is as follows:

- Arizona Priority Care controls the selection of all edit policy
- Claims are run through various interfaces to check against the edits every night
- The program reviews each claim in the file and renders coding recommendations based on Arizona Priority Care's edit policy. The program also provides management support services, including edit policy advisory services. The claims team conducts ongoing research into payment policy sources including, but not limited to, the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and other specialty academies, to provide Arizona Priority Care with the necessary information to make informed decisions when establishing edit policy.

11.9 Reimbursement through Capitation

This information is general in nature and describes general requirements. Additional reimbursement requirements and specific reimbursement rates are set forth in and are governed by the Provider Participation Agreement (PPA) between Arizona Priority Care and the participating provider.

Capitation is a per member per month (PMPM) prepayment to a physician, medical group/IPA or other provider of service for services included within the scope of the capitation. Services outlined in the Arizona Priority Care Provider Participation Agreement (PPA) as included within the scope of capitated services for which the provider receives a monthly capitation payment are not separately reimbursed. Compensation by Capitation however, does require the submission of Encounter data.

11.10 Remittance Advice

Arizona Priority Care's remittance advice (RA) contains important information about claims submissions and cash receipts for overpayments. For a detailed explanation of each field on the RA, refer to the RA Detail document. The RA should be reviewed upon receipt and reconciled against billing records. The RA includes Arizona Priority Care member names and dollar amounts paid for all claims processed during the course of a week. Processing claims and adjustments results in one of the following remittance situations:

- **Positive remittance -** A remittance that totals to a positive amount and results in a payment to the provider. The total at the bottom of the RA agrees with the check or electronic payment the provider receives.
- **Negative remittance -** A remittance produced when the adjusted dollars exceed the total amount of payment on the remittance. The total at the bottom of the RA is negative, and does not result in a check or electronic payment to the provider. Arizona Priority Care sends claims payment notification letters with detailed claim information about the payment error and requests a return of the overpayment. If the physician, medical group, hospital, or ancillary provider does

not dispute or return the requested payment within the specified time period, the overpayment amount is applied and subtracted from a future reimbursement according to the terms of the overpayment letter and the provider's Provider Participation Agreement (PPA).

11.11 Submission of Clinical Information

Arizona Priority Care of Arizona, Inc. routinely requires clinical information at the time of claim submission.

Coordination of benefits (COB) occurs when a member is covered by two or more employer group health insurance plans or insurance products. Most group health plans contain a provision stating that, when a member is covered by two or more group health plans, payment is divided between them so that the combined coverage pays up to 100 percent of eligible expenses, as defined by each payer. COB allows group health plans to eliminate the opportunity for a person to profit from an illness or injury as the result of duplicate group health plan coverage. Generally, one plan is determined to be primary, and that plan pays without regard to the other. The secondary plan then makes only a supplemental payment that results in a total payment of not more than the eligible expenses, as defined by each payer, for the medical service provided. If one plan is an individual plan, not a group plan, both plans pay as primary. The payments do not
coordinate. Participating providers are required to administer COB when such provisions are a requirement of the benefit plans. The participating provider should ask the member for possible coverage through another group health plan and enter the other health insurance information on the claim.

Note: Any work-related injury is not a covered benefit. Claims are not coordinated for workers' compensation.

11.12 Entitlement of Member

If a member is entitled to receive medical/health benefits under another group insurance plan, the benefits under the Arizona Priority Care will be coordinated with benefits under the other plan(s), up to 100% of the member's responsibility. In no event shall Arizona

Priority Care be liable for more than it would have been liable as the primary payer. The member must notify Arizona Priority Care of other coverage and will be responsible for payment of all non-covered services; and shall never be liable for more than their applicable cost share (e.g., copayments, coinsurance, deductibles, etc.) under their Arizona Priority Care Plan.

11.13 Provider Responsibility

- The Provider must bill the other health plan insurance/insurer first, when Arizona Priority Care is the secondary carrier.
- When submitting a claim to Arizona Priority Care as secondary carrier, the Provider must also include the Explanation of Benefits (EOB) from the other health plan.
- The Provider must indicate the other health plan insurance on the bill you submit to Arizona Priority Care.
- The Provider must bill for or submit the procedure codes which are required per their contract with Arizona Priority Care. If the Provider submits procedure codes which are not on their contract/fee schedule, the claim will be denied.

Arizona Priority Care as Primary Carrier:
Arizona Priority Care will pay the full contracted, allowable amount minus applicable cost-sharing or adjustments. (The patient may receive reimbursement from the secondary carrier for any out-of-pocket expenses incurred, such as the copayments, coinsurance and deductibles.)

Arizona Priority Care as Secondary Carrier:
Payment will not be made until a copy of the Explanation of Benefits (EOB) is received indicating the amount paid by the primary carrier.

- Arizona Priority Care will pay up to the member's responsibility under the primary carrier or Arizona Priority Care's contracted amount, whichever is lower.
- Arizona Priority Care recommends that the copayment not be collected at the time of service. Once a provider receives payment from all carriers, determine if there is any remaining billable balance. Most balance billing occurs when the member has a deductible that needs to be satisfied, such as a Medicare Part B deductible, or a commercial carrier deductible.

- The filing limit for claims where Arizona Priority Care is secondary is 60 days after the issue date of the last EOB received from the primary carrier. Claims denied as beyond the filing limit by the primary carrier will not be accepted for payment by Arizona Priority Care.

Note: If the member has medical coverage under their auto carrier, the auto carrier would be primary for claims related to the auto accident, up to the policy maximum

11.14 Coordination with Medicare

Medicare is the secondary payer when the following conditions exist:

- If the member is age 65 or older, has health insurance coverage under an employer group plan with 20 or more employees, and coverage is based on the member's own current employment or the current employment of a spouse of any age
- If the member is under age 65, entitled to Medicare on the basis of disability, has health insurance coverage under a large group health plan (includes at least one employer with 100 employees) by virtue of member's own employment or the current employment of a family member
- For the first 30 months of end-stage renal disease (ESRD) - based Medicare eligibility or entitlement, if the member has ESRD and is covered by an employer group health plan regardless of the number of employees in the group or current employment status
- To any no-fault insurance, including automobile, medical and non-automobile no-fault insurance
- To any liability insurance such as automobile liability insurance and malpractice insurance

By law, Arizona Priority Care may only pay providers who accept assignment up to the Medicare allowable; however, the amount paid cannot exceed the contracting Arizona Priority Care-allowable amount. Arizona Priority Care may pay providers who do not accept assignment up to the Medicare limiting charges; however, the amount paid cannot exceed the Arizona Priority Care allowable amount.

11.15 Coordination of Benefits (COB) Payment Calculations

As the secondary carrier, Arizona Priority Care coordinates benefits and pay balances, up to the member's liability, for covered services. However, the dollar value of the balance payment cannot exceed the dollar value of the amount that would have been paid had Arizona Priority Care been the primary carrier.

In most cases, members who have coverage through two carriers are not responsible for cost shares or copayments. Therefore, it is advisable to wait until payment is received from both carriers before collecting from the member. Copayments are waived when a member has other insurance as primary coverage.

If a participating provider contracts with two HMOs and the member belongs to both, all prior authorization requirements for both carriers must be complied with in order to coordinate benefits. For example, if the primary carrier, as well as Arizona Priority Care, requires authorization for a procedure or service, and authorization is requested and approved by the primary carrier, Arizona Priority Care does not require authorization for that procedure or service. However, if the primary carrier requires authorization and authorization is not requested or approved from the primary carrier, and Arizona Priority Care requires authorization, Arizona Priority Care does not make payment as the secondary carrier unless the prior authorization is requested and approved by primary carrier.

11.16 COB Determination Rules

The following NAIC guidelines are designed to assist in determining primary coverage.

1. If one plan has a coordination of benefits (COB) provision and another plan does not have a COB provision, the plan without the COB provision pays as primary.

2. In the event there are two or more plans covering the same individual, the order of benefit determination is the first of the following rules, which apply:

- The plan that covers the individual as a subscriber
- The plan that covers the individual as a dependent
- Dependent child/parents not separated or divorced.

If a dependent child is covered under two or more plans, primary responsibility and the order of determination is:

- The plan of the parent whose birthday falls earlier in a calendar year is determined to be the primary plan
- If both parents have the same birthday, the plan that covered the parent longer is determined to be the primary plan
- The term "birthday" as used in this provision refers only to the month and day in a calendar year, not the year in which the person was born
- Dependent child/parents separated, divorced or never married. If a dependent child is covered under two or more plans, primary responsibility and the order of benefit determination is:
- The plan of the parent having custody of the child
- The plan of the spouse of the parent having custody of the child
- The plan of the parent not having custody of the child
- If the specific terms of a court order state that one parent is responsible for the health care benefits of such child, and the plan entity who is obligated to pay or provide expenses of the plan of that parent has actual knowledge of the court order, then the benefits of that plan are determined first. This does not apply with respect to any claim determination period or year during which any benefits are actually paid or provided before the entity has that actual knowledge
- Dependent child/parents separated, divorced or never married having joint custody. If the specific terms of a court order state that the parents have joint custody of the child, without specifying which parent has responsibility for the child's health care expenses, benefits are determined on the same basis as for a child whose parents are not separated or divorced

- If one of the other plan(s) is issued out of the state of Arizona and has a rule based upon the gender of the parent, and not the birthday rule as described above, and as a result, the plans do not agree on the order of benefits, then the gender rule as described above prevails. Otherwise, the birthday rule prevails

3. Active/inactive employee. The benefits of a plan that covers a person as an employee (or as that employee's dependent) are determined before those of a plan, which covers that person as a laid-off or retired employee (or as that employee's covered service). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

4. Continuation coverage. If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following is the order of benefit determination:

- First, the benefits of a plan covering the person as an employee (or as that employee's dependent)
- Second, the benefits of coverage purchased under the continuation plan. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored

5. Longer/shorter length of coverage. If none of the above rules determine the order of benefits, the benefits of the plan that covered the member longer are determined before those of the plan, which covered that person for the shorter term.

11.17 Arizona Priority Care COB Entitlements

Arizona Priority Care is entitled to:

- Determine whether and to what extent a member is entitled to services or benefits under a payer other than Arizona Priority Care for covered services
- Establish in accordance with the priorities for determining primary responsibility among the payers obligated to provide services or indemnity
- Release to or obtain from any other payer information needed to implement coordination of benefits

- Recover the value of covered services rendered to the member to the extent that they are actually provided or indemnified by another payer

Coordination with Consolidated Omnibus Budget Reconciliation Act (COBRA)
Medicare is primary over COBRA when a member has Medicare due to age or disability.

11.18 Providing COB Information

In order for Arizona Priority Care to document member records and to process claims appropriately, include the following information on all coordination of benefits (COB) claims:

- Name of the other carrier
- Subscriber identification (ID) number with the other carrier

If an Arizona Priority Care member has other group health coverage, follow these steps:

- Determine which carrier is primary using the guidelines found in the Order of Benefit Determination Rules discussion
- If Arizona Priority Care is the primary carrier, submit the claim to Arizona Priority Care
- If Arizona Priority Care is the secondary carrier, file the claim with the primary carrier first
- After the primary carrier has paid, attach a copy of the Explanation of Benefits (EOB) to a copy of the claim and submit both to Health Net. Claims submitted to Arizona Priority Care for secondary payment must be submitted within 60 days of payment from primary carrier's EOB payment or denial. Claims submitted after this period of time are denied for timely filing. If denied on the basis of timeliness, the claims are treated as non-reimbursable and cannot be billed to the member.

Section 12: Provider Disputes & Appeals

If a participating contracted provider disagrees with an Arizona Priority Care claim determination, a dispute may be requested. Arizona Priority Care recommends that providers submit dispute requests on the Provider Dispute Resolution Request form.

Compliance with the following is required to file a Dispute:

- The provider who rendered the service must submit the dispute request with all necessary information, including new information that was not originally submitted, documenting the reason for the appeal request, the original claim, Explanation of Benefits (EOB), prior authorization letter or form, and supporting medical records to the Arizona Priority Care Provider Dispute Department as documented on the EOB.
- Dispute requests must be received by Arizona Priority Care within 365 calendar days of the Explanation of Benefits (EOB) determination unless the Provider Participation Agreement (PPA) states otherwise
- The reason for the dispute must be clearly stated
- The disputed amount for each claim must be clearly stated

Upon receipt of the dispute, the Provider Dispute Department reviews the dispute and approves or denies it within 30 calendar days of receipt of the request based upon the information submitted. If a dispute is denied based on failure to comply with the dispute submission requirements, including those listed above and timeliness requirements, the underlying claims may be denied.

If denied, they are treated as a non-reimbursable service and cannot be billed to the member.

(See Attachment C for Provider Dispute Resolution Request Form)

Section 13: FRAUD, WASTE & ABUSE

Fraudulent Statements & Claims
Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable under applicable laws.

All providers acknowledge that Arizona Priority Care is receiving federal funds and that payments to providers for covered services are in whole or in part, from federal funds.

State law requires that Arizona Priority Care report instances of suspected insurance fraud. Such instances may include, but are not limited to:
- Material misstatements of facts or omissions on insurance applications
- False claims
- False, forged or altered prescriptions
- Misuse of Arizona Priority Care identification (ID) cards

Providers must report suspected fraud involving an Arizona Priority Care member to an Arizona Priority Care Provider Network Management Department representative, who works with the appropriate Arizona Priority Care departments to investigate the suspected fraud.

Arizona Priority Care also asks providers to assist Arizona Priority Care and, if necessary, the Arizona Department of Insurance (ADOI) in investigating instances of suspected fraud.

SECTION 14: GLOSSARY OF COMMON TERMS

Accessibility - The extent to which a patient of a Health Plan can obtain available services.

Acute Care - A level of health care that can be provided only in a hospital.

Adjudication - Determination of allowance on a claim based on type of coverage and use of benefits.

Amendment - A legal document that is used to change terms of a contract.

Appeal – Any of the procedures that deal with the review of adverse organization determinations on the health care services a patient believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the patient), or on any amounts the patient must pay for a service. These procedures include reconsideration by Arizona Priority Care and if necessary, an independent review entity, hearings before the Administrative Law Judges (ALJ), and judicial review.

Authorized Representative - An individual authorized by the patient to act on their behalf in pursuing payment of a claim, obtaining a referral/prior authorization or dealing with any level of the grievance process.

Care Management - A process of identifying patients with special healthcare needs, developing a health-care strategy that meets those needs, and coordinating and monitoring care. By offering alternatives to high cost settings or treatment, Care Management provides an opportunity to contain costs and still maintain the appropriate level of services.

Clinical Privileges - Authorization by the governing body for a provider to provide specific patient care and treatment services in the organization, based on the provider's license, education, training, experience, and competence.

Clean Claim - A claim that has no defect, impropriety, or lack of any required substantiating documentation. A clean claim contains all the data elements required on an industry standard CMS claim form. For claims submitted to Arizona Priority Care electronically, Provider shall transmit claims in compliance with the requirements set forth in 45 CFR Parts 160 and 162 (the HIPAA requirement for standard transactions), or as are amended from time to time. A submission which does not include all the required information, or for which we must request additional information (for example, medical records, other coverage information, or subrogation information) is not a clean claim until Arizona Priority Care receives the required information.

Coinsurance - A charge expressed as a percentage of the fee for covered expenses that patients are required to pay for certain covered expenses provided under the policy. Patients are responsible for the payment to the provider for any coinsurance charge.

Concurrent Review - A type of utilization review that occurs while treatment is in process and typically applies to services that continue over a period of time.

Confinement/Confined - The period of time between admission and discharge as an inpatient or outpatient to a hospital, alcohol, and other drug abuse residential treatment center, skilled nursing facility, or freestanding surgical facility. Confinement shall also include time spent in a hospital receiving care for a sickness or injury. Hospital swing bed confinement is considered the same as confinement in a skilled nursing facility. If patients are confined and transferred to another facility for continued treatment it is considered one confinement.

Coordination of Benefits (COB) - A method of integrating benefits payable under more than one group health care program so that benefits from all sources do not exceed 100% of allowable expenses.

Copayment - A specific amount, usually expressed in dollars, or a charge for a service, that patients must incur before Arizona Priority Care assumes any liability for the remaining part of the charges for that service.

Corrective Action - A quality management process that is implemented to address complaints or errors for the purpose of eliminating future occurrences.

Cosmetic Surgery - Any operative procedure performed primarily to: improve physical appearance, to treat a mental or nervous disorder through a change in bodily form, to change or restore bodily form without correcting or materially improving a bodily function.

Covered Expense - An expense for medical services, supplies or treatment for which a fee or charge is incurred by or on the patient's behalf because of injury or sickness, and for which Arizona Priority Care provides a benefit. The expense is incurred on the date the service is performed or the supply or treatment is received. Covered expenses: 1) must be incurred while this coverage is in force for the patients, 2) must be medically necessary, 3)

must be listed as a covered expense in the patient's certificate, 4) must not be excluded from coverage, 5) must not exceed any maximum amount payable under the patient's certificate, and 6) must be received from a participating provider with a referral, or a non-participating provider with an authorization.

Credentialing - The process by which Arizona Priority Care evaluates and recommends practitioners who are licensed to practice independently, to provide services to its patients. Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability and accessibility, and conformance with Arizona Priority Care's utilization and quality management requirements.

Custodial Care - Such care does not entail or require the continuing attention of trained medical personnel, such as nurses. Custodial Care includes the provision of room and board, nursing care, personal care, or other care designed to assist an individual in the activities of daily living, such as help in: walking, getting in and out of bed, assistance in bathing or dressing, eating, using the toilet, preparing special diets, or supervision of medication, which usually can be self-administered. Care may still be custodial, even though such care involves the use of technical medical skills, if such skills can be easily taught to a layperson. In the case of an institutionalized person, custodial care also includes room and board, nursing care, or other care, which is provided to an individual for whom it cannot reasonably be expected, in the opinion of the physician, that medical or surgical treatment will enable that person to live outside an institution. Custodial care includes: rest cures, respite care, and home care provided by family patients.

Deductible - The amount the patient must pay for covered services before Arizona Priority Care assumes liability for all or part of the remaining costs for covered services. The deductible is an annual out of pocket expense for the patient.

Disease Management - A coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, quality healthcare for a patient population who have or are at risk for a specific chronic illness or medical condition.

Disenrollment - Disenrollment means that a patient's coverage under the policy is being terminated.

Durable Medical Equipment - Equipment that must:

1. Be able to withstand repeated use.
2. Be primarily and customarily used to serve a medical purpose.
3. Not be generally useful to a person, except for the treatment of an injury or sickness.
4. Be medically necessary.

Examples include, but are not limited to: crutches, wheelchairs, hospital beds, and equipment used in the administration of oxygen, initial acquisition of artificial limbs or eyes, and custom-made orthotics.

Effective Date - The date on which the patient became enrolled and entitled to the benefits specified in the policy.

Electronic Data Interchange (EDI) - The computer-to-computer transfer of data between organizations (provider, payer, clearinghouse) using a standard data format.

Eligibility - The right to receive benefits based on the type of contracts held.

Emergency Services - Services related to a medical condition involving acute symptoms that would lead a prudent lay-person, who possess an average knowledge of health and medicine, to reasonably conclude that a lack of immediate medical attention would result in serious jeopardy to the person's health, impairment to bodily functions, or serious dysfunction to one or more organs.

Exclusions - Contract provisions, which cite situations, conditions or treatments that are not covered.

Expedited Grievance - Expedited Grievance means a grievance where the standard resolution process may include any of the following: (1) serious jeopardy to the patient's life or health or ability to regain maximum function, (2) in the opinion of a physician, with knowledge of the patient's medical condition, would subject them to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance, or (3) it is determined to be an expedited grievance by a physician with knowledge of the patient's medical condition.

Experimental or Investigational - Treatments, procedures, drugs or medicines, which are experimental or investigational, and includes one or more of the following: 1) the device, drug or medicine cannot lawfully be marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the device, drug or medicine is furnished, 2) reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing Phase I, II, or III clinical trials, or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy compared with the standard means of treatment or diagnosis, or 3) reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedures, device, drug or medicine, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, the written protocols used by the treating facility, or the protocols of another facility studying substantially the same treatment, procedure, device, drug or medicine, or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Explanation of Benefits (EOB) - A statement sent to the patient explaining action taken by Arizona Priority Care regarding a claim filed on his or her behalf.

Fee Schedule - A listing of established allowances for specific procedures. It usually represents either standard or maximum amounts the insurer pays.

Formulary - A listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given managed population and that are to be used by Arizona Priority Care providers in prescribing medications to patients.

Grievance - Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which Arizona Priority Care provides health care services, regardless of whether any remedial action can be taken. A patient may make the complaint or dispute, either orally or in writing, to the Health Plan, Arizona Priority Care provider, or facility. A grievance may also include a complaint that Arizona Priority Care refused to expedite an organization determination or

reconsideration, or invoked an extension to an organization determination or reconsideration time frames. Grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards of delivery of health care.

Health Maintenance Organization (HMO) - An organized system for providing health care in a geographic area that assures delivery of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of people for a predetermined, fixed prepayment fee.

HIPAA - The Health Insurance Portability & Accountability Act of 1996 (August 21), Public Law 104-191, which amends the Internal Revenue Service Code of 1986. Also known as the Kennedy-Kassebaum Act.

Locum Tenens - A provider who is replacing a plan affiliated provider for a specified period of time while the plan provider is absent from their practice.

Maintenance Therapy - Ongoing therapy delivered after the acute phase of an illness has passed. It begins when a patient's recovery has reached a plateau or improvement in his/her condition has slowed or ceased entirely and only minimal rehabilitative gains can be demonstrated. The determination of what constitutes maintenance therapy is made by Arizona Priority Care after reviewing an individual's case history or treatment plan, submitted by a health care provider.

Medical Director - A physician employed by Arizona Priority Care to direct and manage the delivery of appropriate medical care in a cost-effective manner while maintaining the highest quality of care possible.

Medical Management - A department within Arizona Priority Care consisting of health professionals who provide utilization management, prior authorization, concurrent review of hospitalizations, and case management.

Medically Necessary - Medical treatment, services or supplies that are required to identify or treat a sickness or injury and which, as determined by Arizona Priority Care are:

1. Consistent with the symptoms, diagnosis or treatment of the patient's medical condition,
2. Appropriate with regard to standards of good medical practice,
3. Not primarily for the patient's convenience, their immediate family, or that of the physician or another provider,
4. The most appropriate and cost-effective level of medical service or supplies, which can be safely provided. When applied to inpatient care, it further means that the medical symptoms or conditions require that the medical services or supplies cannot be safely provided as an outpatient, and of proven value or usefulness.

The fact that a physician or participating provider has prescribed, ordered, recommended or approved a treatment, service or supply, or has informed patients of its availability, does not in itself make it medically necessary.

Medicare Advantage Organization – An entity licensed by the State as a risk-bearing entity that is contracted with the Centers for Medicare and Medicaid Services, to provide a network of providers through contractually specified reimbursement terms for covered benefits for Medicare eligible beneficiaries.

Patient Advocate - An individual employed by Arizona Priority Care specializing in the appeal and grievance process.

Patients - Individuals for whom Arizona Priority Care has a contractual obligation to provide or arrange for the provision of health services.

National Committee for Quality Assurance (NCQA) - The not-for-profit, Washington D.C.-based organization that is widely recognized as the authority on quality for managed care organizations. NCQA has developed over fifty (50) standards in six (6) categories (Quality Improvement, Credentialing, Utilization Management, Preventive Health Services, Patients' Rights and Responsibilities, and Medical Records) and evaluates internal quality processes through accreditation site visits.

Network - The physicians and other professional providers, clinics, health centers, and hospitals that a managed care organization has affiliated and contracted with to provide care to its patients.

Non-Participating Provider - A physician or other health care provider who has not signed a participating provider contract with Arizona Priority Care to provide medical treatment, services or supplies, to patients. Except for emergency care, benefits are excluded when a patient receives medical treatment, services or supplies, from a non-participating provider without a Prior authorization.

Observation Status - Observation status means a stay in a hospital or qualified treatment facility not to exceed twenty-four (24) hours if:

1. Patient has not been admitted as an inpatient;
2. Patient is physically detained in an emergency room, treatment room, observation room, or other such area; or
3. Patient is being observed to determine whether an inpatient confinement will be required.

Out of Network - See "Non-Participating Provider."

Participating - Refers to a status when a provider/practitioner of health care services has signed a contract to participate in Arizona Priority Care's network.

Participating Provider - A health care facility, institution, or clinic which agrees by contract to provide services for patients.

Peer Review - The evaluation by practicing physicians or other health care providers of the effectiveness and efficacy of services provided by other patients of the same profession.

Plan - An insurance group, healthcare organization or worker's compensation program, which contracts with providers for health care services.

Prior Authorization/Prior Authorized - The process of obtaining prior written approval from Medical Management as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

Provider Services Agreement - A legal contract between Arizona Priority Care and a provider citing legal responsibilities of both parties.

Arizona Priority Care Referral - The written or electronically issued referral of a patient by a participating provider to another health care provider that may be required under a Benefit Program or a Group or Payor Policy prior to the rendition of Covered Services, usually for a specified number of visits or type or duration of treatment. Certain referrals may require Prior Authorization in accordance with the Group's Utilization Management Plan.

Routine Examination - Any physical exam or evaluation done in accordance with our preventative care guidelines indicated for age and gender.

Service Area - The geographic area as defined by Arizona Priority Care.

Skilled Care - Medical services rendered by a registered or licensed practical nurse, physical, occupational, or speech therapist.

Skilled Nursing Facility - An institution which is licensed by the State of Arizona, or other applicable jurisdiction, that maintains and provides the following:

1. Permanent and full-time bed care facilities for resident patients,
2. A physician's services available at all times,
3. A registered nurse or physician in charge and on full-time duty and one or more registered nurses or licensed vocational or practical nurses on full-time duty, 4. A daily record for each patient, and
4. Continuous skilled care for sick or injured persons during convalescence from sickness or injury.

Unbundling - A coding inconsistency that is a non-industry standard, which involves separating a procedure into parts and coding/charging for each part rather than using a single code for the entire procedure.

Urgent Care - Care for an injury or sickness, which is needed sooner than a routine doctor's visit.

Utilization Management (UM) - Managing the use of medical services to ensure that a patient receives necessary, appropriate, high-quality care in a cost-effective manner.

Utilization Review - An evaluation of the necessity, appropriateness and efficacy of the use of medical or institutional services.