CHAPTER 600

PROVIDER QUALIFICATIONS AND PROVIDER REQUIREMENTS

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600 CHAPTER OVERVIEW

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This Chapter presents the Federal and State provider qualifications and network requirements for AHCCCS. Provider qualifications, requirements and recommendations are identified as they relate to the provision of quality health care in a timely manner and in a location, which is convenient and accessible for AHCCCS members.

These provider qualifications and network requirements/recommendations apply to providers of the following AHCCCS covered services:

1. AHCCCS acute care program services provided to AHCCCS members by or through Contractors and AHCCCS registered Fee-For-Service (FFS) providers.

   Refer to Chapter 400 for additional requirements specific to maternity services and/or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Additional requirements for registration of FFS providers are in the AHCCCS FFS Provider Manual.

2. Arizona Long Term Care System (ALTCS) program services.

3. AHCCCS behavioral health program services are provided through a contract with Arizona Department of Health Services (ADHS) for acute care members and Contractors for ALTCS members. Emergency behavioral health services may also be provided by FFS providers. See the Behavioral Health Services Guide for additional information.

Provider qualifications and network requirements are presented as follows:

1. AHCCCS provider qualifications, and

2. AHCCCS FFS minimum network requirements.

610 AHCCCS PROVIDER QUALIFICATIONS

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All providers of AHCCCS-covered services, both Fee-For-Service [FFS] and managed care shall:

1. Register with the AHCCCS which requires signing the Provider Participation Agreement or Group Biller Participation Agreement that includes all federal and state requirements as applicable, and

2. Comply with all federal, state, and local laws, rules, regulations, executive orders and agency policies governing performance of duties under this agreement.

3. Effective August 2, 2012, sign and return attestations found on the Provider Registration section of the AHCCCS website that are applicable to their individual practices or facilities.

4. Meet AHCCCS requirements for professional licensure, certification or registration including current Medicare certification.

5. Complete all applicable registration forms.

6. Institutional and other designated providers are required to submit an enrollment fee, effective January 1, 2012 (See the Exhibit 610-1).

7. Specific provider types will require an AHCCCS Office of the Inspector General (AHCCCS-OIG) site visit prior to enrollment, and are subject to unannounced post enrollment site visits (See Exhibit 610-1).

AHCCCS registration is mandatory for consideration for payment by:

1. AHCCCS for services rendered by FFS providers, and

2. AHCCCS Contractors for services rendered by managed care providers as well as submission of encounter data to the AHCCCS Administration by the Contractors.

A. AHCCCS PROVIDER REGISTRATION MATERIALS

AHCCCS-OIG Provider Registration materials are available on the AHCCCS web site. Click on the "Plans/Providers" tab. On the "New Providers" click on the "Provider Reenrollment" tab. The forms can be completed on the AHCCCS website; however, must be submitted by fax or mail.

B. AHCCCS PROVIDER TYPES

AHCCCS providers are registered under a provider type (e.g., hospital, nursing facility, physician) established by AHCCCS. The AHCCCS-OIG Provider Registration Section will assist providers in identifying the most appropriate provider type, based on the provider's license/certification and other documentation.

C. SCREENING OF PROVIDERS BASED ON CATEGORICAL RISK

As part of the implementation of the Section 6401 of the Affordable Care Act, Provider Screening and Other Enrollment Requirements under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), CMS requires that AHCCCS comply with the following provisions:

1. To screen providers according to the provisions of Part 455 subpart E under 42 CFR 455.450.

2. To screen all applications, including initial applications, applications for a new practice location, and applications for re-enrollment or revalidation, based on a categorical risk level of "limited," "moderate," or "high." 42 CFR 455.410(a).

3. To establish categorical risk levels for providers and provider categories who pose an increased financial risk of fraud, waste or abuse to the Medicaid Program.

4. When AHCCCS determines that a provider's categorical risk level is "high," or when the agency is otherwise required to do so under State law, the agency must require providers to consent to criminal background checks, including fingerprinting.

Exhibit 610-2 contains all the applicable requirements for each risk category as defined by CMS and AHCCCS. Not all providers are required to pay enrollment fees, these are only applicable to institutional providers.

AHCCCS is not required to conduct a Fingerprint Based Criminal Background Check (FCBC) on a "high" risk provider if that provider is considered a "high" risk provider by Medicare and the provider has been enrolled by Medicare. (Under 42 CFR 424.518(c), Medicare considers newly enrolling home health agencies and suppliers of Durable

Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to be "high" categorical risk).

Under 42 CFR 455.434(b), the requirement to submit fingerprints applies to both the "high" risk provider and any person with a five percent or more direct or indirect ownership interest in the provider, as those terms are defined in 42 CFR 455.101.

D. RISK ASSESSMENT AND CRITERIA FOR RISK ADJUSTMENT

In accordance with 42 CFR 455.450 AHCCCS-OIG will adjust the categorical risk level from "limited" or "moderate" to "high" when any of the following occurs:

1. AHCCCS imposes a payment suspension on a provider based on credible allegation of fraud, waste or abuse; the provider has an existing Medicaid overpayment; or the provider has been excluded by the HHS-OIG or another State's Medicaid program within the previous 10 years.

2. AHCCCS or CMS in the previous six months lifted a temporary moratorium for the particular provider type and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

AHCCCS-OIG Provider Registration will notify each high-risk provider regarding the fingerprint based background checks. The individual(s) subject to the FCBC requirement will be listed as part of the notification process and will have 30 days to comply, from the date of notification. AHCCCS-OIG Provider Registration will notify the provider with a 15-day notification letter to remind the provider of the fingerprint background requirement.

Once the individual(s) have complied with the requirement, AHCCCS-OIG Provider Registration will send the fingerprints to the Department of Public Safety (DPS) to complete the background check. Upon receipt of the background results, AHCCCS-OIG Provider Registration 'designee' will review results and elevate any individual(s) with a criminal history to the AHCCCS-OIG High Risk Provider Review Committee (HRPRC) to review. The provider will be issued an AHCCCS provider identification number if the results are positive. If AHCCCS-OIG Provider Registration denies the enrollment based on the FCBC results, the individual(s) or provider will be notified. The notice will include the appeal rights in accordance with A.R.S. §36-2903.01.B.4 and A.R.S. §41-1092.01 et seq.

In accordance with the CMS SMD 15-002, a provider that has failed to comply with the FCBC requirement or fails the background check must be terminated or the agency has a basis to deny their enrollment, unless AHCCCS determines that termination is not in the best interests of the Medicaid Program and documents that determination in writing.

Exhibit 610-1 identifies the complete list of AHCCCS Medicaid provider types. The list identifies the registration requirements per provider type along with the regulatory organization(s) for providers of AHCCCS covered services. Refer to AMPM Chapter 300 for a description of all AHCCCS-covered services. Refer to AMPM Chapter 1200 for long-term care services, and the Behavioral Health Services Guide for behavioral health services.

Refer to the AHCCCS website for additional information regarding provider registration requests.

REFERENCES

- Exhibit 610-1, AHCCCS Provider Types
- Exhibit 610-2, Screening Tool
- www.AZAHCCCS.com
- AHCCCS Contracts
- AHCCCS-OIG Provider Registration
- Behavioral Health Services Guide for behavioral health services
- Children's Health Insurance Program (CHIP)
- A.R.S. §36-2903.01.B.4
- A.R.S. §41-1092.01 et seq.
- 42 CFR 424.518(c)
- 42 CFR 455.101
- 42 CFR 455.410(a)
- 42 CFR 455.434(b),
- 42 CFR 455.450
- 42 CFR 455.450
- CMS SMD 15-002

EXHIBIT 1, AHCCCS PROVIDER TYPES

SEE THE AMPM WEBPAGE FOR EXHIBIT 1 OF THIS POLICY

EXHIBIT 2, SCREENING TOOL

SEE THE AMPM WEBPAGE FOR EXHIBIT 2 OF THIS POLICY

620 AHCCCS FFS MINIMUM NETWORK REQUIREMENTS

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AHCCCS must maintain a sufficient number of AHCCCS registered Fee-For-Service (FFS) providers to provide medical services to those members not assigned to a Contractor. These members include, but are not limited to:

1. Indian Health Service (IHS) members (Native Americans)

2. Emergency Services Program (ESP) recipients

Refer to the applicable AHCCCS contract for Contractor minimum provider network requirements and staffing requirements.

630 MEDICAL RECORD REQUIREMENTS

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All AHCCCS providers and Contractors must protect member information in accordance with Federal and State laws, Rules, AHCCCS policies and AHCCCS contracts.

Consistent with 9 A.A.C. 22, Article 5, AHCCCS and its Contractors, providers and non-contracted providers must safeguard the privacy of records and information about members who request or receive services from AHCCCS or its Contractors.

Information from, or copies of, medical records may be released only to authorized individuals, and processes must be in place to ensure that unauthorized individuals cannot gain access to, or alter, member records.

Original and/or copies of medical records must be released only in accordance with Federal or State laws, or Court orders. Contractors and providers must comply with the Health Insurance Portability and Accountability Act ([HIPAA] and 42 CFR 431.300 *et seq*).

A. DESIGNATED RECORD SET (DRS)

The following applies to the member's DRS:

1. The DRS is the property of the provider who generates the DRS. The DRS is a group of records maintained by the provider. The DRS may include the following:
   a. Medical and billing records maintained by a provider
   b. Case/medical management records, or
   c. Any other records used by the provider to make medical decisions about the member.

2. The member:
   a. May review, request, and annually receive a copy, free of charge, of those portions of the DRS that were generated by the provider
   b. May request that specific provider information is amended or corrected, and
   c. May not review, request, amend, correct or receive a copy of the portions of the DRS that are prohibited from view under the Health Insurance Portability and Accountability Act (HIPAA)

3. AHCCCS is not required to obtain written approval from a member before requesting the member's DRS from a healthcare provider or any agency. For purposes relating to treatment, payment or health care operations, AHCCCS may request sufficient copies of records necessary for administrative purposes, free of charge.

4. Written approval from the member is not required by the Primary Care Provider (PCP) when:
   a. Transmitting member records to a provider when services are rendered to the member through referral to a Contractor's subcontracted provider,
   b. Sharing treatment or diagnostic information with the member's Integrated Regional Behavioral Health Authority (Integrated RBHA) or Regional Behavioral Health Authority (RBHA) acting as a provider, or its contracted providers, if the member is receiving behavioral health services through the Integrated RBHA/RBHA system, or
   c. Sharing medical records with the member's health plans.

5. Medical records or copies of medical record information related to a member must be forwarded by any AHCCCS-registered provider to the member's PCP within ten business days from receipt of a request from the member or the member's PCP.

6. AHCCCS must have access to all member records, whether electronic or hard copy, within at least 20 business days of receipt of a request.

7. Information related to fraud and abuse against the AHCCCS program may be released to authorized officials in compliance with Federal and State statutes and rules.

Refer to Chapter 900 for a discussion of member record/information for AHCCCS Contractors.

Refer to Chapter 500 for a discussion of member medical records regarding member transitions.

REFERENCES

- AMPM Chapter 500
- AMPM Chapter 900
- AHCCCS Contracts
- 9 A.A.C. 22, Article 5
- 42 CFR 431.300 *et seq*
- Health Insurance Portability and Accountability Act (HIPAA)

640 ADVANCE DIRECTIVES

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A hospital, nursing facility and/or home health agency and individual providers must comply with Federal and State laws regarding advance directives for adult members. At a minimum, providers must:

1. Maintain written policies for adult members receiving care through their organization regarding the member's ability to make decisions about medical care, including the right to accept or refuse medical care and the right to execute and advance directive

2. Provide written information to adult members regarding the provider's policies concerning advance directives

3. Document whether the adult member has executed an advance directive

4. Prevent discrimination against a member, and not place conditions on the provision of care to the member, because of his/her decision to execute or not execute an advance directive, and

5. Provide education for staff on issues concerning advance directives.

650 RESERVED