

# **REFERENCE GUIDE**

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**Network Management**

7878 North 16th Street, #105, Phoenix, AZ 85020

Phone: (602) 824-3700 or (800) 747-7997

Fax: (602) 674-6670

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**CONTACT US**

**Provider Phone Menu**  
**(602) 824-3700 / (800) 747-7997**  
**Choose Option 3 for Provider Menu**

<b>Claims Customer Service</b>
<b>Prior Authorization</b>
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➤ <b>Case Management</b>
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**Provider Fax Menu**

<b>Appeals/Compliance</b>	<b>(602) 674-6673</b>
<b>Case Management</b>	<b>(602) 674-6674</b>
<b>Claims</b>	<b>(602) 674-6651</b>
<b>Credentialing</b>	<b>(602) 674-6671</b>
<b>Dental Prior Authorization</b>	<b>(602) 674-6677</b>
<b>Grievance</b>	<b>(602) 674-6673</b>
<b>Inpatient Notification</b>	<b>(602) 674-6650</b>
<b>Medical Prior Authorization</b>	<b>(602) 674-6678</b>
<b>Member Services</b>	<b>(602) 674-6613</b>
<b>Network Management</b>	<b>(602) 674-6670</b>
<b>Pharmacy Prior Authorization</b>	<b>(602) 674-6652 or (888) 887-9982</b>

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### WEBSITE

**[www.phoenixhealthplan.com](http://www.phoenixhealthplan.com)**

Our website is an excellent source of information and resources to providers and office staff on the following:

- Provider and Member Communications including faxes and letters
- Cultural Diversity information
- EFT – Electronic Funds Transfer information
- EDI – electronic claims submission information
- Forms
- Formulary
- On-Line Directory and Physician Provider Search
- Practice Guidelines
- Prior Authorization Guidelines
- Provider Manual
- Behavioral Health Information
- Links to AHCCCS and other health care websites

For those providers and office staff who have registered for security access to the website's Provider Portal, will have availability to the following applications:

- Primary Care Physician Membership Roster (PCP only)
- Real-Time Eligibility Verification
- Real-Time Claims Status Inquiry
- Review Claims Remit with Downloading Capability
- Real-Time Prior Authorization Status Inquiry

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### APPOINTMENT AVAILABILITY & WAIT TIME STANDARDS

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#### STANDARDS DEFINITIONS:

- **New Patient** – A member that has not received any professional services from the physician or another physician of the same specialty belonging to the same practice, within the past 3 years.
- **Established Patient** – A member that has received any professional services from the physician or another physician of the same specialty belonging to the same practice, within the past 3 years.
- **Urgent** – An acute, but not necessarily life-threatening condition which, if not attended to, could endanger the patient's health.

#### PCP, SPECIALTY, DENTAL AND MATERNITY CARE

Below are the AHCCCS' standards for appointment availability by provider type:

##### **Primary Care Appointments (New & Established)**

- Routine Care – within 21 days of request
- Urgent Care – within 2 days of request
- Emergency Care – same day of request

##### **Dental Appointments (New & Established)**

- Routine Care – within 45 days of request
- Urgent Care – within 3 days of request
- Emergency Care – within 24 hours of request

##### **Specialty Appointments (New & Established)**

- Routine Care – within 45 days of referral
- Urgent Care – within 3 days of referral
- Emergency Care – within 24 hours of referral

##### **Maternity Care Appointments (New & Established)**

- First Trimester – within 14 days of request
- Second Trimester – within 7 days of request
- Third Trimester – within 3 days of request
- High Risk – within 3 days of identification of high risk or immediately if an emergency exists.

##### **Wait Time in Office**

- The time a patient has to wait in the provider's office beyond their scheduled appointment time should be no more than 45 minutes, except when the provider is unavailable due to an emergency, when the member does not show up on time for an appointment, and when the member is a walk-in. If the waiting time for a scheduled appointment is expected to exceed 45 minutes the member should be informed of the situation and offered an alternative appointment if desired.

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### CLAIMS & REIMBURSEMENT

#### CLAIMS CUSTOMER SERVICE

Monday – Friday 8:00-12:00 & 1:00-4:30  
Phone: (602) 824-3743 or (800) 747-7997

All claims must be submitted within 180 days from the oldest date of service or discharge date on the claim

All claims must be mailed to the billing address as listed below. Any claims mailed to directly to the PHP office address will cause a delay in payment.

PHP Claims  
P.O. Box 81000  
Phoenix, AZ 85069

#### CLAIMS FORMS

Each provider must report all covered services to PHP either by encounter submission and/or the appropriate claim form for payment.

- Physicians – CMS-1500 (08/05)
- Facilities – UB-04
- Dental – J4000 (2008 Version)

PHP is unable to reimburse providers for any services provided to any member if the provider is not registered with AHCCCS.

#### EDI (PHP Payer 03440 Route ID 7)

Submitting claims electronically means faster processing and reimbursement, allows for documentation of timely filing and decreased submission costs. PHP encourage you to consider EDI for your practice.

- For Medical claims, please contact Emdeon at (800) 369-8805 or go to the website [www.emdeon.com](http://www.emdeon.com) for more information.
- For Dental claims, please contact Tesia at (800) 724-7240 or go to the website [www.tesia.com](http://www.tesia.com) for more information.

For questions or assistance with this process, please contact our EDI Specialist at (602) 824-3861.

Any claim requiring an attachment such as an explanation of benefits or medical records must be submitted via paper submission.

#### ELECTRONIC FUNDS TRANSFER

PHP offers EFT to providers, which allow payments to be deposited electronically directly into a designated bank account without the need to manually deposit a paper check. Providers have the capability to view remits online allowing no delay between receipt of dollars and the ability to post payment. The form can be found on the PHP website under the provider tab and forms section. Please complete the form EFT form and fax or mail as directed on the downloaded form.

#### CLAIMS EDUCATION

The PHP Claims Educator is an excellent resource and is available to assist your office via phone or in person with questions regarding claims submission and can be reached at (602) 824-3747.

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**CLAIMS & REIMBURSEMENT****DUPLICATE CLAIMS**

Our goal for paying claims is 30 days from the date of receipt. Please allow enough time for your staff to post our remittance advice prior to resubmitting your claims. Claims status can be obtained by utilizing our website or by calling Claims Customer Service. If you have questions on how to register for the website, contact Network Management.

**NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER**

Providers are required to use your NPI on every claim submitted. PHP will deny paper claims and reject electronic claims submitted without the appropriate NPI numbers.

Providers that bill with a facility/legal entity name, in box 33, are required to obtain a Type II (Organizational) NPI number for the legal entity. Once obtained, the Type II NPI number will need to register with AHCCCS.

The rendering providers NPI is allowed in box 33a only if he/she is a sole provider. Facilities with more than one provider require a type 2 NPI.

**CMS 1500 Submissions**

For providers who submit for reimbursement on a CMS 1500 form, the facility's NPI number must appear in box 33a along with the provider's facility name as registered with the IRS in box 33 along with the rendering provider's NPI in box 24j. If you do not have a facility NPI, the rendering physicians NPI number must appear in box 33a.,

**ADA Submissions**

For dental providers who submit for reimbursement on an ADA J400 2008 form, the billing dentist or Dental Entity's NPI number must appear in box 49. For the treating dentist, the NPI number must appear in box 54.

**UB-04 Submissions**

For providers/facilities who submit for reimbursement on a UB-04 form, the facility's NPI number must appear in box 56. For those that enter the attending, operating and/or other physicians, the NPI number must be placed in boxes 76-79.

**DIAGNOSIS CODES**

In compliance with AHCCCS guidelines, diagnosis codes that require a 4<sup>th</sup> and 5<sup>th</sup> digit will be denied if not submitted with appropriate specificity. PHP will never change or alter a diagnosis code. If a claim is submitted improperly a revised claim must be submitted.

**MODIFIERS**

Appropriate modifiers should be used when submitting claims to PHP. Claims that are submitted with an inappropriate or missing modifier will be denied.

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### CLAIMS & REIMBURSEMENT

#### SCANNING TIPS

All paper claims are inputted into our system using a process called data lifting. The recommendations below will help to prevent claims rejections and denials.

- Printing claims on a laser printer creates the best possible character quality
- When using a dot matrix printer change the ribbon regularly
- The best font for clean scanning is Courier 12 pitch non proportional
- Print all characters in uppercase
- Ensure that clean character formation occurs when printing paper claims (i.e. one side of the letter/number is not lighter/darker than the other side of the letter/number)
- Ensure that the claim form is lined up properly within the printer prior to printing
- Do not place additional stamps on the claim such as received dates, sent dates, medical records attached, resubmission, etc. (characters on the claim from outside of the lined boxes have a tendency to “throw off” the registration of the characters within a box during scanning)
- Use an original claim form as opposed to a copied claim form
- Use a standard claim form as opposed to a form of your own creation (individually created forms have a tendency to not line up correctly, prohibiting the claim from scanning cleanly)

#### PRIOR AUTHORIZATION NUMBER REQUIRED

For services requiring prior authorization, the prior authorization number must be included on your claim in order for claims adjudication and payment to occur. If not included, the claim may be denied.

#### VACCINES FOR CHILDREN (VFC) PROGRAM

PCPs seeing children ages 0-18 must participate in the VFC program. Certain codes have associated age limits. Please check the age of the member prior to submitting codes for reimbursement.

- Per AHCCCS guidelines, use the correct VFC code and include the SL modifier.
- Please note, only one administration fee will be paid for each immunization given, including combination vaccines.

#### Helpful Hints

- The explanation for a claim recoupment is specified on the initial remittance advice with the recouped claim(s). A provider has sixty (60) days from the date of the initial recoupment to resubmit for a corrected payment.
- All secondary claims must be submitted as paper claims with the primary EOB attached.
- For secondary claims that exceed the timely filing requirements, PHP allows an additional sixty (60) days from the date of the Primary EOB for the submission of secondary claims.

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**CLAIMS & REIMBURSEMENT****PHP CLAIM DISPUTE / APPEAL PROCESS**

PHP encourages providers to contact Claims Customer Service for assistance with questions or issues surrounding claim payment, partial payment, or non-payment. Claims Customer Service can be reached at 602-824-3743 or 1-800-747-7997. As a reminder, claims must be received within 180 days from the date of service. A provider may dispute any claim payment, payment reduction or claim denial, by filing a claim dispute.

AHCCCS guidelines require that all claim disputes (i.e. complete or partial denial of a claim) must be submitted in writing within 12 months from the date of service, the date of discharge (for an inpatient claim) or within 60 days of the last adverse action, whichever is greater.

All requests for dispute should include:

1. A completed PHP claim dispute form OR a letter detailing the factual and legal basis for the dispute along with the relief requested.

(If you are submitting a claim dispute using PHP's claims dispute form please use one form for each disputed claim. You may download the claim dispute form from our website or contact Network Management for a copy.)

2. A copy of original claim and remittance advice

3. Documentation to support the dispute, such as medical records, operative notes, etc. PHP will not solicit missing documentation.

4. Mail the completed form(s) and documentation to:

Phoenix Health Plan  
Provider Claim Disputes  
7878 N. 16th St. #105  
Phoenix, AZ 85020

Fax requests to PHP at: (602) 674-6673

Note: PHP will deny a dispute that fails to detail the facts of the case, the legal argument or are submitted with incomplete information will be denied without medical review. PHP will not attempt to solicit supporting documentation.

- PHP acknowledges all claim disputes in writing within five working days of receipt. The dispute is assigned a tracking number for future reference or inquiry.
- A written claim dispute resolution decision is issued within 30 calendar days from receipt. PHP may request an extension of up to 14 calendar days, if necessary.
- If a provider disagrees with PHP's resolution, the provider may file a request to elevate the matter to a state fair hearing. The request for a state fair hearing must be filed in writing with PHP within 30 days from the date of the receipt of the resolution letter. The request will be forwarded to AHCCCS Office of Administrative Legal Services who will schedule the matter for a hearing with an Administrative Law Judge. **AHCCCS will contact the provider directly when the hearing has been scheduled.**
- Submit Requests for a state fair hearing to:  
Phoenix Health Plan, Attn: Provider State Fair Hearing Request, 7878 N. 16<sup>th</sup> Street, Ste. 105, Phoenix, AZ 85020 or FAX to: 602-674-6673.

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### CLAIMS & REIMBURSEMENT

#### MEDICAL RECORD REQUIREMENTS

PHP requires medical records to be submitted with claims for specific hospital visits and inpatient admissions

Claims that require medical records are:

- Outliers
- Inpatient PPC Claims
- Claims associated with an authorization that is pended for Medical necessity retro review
- Outpatient ER claims billing with revenue code 450 and the paid amount is greater than \$10,000

For a complete listing of hospital claims that require medical records contact the Network Management Department

#### Prior Period Coverage

Prior Period Coverage (PPC) extends from the beginning date of an AHCCCS recipient's eligibility to the date prior to the recipient's date of enrollment with the health plan. PHP reimburses providers for covered services rendered to eligible members during PPC in accordance with AHCCCS guidelines.

- PPC members can be identified by rate codes - with 3 numbers and a letter.
- Capitated providers are reimbursed fee-for-service for medically necessary covered services rendered to eligible members during PPC.
- Providers have 180 days from the day member eligibility is posted to submit PPC claims.
- There are no prior authorization requirements during the PPC time frame.
  - The health plan is responsible for reimbursing providers only for emergency medically necessary services rendered during the PPC period. If the health plan denies for lack of medical necessity an inpatient hospital stay that includes both PPC and prospective enrollment, the entire stay will not be paid.
  - Prior authorization requirements do apply in accordance with the provider's contract once prospective enrollment begins.

#### MEMBER BILLING

- Members cannot be billed for AHCCCS covered services. This includes charges for copying medical records, completing any type of form(s), or "no-show" appointment
- Members requesting non-covered services must sign a detailed consent form prior to receiving non-covered services. The consent form must be reviewed prior to rendering the service and must be easy for the member to understand. The form must include the exact cost to the member of the service (non-covered benefit). The consent form must ask the member if they understand the procedure is not covered by their insurance and if they understand they will be charged for the services provided. General forms signed at a member's first visit are not considered written consent.

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### FRAUD, WASTE & ABUSE

#### FALSE CLAIMS ACT

AHCCCS and CMS require all providers to train their staff on the following aspects of the Federal False Claims Act:

- The administrative remedies for false claims and statements
- Any state laws relating to civil or criminal penalties for false claims and statements
- The whistleblower protections under such laws
- Refer to our websites for educational tools and resources available to assist in staff education and training

#### REPORTING FRAUD, WASTE AND/OR ABUSE

##### Member and provider fraud, waste and/or abuse

To report member or provider fraud, waste and/or abuse to PHP, please contact our compliance officer at (602) 824-3700 or (800) 747-7997. You may also forward information in writing to:

Phoenix Health Plan  
Attention: Compliance Officer  
7878 N 16<sup>th</sup> St. # 105  
Phoenix AZ 85020

If you want to report suspected fraud of a provider directly to AHCCCS please call:

- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

If you want to report suspected member fraud directly to AHCCCS please call the number below:

- In Maricopa County: 602-417-4193
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

PHP encourages the use of the AHCCCS preliminary investigation referral form, which is available in the PHP Provider Manual (Section B) or by visiting the AHCCCS website at:

<http://www.azahcccs.gov/fraud/reporting/reporting.aspx>

#### Questions

If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please contact the AHCCCS Office of Inspector General (OIG).

Email: [AHCCCSFraud@azahcccs.gov](mailto:AHCCCSFraud@azahcccs.gov)

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### BEHAVIORAL HEALTH SERVICES

#### BEHAVIORAL HEALTH REFERRAL GUIDELINES

PHP's goal for its members is to ensure that behavioral health services are readily available for Title XIX (Medicaid) and the Title XXI (KidsCare) members.

Comprehensive behavioral health services are covered, as medically necessary, for all Title XIX (Medicaid) and Title XXI (KidsCare) members through the Regional Behavioral Health Authority (RBHA). For SOBRA Family Planning members, there is no behavioral health coverage. As of 10/1/10 all AHCCCS eligible Title 19 members are auto enrolled with their County RBHA. This is an administrative enrollment only and not an indication that a member is actually receiving behavioral health services from the RBHA.

Below is a list of covered behavioral health services for Title XIX and XXI members through the RBHA:

- Behavior management (behavioral health personal assistance, family support, peer support)
- Case management services
- Emergency/crisis behavioral health services and emergency transportation
- Evaluation and screening
- Group and individual therapy and counseling
- Family therapy and counseling
- Inpatient hospital
- Inpatient psychiatric facilities (residential treatment centers and sub-acute facilities)
- Institutions for mental diseases (with limitations)
- Laboratory and radiology services for psychotropic medication regulation and diagnosis
- Non-emergency transportation
- Partial care (supervised day program, therapeutic day program, and medical day program)
- Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support)
- Psychotropic medication
- Psychotropic medication adjustment and monitoring
- Respite care (with limitations)
- Behavioral Health Therapeutic Home Care Services
- Rural Substance Abuse Transitional Agency Services

#### Behavioral Health Tool Kits

To assist PCP's with practice guidelines, AHCCCS has put together clinical tool kits to help in assessing the needs of the child/adolescent ranging in age from 9 through 17, and adults, regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the RBHA if clinically indicated. These tool kits can be found on the PHP website at [www.phoenixhealthplan.com](http://www.phoenixhealthplan.com) or in the AHCCCS Medical and Policy Manual with can be found on line at the address listed below.

<http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=contractormannuals>

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**BEHAVIORAL HEALTH SERVICES**

**Identification and Referral**

PCPs may provide medication management services (prescriptions, medication monitoring visits, laboratory and other diagnostic tests necessary for diagnosis and treatment of behavioral health disorders) for PHP members with select behavioral health disorders, including ADD/ADHD, mild depressive disorders and anxiety disorders (see section **Pharmacy and Prescription Services**). PCPs are required to follow and comply with all PHP, AHCCCS and RBHA guidelines for referring their assigned members for behavioral health services.

While seeing members for routine examinations and other chronic and acute conditions, the PCP also is responsible for assessing members for behavioral health needs using the following steps:

- Identify that the member is in need of behavioral health services
- Assess current behavioral health symptoms
- Assess for previous mental health treatment and/or history
- Assess for family mental health history and/or treatment
- Identify substance abusing pregnant women on the total obstetrical service request or perinatal case assessment form
- Screen children at each comprehensive EPSDT visit up to age 21 for mental health and substance abuse problems

Based on the complexity of the member's treatment needs, PCPs will not provide ongoing psychiatric care to adults or children who may have a severe behavioral health disorder. PCPs must refer these members to the Regional Behavioral Health Authority (RBHA) in the county where the member resides.

For a PCP to refer a PHP member to the RBHA, the preferred method is as follows:

- Complete DBHS Referral Form 3.3.1 and fax this to the county RBHA
- Fax a copy of this DBHS Referral Form 3.3.1 to the PHP BH Dept. (Fax 602-674-6674), who will then confirm the referral with the county RBHA. Please write COPY on the document before faxing to PHP Behavioral Health Dept.
- See website link for form: <http://www.azdhs.gov/bhs/provider/forms/pm3-3-1.pdf>

Note: A member and/or member's parent may also initiate a self referral for behavioral health services by contacting the RBHA by telephone.

All the RBHA's in Arizona offer free consultations to providers who would like assistance with evaluating an AHCCCS member even before a member is referred for behavioral health services with the RBHA. To obtain a consultation, PCPs can call the county RBHA and request a consultation with a clinical staff member.

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**BEHAVIORAL HEALTH SERVICES**

COUNTY	RBHA	CONTACT NUMBERS
Maricopa	Magellan	Referral: (800) 564-5465 Crisis: (602) 222-9444 or (800) 631-1314
Gila Pinal	Cenpatico	Referral: (866) 495-6733 Crisis: (866) 495-6735
Pima	Community Partnership of Southern AZ (CPSA)	Phone: (800) 771-9889 Crisis: (800) 796-6762
Apache, Coconino, Mohave, Navajo, and Yavapai	Northern AZ RBHA (NARBHA)	Phone: (800) 640-2123 Crisis: (877) 756-4090

Coordination of Care for Members Transitioning From the RBHA

If you are notified by the RBHA that your patient with the above diagnoses is stable and wants to transition back to you please call the PHP behavioral health coordinator at (602) 824-3957 or (602) 824-3934 for assistance in coordinating the transition. If the member has completed step therapy while being treated by the RBHA and stabilized on a treatment regimen using a PHP non-formulary drug PHP will authorize the drug for 12 months subsequent to your prior authorization request. Submit the Pharmacy Prior Authorization request to PHP Behavioral Health Coordinator via fax at (602) 674-6674.

If an emergency exists, immediately contact the RBHA crisis line at the numbers listed above. If further assistance is required, you may call the PHP Behavioral Health Coordinator at (602) 824-3957 or (602) 824-3934.

Please refer to the AZ Department of Health Services for more information on Behavioral Health and the RBHA carriers go to [www.azdhs.gov/bhs/aboutbhs.htm](http://www.azdhs.gov/bhs/aboutbhs.htm). **Note: Native American members may utilize their Tribal RBHA.**

**Step Therapy**

PHP Step Therapy for administering psychotropic medications for Depression, Anxiety and ADHD: PCPs are expected to use the concept of Step Therapy when prescribing psychotropic medications. The protocol is to prescribe a drug listed in the PHP formulary requiring trials and failures of first line formulary agents. A logical sequence of formulary drugs must be filled prior to coverage of the Step Therapy drug (non formulary drug requiring prior authorization), in order for members to have coverage of their medications. Step therapy is based on medical guidelines and best practices. Please contact the PHP Behavioral Health staff at 602-824-3957 if you have questions concerning Step Therapy or formulary concerns.

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### BEHAVIORAL HEALTH SERVICES

The recent 10-01-2010 change in eligibility rules surrounding the Arizona Healthcare Cost Containment System (AHCCCS) Behavioral Health population has caused some confusion in the marketplace.

The following is intended to clarify Behavioral Health hospital services reimbursement and to delineate when to expect payment from Phoenix Health Plan (PHP) vs. your Regional Behavioral Health Authority (RBHA)

When a PHP member receives Emergency Room services and is released, if the:

- PHP will reimburse 100% of the contractual allowable \* excluding professional Psych Evaluation codes.

When a PHP member is admitted as inpatient, if the:

- Primary Discharge Diagnosis is Medical = PHP will reimburse 100% of the contractual allowable\* if the member meets Medical Necessity criteria and authorization is obtained where applicable
- Primary Discharge Diagnosis is Behavioral Health with Medical Secondary Diagnosis = PHP will reimburse per diem services associated with Medical Necessity based upon and evidenced by concurrent review prior authorization and/or retro medical claims review. PHP will deny (cut back) per diem payment after the member is medically stable and does not meet Medical Necessity criteria.
- Primary Diagnosis is Behavioral Health with unrelated minor/no Medical secondary diagnosis = PHP will deny payment; Hospital should bill RBHA for facility and any related hospital billed professional services

When a PHP member is admitted for observation, if the:

- Primary Discharge Diagnosis is Medical = PHP will reimburse 100% of the contractual allowable\* not to exceed 48 hours, if the member meets Medical Necessity criteria and authorization is obtained where applicable
- Primary Discharge Diagnosis is Behavioral Health with Medical Secondary Diagnosis = PHP will reimburse up to (2) 24 hour observation periods and allocated related charges associated with Medical Necessity based upon and evidenced by concurrent review prior authorization and/or retro medical claims review.
- Primary Diagnosis is Behavioral Health with unrelated minor/no Medical secondary diagnosis = PHP will deny payment; Hospital should bill RBHA for outpatient charges and any related hospital billed professional services

\* less applicable copay and coordination of benefits

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**MEDICAL SERVICES****ARIZONA EARLY INTERVENTION PROGRAM (AzEIP)**

AZEIP is a statewide system of supports and services for families of children, birth to three, with disabilities or development delays. If a PCP evaluation(s) indicates concerns about a child's development, the PCP will notify and refer the member to AzEIP. Evaluation reports and any other relevant records should be included with the referral. AzEIP will review the documentation and, if needed, conduct evaluation and assessment to supplement the existing records and determine AzEIP eligibility. You can refer a child to AzEIP using the on line referral form found at [www.azdes.gov/AzEIP/default.asp](http://www.azdes.gov/AzEIP/default.asp) or contact DES at 602-532-9960.

If the child is eligible for AzEIP, an Individualized Family Service Plan (IFSP) will be developed. The IFSP will identify:

- (1) Child's present level of development,
- (2) Child's outcomes,
- (3) Services that are needed to support the family and child in reaching the IFSP outcomes, and
- (4) IFSP will be sent to PHP.

PHP staff will initiate coordination of medically necessary EPSDT covered services, including physical therapy (PT), occupational therapy (OT) and speech therapy (SP) identified on the IFSP with the PCP. The PCP will request authorization for AzEIP services within 14 days from the date of the AzEIP referral outcome notification for medically necessary services that PHP will be responsible for covering. PHP staff will assist the parent/caregiver in scheduling the EPSDT covered services, as necessary or requested. The EPSDT services will be provided by the PHP until the services are no longer medically necessary or the child is eligible to be covered by a school program.

For additional information, contact Department of Economic Security (DES)/AzEIP at (602) 532-9960. Or visit their website at [www.azdes.gov/AzEIP/default.asp](http://www.azdes.gov/AzEIP/default.asp). Or email: [allazeip@azdes.gov](mailto:allazeip@azdes.gov).

**IMMUNIZATIONS**

Under AHCCCS coverage, immunizations for children are covered under the Arizona Department of Health Services (ADHS) Vaccine for Children (VFC) program. Immunizations must be provided recommended by the Advisory Committee on Immunization Practices (ACIP). The immunization schedule can be found on the CDC website found at <http://www.cdc.gov>. Please refer to chapter 400 of the AHCCCS medical policy manual for additional information at: [www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf](http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap400.pdf). Please contact Medical Services at (602) 824-3700 or (800) 747-7997 for any additional information or clarification on covered vaccines.

**ASIIS**

PHP and the State of Arizona (ARS 36-135 and AAC R9-6-706 and R9-6-707) require that immunizations that are administered to children be reported at least monthly. It is recommended that high volume immunization providers report on a more frequent basis than monthly. Your office can report electronically or by paper. ASIIS can also accept data exports from a patient management/billing system. Training by ADHS is provided free of charge. For additional information, go to ASIIS website at: [www.azdhs.gov/phs/asiis](http://www.azdhs.gov/phs/asiis). For Technical Support, paper forms, or free ASIIS web-based application; contact (877) 491-5741 and for other methods of electronic data transfer, contact (602) 364-3619.

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**Network Management**

7878 North 16th Street, #105, Phoenix, AZ 85020

Phone: (602) 824-3700 or (800) 747-7997

Fax: (602) 674-6670

**MEDICAL SERVICES**

**EPSDT**

Early Periodic Screening Diagnosis and Treatment (EPSDT) apply to all PCPs and OB/GYNs. Services must be provided to members age 20 and younger. Please take every opportunity to perform EPSDT screening regardless of whether the member is sick or well. EPSDT forms should be completed according to the current periodicity schedule. Use appropriate preventative medicine CPT code when billing for EPSDT services. Mail completed forms to:

Phoenix Health Plan  
Attention: PHP EPSDT coordinator  
7878 N. 16th Street, Suite 105  
Phoenix, AZ 85020

EPSDT forms may be ordered by downloading the request from [www.phoenixhealthplan.com](http://www.phoenixhealthplan.com). Complete and fax per the instructions on the form. EPSDT forms will then be mailed to your office. Or, you may print the forms directly from the PHP website linking to AHCCCS or directly from AHCCCS website at: [www.ahcccs.state.az.us/Regulations/OSPpolicy/Appendicies/appx\\_b.asp](http://www.ahcccs.state.az.us/Regulations/OSPpolicy/Appendicies/appx_b.asp). Should you print the forms directly from the websites, remember to make copies before submitting.

AHCCCS requires providers that provide and submit EPSDT forms to use the most current and correct EPSDT forms. Outdate forms will be rejected by AHCCCS.

<b>New Patient</b>	<b>Code</b>	<b>Established Patient</b>	<b>Code</b>
< age 1 year	99381	< age 1 year	99391
Ages 1 – 4 years	99382	Ages 1 – 4 years	99392
Ages 5 – 11 years	99383	Ages 5 – 11 years	99393
Ages 12 – 17 years	99384	Ages 12 – 17 years	99394
Ages 18 – 20 years	99385	Ages 18 – 20 years	99395

**Helpful Hint**

**If your office uses an Electronic Medical Records (EMR) system, you may send to PHP the EPSDT information from your EMR system, as long as; all of the required information requested on the EPSDT form is on your EMR form.**

**PEDS TOOL**

Parental Evaluation of Developmental Status (PEDS) Developmental Screening Tool is a standardized tool utilized to detect and address developmental and behavioral problems in children from birth to 8 years of age. The PEDS screening can be conducted at each EPSDT well child visit for those that were born on or after 01.01.06 who were in the NICU following birth.

The following conditions below must be met to bill for developmental screening:

- Completion of PEDS training (go to [www.azaap.org/default.aspx](http://www.azaap.org/default.aspx) for additional information)
- Use of code 96110 with EP modifier used when submitting claims
- Submission of PEDS score and interpretation form to PHP Quality Department along with the yellow copy of the EPSDT form.

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### MEDICAL SERVICES

#### **PEDS TOOL continued**

PHP sends a monthly list of all children assigned to Providers who are due for EPSDT visits. Please note, PHP is now flagging the children who are eligible NICU grads with the word “PEDS”. Providers can obtain further information about the PEDS Tool or order hard copies of the PEDS tool for use in their office at [www.pedstest.com](http://www.pedstest.com) or [www.forepath.org](http://www.forepath.org).

#### **FAMILY PLANNING & STERILIZATION**

Annually, all PCP’s must verbally notify their AHCCCS members of the availability of family planning services. Covered services include medical, surgical, pharmacological and laboratory services, contraceptive devices, as well as information and counseling necessary to allow members to make informed decisions regarding family planning methods. No authorization is required for family planning, but for members with rate codes of 55xx the diagnosis must indicate family planning. For more information, please contact Network Management or Medical Services for assistance.

Prior authorization is not required for family planning services with the exceptions of tubal ligations and vasectomies. AHCCCS requires a completed federal consent form for all voluntary sterilization procedures and the form must accompany the request for authorization for the sterilization. The Consent for Sterilization form can be found at [www.hhs.gov/forms/HHS-687.pdf](http://www.hhs.gov/forms/HHS-687.pdf). For additional information on sterilization, please refer to the PHP Provider Manual (Section G).

For those member’s whose benefit is limited to Family Planning Services only who are screened and determined to have a sexually transmitted disease can be referred to the County Health Department (based on geographic location) for low cost treatment.

#### **CASE MANAGEMENT**

Case Management is available to members who have complex medical conditions. Our goal is to join with providers, community outreach programs, and family members to achieve optimal outcomes.

Current programs include but are not limited to:

- Behavioral Health
- Complex Case Management
- ESRD
- HIV
- Transplant
- Pain Management

Please contact Case Management at (602) 824-4081 or (800) 747-7997 for additional information and assistance.

#### **DISEASE MANAGEMENT**

Disease management programs are available to assist with your chronically ill members. Our goal is to assist members in reaching their optimal health through partnering with the member, the PCP and the specialist(s). Current programs include but are not limited to:

- Asthma
- Behavioral Health
- Diabetes
- ESRD
- High-risk Pregnancy
- HIV
- Transplantation

Please call our disease management team at (602) 824-4081 or (800) 747-7997 for more information and assistance.

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**OB/GYN SERVICES**

**APPOINTMENT STANDARDS**

Maternity Care appointment scheduling should occur as follows:

- First trimester: Within 14 days of request
- Second trimester: Within 7 days of request
- Third trimester: Within 3 days of request
- High risk pregnancies: Within 3 days of identification of high risk by the Contractor or maternity care provider, or immediately if an emergency exists

Return appointments should be scheduled per the ACOG standards indicated below:

- Monthly through 28 weeks
- Bi-weekly through 35 weeks
- Weekly 36 weeks-delivery

**HIGH RISK PRENATAL HOME CARE INFUSION SERVICES**

Matria (800) 950-3963

**BABY ARIZONA**

Baby Arizona is a simple, faster way for pregnant women to start getting health care before the application process for AHCCCS health insurance is complete. Baby Arizona is a program to help pregnant women begin the important prenatal care they need while waiting for the AHCCCS eligibility process. This process insures that care is received immediately and increases the chances for a healthy pregnancy and a healthy baby. Pregnant women who live in Arizona, have little or no income, are United States citizens or qualified non-citizens qualify for the program.

Providers can increase their patient base by participating in the Baby Arizona program. The patient starts the application process by calling the Pregnancy and Breast Feeding Hotline at 1-800-833-4642. They are given names of doctors, clinics and community health centers who participate in the Baby Arizona Program. Once a woman goes to the Baby Arizona provider she chooses, they will help her apply for AHCCCS health insurance and pre-enroll her in a health plan. The application process is typically 20 working days from the time the complete application is received at DES. Women begin prenatal care at no cost while their eligibility is processed. If a woman is ineligible for AHCCCS once her application is processed, the Baby Arizona doctor who began her prenatal care should work out a reasonable payment plan with the woman and continue care. Information on becoming a participating provider can be found at

<http://www.babyarizona.gov/BecomeProvider.aspx>

**INCLUDED IN TOTAL OB CARE PACKAGE**

Obstetrical care requires prior authorization. OB/GYN providers act as the PCP during pregnancy and through six weeks post partum. Please refer to your contract and the Provider Manual for a list of services that are included in the OB Package.

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**PHARMACY SERVICES****FORMULARY**

All offices should be prescribing medications listed on the current formularies, which are available online at [www.phoenixhealthplan.com](http://www.phoenixhealthplan.com). Please consider all formulary alternatives before submitting a prior authorization request for non-formulary medication. Any physician may request a prior authorization, formulary exception or an exception to a utilization management edit by completing a Pharmacy Prior Authorization and Formulary Exception form. The Formulary forms can be found on the PHP website. The requests and supporting medical or laboratory documentation should be faxed to (602) 674-6652.

**SPECIALTY MEDICATIONS PURCHASING PROGRAM AND INJECTABLE PRIOR AUTHORIZATION \***

Specialty injectable drugs may be obtained through our contracted vendor, CuraScript. If applicable, please use one of the following options to procure specialty drugs:

**1. If Prior Authorization is needed:**

- Send a pharmacy prior authorization request to PHP **prior** to placing the order. To obtain a request form, please go to our websites or contact Network Management.
- If approved, Providers can call CuraScript at (866) 848-9870 to order or complete the CuraScript Order form which is located on our website and fax to CuraScript at (888) 773-7386. Providers may also utilize their own supplier (see below for more information).
- If denied, review and address the instructions on the PHP Communication Form sent to you.

**2. If Prior Authorization is not required:**

- Order specialty injectable drugs directly from CuraScript and they will review within 24-48 hours and schedule the medication for overnight delivery. Please contact CuraScript Special Distribution for questions regarding medications that are available through the purchasing program. Curascript will bill PHP for reimbursement.
- Utilize your own supplier of specialty injectable drugs and bill PHP on the appropriate claim form using accurate HCPC code(s). You will be reimbursed at the plan's fee schedule. All injectables billed to the health plan are reimbursed at this rate. Please check the most current prior authorization guideline for injectables that require prior authorization.

PLEASE NOTE: Prior authorization requests must be submitted to the PHP prior to order being placed. If prior authorization is not obtained before the order is placed, the plan decision and patient care may be delayed.

**\* This program does not include vaccines. In addition, all unclassified drugs (i.e. J3490, J9999) require prior authorization and will be evaluated by the Prior Authorization Dept on a case by case basis for approval and reimbursement. Call CuraScripts directly for questions regarding those medications that are available through the purchasing program.**

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**DENTAL SERVICES****AHCCCS COVERED DENTAL SERVICES**

PHP covers dental services for all EPSDT members 0 through 20 years of age. This includes all medically necessary dental services such as dental screenings, preventive services (in accordance with the AHCCCS periodicity schedule), therapeutic dental services, medically necessary dentures, and pre-transplantation dental services. There are limited benefits for members twenty-one (21) years of age and older. Please refer to Section H of the PHP Provider Manual for further information regarding dental services.

**PRIOR AUTHORIZATION**

At times PHP members may require services that go beyond the scope of their Primary Care Provider (PCP). When this occurs, the PCP refers the member to an appropriate Specialty Care Provider. Our prior authorization guidelines are available on our website [www.phoenixhealthplan.com](http://www.phoenixhealthplan.com). You may also contact network management for a copy to be faxed or mailed to your practice.

Authorizations for consults and follow-up visits are valid for 120 days as long as the member retains AHCCCS eligibility with PHP. Prior Authorization requirements apply even if PHP is not the primary insurance.

If you are unable to schedule the consult with the member within the appropriate timeframes referenced above, please contact the prior authorization department and request to have the authorization extended prior to rendering the service.

**STANDARD AUTHORIZATION REQUESTS**

A routine request is non-urgent and will be responded to within 14 days upon receipt of a request. Please supply all supportive documentation to assist in rapid processing of your request.

When requesting multiple services for member(s), submit each request separately. Bundled requests cause delays in processing as the submission requires unbundling. Determinations will be faxed to the requesting provider within 1 business day of rendering a determination.

**EXPEDITED AUTHORIZATION REQUESTS**

PHP's goal is to process expedited requests within 3 days or sooner of receipt of all supportive documentation. Determinations will be faxed to the requesting provider within 1 business day of rendering a determination. AHCCCS defines an "expedited" request as "when using the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum functioning." Please remember not to use "expedited" for the convenience of the member or physician. In cases when the request does not meet the "expedited" criteria, but is time sensitive, PHP will attempt to process the request in the timeframe requested."

**COORDINATION OF BENEFITS**

Prior authorization requirements apply to all members. All members are required to see contracted providers. If the member has primary coverage other than PHP and the physician is not a contracted provider, services will be denied unless prior authorized.

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### PRIOR AUTHORIZATION

#### REFERRAL PROCESS FROM SPECIALIST TO SPECIALIST

Should a Specialist need to refer a member to another Specialist, it is not necessary for the member to be physically referred back to the PCP as long as the PCP has been informed of the impending referral. The referring Specialist must refer to the prior authorization guideline to determine if an authorization is required for the needed specialty. If a prior authorization is required, the prior authorization form should be completed and faxed as outlined above.

#### SPECIALIST RESPONSIBILITY

Specialists and other providers are required to keep the PCP informed regarding the care and services they provide to the PCP's assigned PHP members.

#### OFFICE VISIT AUTHORIZATIONS AND IN-OFFICE PROCEDURES

- For specialties that require authorization for the initial consultation and/or follow-up visits, all visits and in-office procedures performed must fall within the authorization date range of the approved visit.
- An in-office procedure that does not require authorization may be performed as long as there is an open visit authorization on file at the time of the procedure.
- Please refer to the prior authorization guideline for those procedures that must be approved in addition to the visit.
- Please be aware that all services requested for a non-contracted provider require prior authorization.

Please contact Network Management for a copy of the PHP prior authorization guidelines or visit our website to download them.

#### PRIOR AUTHORIZATION TIPS

Your prior authorization (PA) request will be processed more expeditiously if you consider the following:

- Please fax your medical or pharmacy prior authorization requests to the appropriate fax numbers.
- Allow sufficient time to process your requests (especially on Friday afternoons following hospital discharges).
- Please contact PHP Prior Authorization at 602.824.3760 or 800.747.7997 for the status of your request before sending a duplicate request.
- Provide the past year's medical records if they pertain to your request.
- Provide laboratory results such as cultures and sensitivities or cholesterol panels to expedite the reviews for both medical and pharmacy requests.
- Please note a seven day supply of medication following a hospital discharge does not require PA as long as the prescription is written on a hospital or ER discharge prescription pad.

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**ADDITIONAL SERVICES**

**DME & MEDICAL SUPPLIES**

*(i.e., colostomy/ostomy, catheters, etc.)*

Preferred Homecare Phone: (800) 636-2123  
Animas Diabetes Care (Insulin Pumps) Phone: (877) 937-7867  
Medtronics (Insulin Pumps) Phone: (818) 678-6717

Please have the following information available when faxing your request:

- Amount, type and size of equipment desired including HCPC code
- Member information
  - Name
  - Member identification number
  - Weight
  - Address
  - Phone number
  - Diagnoses
- Recent blood gases if the request is for oxygen
- Completed and Signed Certificate of Medical Necessity

**GLUCOSE MONITORS**

*(Includes test strips & lancets)*

- Members obtain through pharmacy
- Aviva and Actives are the preferred brands.

**HOME HEALTH**

*(Skilled Nursing and Home Health)*

Professional Cares, LLC Phone: (602) 395-5114

**ENTERAL**

Option 1 Nutrition Solutions Phone: (866) 883-1188  
Innovative Enteral (Pediatric only) Phone: (877) 943-5782

**INFUSION**

Preferred Homecare Infusion Phone: (800) 636-2123

**TRANSPORTATION SERVICES**

- Members are responsible for contacting PHP Member Services to arrange transportation.
- Routine appointments require a three day advance notice.

**HEARING SERVICES**

Covered services are available for members under age 21.

*Refer to the Physician Directory located on our website for a listing of providers.*

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**ADDITIONAL SERVICES**

**LAB SERVICES**

LabCorp is contracted for all outpatient laboratory work, including presurgical work ups and special services. Please ensure accurate diagnosis codes are marked when completing the requisition form. For billing, supplies, results, courier service, cytology and surgical pathology, contact: LabCorp Client Services (800) 788-9738. Service locations are available at [www.labcorp.com](http://www.labcorp.com) by clicking the patient service center locator tab. In certain geographic service areas LabCorp has subcontracted with certain hospital providers to perform stat lab services to PHP members.

The following lab services can be performed in the provider's office and will be reimbursed to the provider:

In-Office Lab Test List (Fee-For-Service Provider):

36410	Blood draw
36415	Blood draw
81000	Urinalysis w/microscopy
81002	Urinalysis w/o microscopy, non-automated
81003	Urinalysis w/o microscopy; automated
81025	Urine pregnancy test
82962	Glucose, blood by Glucose Monitoring Device
85013	Spun Hematocrit
85007	Blood Count; Blood Smear; Microscopic exam with Manual Differential WBC Count ( <u>For Oncologist Only</u> )
85008	Blood Count; Blood Smear; Microscopic exam without Manual Differential WBC Count ( <u>For Oncologist Only</u> )
85025	Automated Hemogram ( <u>For Oncologist Only</u> )
85027	Hemogram and Platelet Count ( <u>For Oncologist Only</u> )
85044	Reticulocyte Count ( <u>For Oncologist Only</u> )
86403	Strep Quick Test (particle agglutination; screen, each antibody)
86490	Cocci Intradermal Test
86580	TB Intradermal Test
87210	Wet Mount
87804	Influenza Assay w/ Direct Optical Observation
87880	Streptococcus, group A
89050	Body Fluid Cell Count ( <u>For Oncologist Only</u> )

In-Office Lab Test List (Capitated PCPs)

Capitated PCPs will be reimbursed fee-for-service (FFS) for the following lab codes:

36410	Blood draw
36415	Blood draw
81025	Urine pregnancy test
86403	Strep Quick Test (particle agglutination; screen, each antibody)
86490	Cocci Intradermal Test
86580	TB Intradermal Test
87880	Streptococcus

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**ADDITIONAL SERVICES**

**OUTPATIENT THERAPY SERVICES**

- Physical Therapy (PT) and Occupational Therapy (OT) for an acute episode may be referred for an initial evaluation without prior authorization to **contracted PHP PT, OT and ST Providers**. A listing of the contracted PHP PT, OT and ST Providers can be found on the PHP website. The therapy provider is responsible for prior authorizing the treatment plan after the initial consultation.
- Speech Therapy (ST) requires prior authorization for an initial evaluation and treatment. The therapy provider is responsible for prior authorizing the treatment plan after the initial authorized consultation.
- Occupational and Speech Therapies are not a covered benefit for PHP members over the age of 21.

**ROUNTINE VISION SERVICES**

Covered services are available for members under age 21. Members may self refer to Nationwide Vision, and other contracted providers in areas not serviced by Nationwide. Areas outside of Maricopa, Gila and Pinal Counties have a limited Nationwide network. Members in Maricopa, Gila and Pinal Counties should utilize the Nationwide network.

Covered services are:

- One exam per year
- One pair of prescription lenses or additional frames and glasses if medically necessary
- One repair of prescription lenses per year
- Members 21 years and older includes emergency and some medically necessary vision services may be referred to DES Sight Conservation at (602) 266-7284.

*Refer to the Ancillary Directory located on our website for a listing of providers.*

**CHIROPRACTIC SERVICES**

Covered services are available for members under age 21 and “QMB” members are limited to manual manipulation of the spine to correct subluxation

- Members may contact Member Services for benefits and additional information.
- Members must be referred by their PCP for services
- Chiropractic services require prior authorization for an initial consultation and for treatment. The chiropractic provider is responsible for prior authorizing the treatment plan after the initial authorized consultation.
- When medically necessary per the PA guidelines codes that can be billed are 98940 to 98943

*Refer to the Physician Directory located on our website for a listing of providers.*

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**OTHER REMINDERS****CULTURAL COMPETENCY**

PHP is aware of the diverse backgrounds of its members and makes every effort to offer services that are sensitive to the differences in payor source, marital status, sexual preference, genetic information, physical or mental handicap, ancestry, color, creed, race, ethnic background, linguistic group age, gender, lifestyles, education, literacy level, disability, religion, social group or geographic location and to respect the traditions of all of our members. We offer a choice of qualified doctors and hospitals to meet the member's needs in a culturally appropriate manner. We want our community to know that our providers and members are being served regardless of the language they speak. We provide interpretation services upon request or when a language need has been identified. **Listed below are two services that we provide to our providers and members at no cost:**

**LANGUAGE LINE SERVICES**

Language Line Certified Medical Interpretation Services is contracted to provide services with access to more than 140 languages, 24 hours a day, and 7 days a week. All translation services can be accessed by contacting PHP Member Services at (602) 824-3700 or (800) 747-7997.

**AMERICAN SIGN LANGUAGE INTERPRETATION SERVICES**

Sign Language Interpretation services will be arranged through PHP Member Services. Please contact Member Services at (602) 824-3700 or (800) 747-7997 to make arrangements for an interpreter.

- Sign Language Interpreters are available at no cost to members or providers when scheduled through Member Services.
- Interpreters require at least 24-48 hours in advance notice.
- Interpreters will attend scheduled appointments.

**CANCELED AND MISSED APPOINTMENTS**

Providers are required to have a system to document and follow-up on canceled or missed appointments. This is necessary in order to ensure appropriate continuity of care for members. Member services also will assist with this process through member education. PHP requests that Providers complete the No Show Log to report canceled and missed appointments on a monthly basis. The log should be faxed to 602-674-6670 attention Provider Services. The log can be submitted more frequently if needed.

**PROVIDER UPDATES/CHANGES**

PHP should be notified in advance of any demographic and panel changes. Any new providers to the practice must be credentialed and loaded in our system prior to services being rendered to members. If the provider is not credentialed and loaded in the PHP system claims will be denied. Other relevant changes including address, tax ID and new office locations must be reported in writing to the Network Management Department in advance of the change or claims may be denied.

**DATA VALIDATION**

Annually, AHCCCS performs a data validation study by requesting a random selection of medical records from providers for the "data validation" study of claims data encounters. The study audits the integrity of claims submitted to AHCCCS Health Plans and ultimately to AHCCCS Administration. PHP's quality indicators are affected by the accuracy of the claims submitted to PHP. The reimbursement to your practice can be negatively impacted by inaccurate claims submission.

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### OTHER REMINDERS

#### ADVANCE DIRECTIVES

The Patient Self-Determination Act, passed by Congress in 1991, requires that health care providers educate patients on issues related to Advance Directives. The Act requires all Medicare and Medicaid providers to furnish timely information so patients have the opportunity to express their wishes regarding the refusal of medical care. PHP as AHCCCS and CMS must comply with this Act, and request your cooperation in helping us become compliant. Documentation is required in the medical record as to whether or not an adult member has completed an Advanced Directive. Below are suggestions to assist in bringing your medical records into compliance with this standard:

1. Add a line to your initial patient assessment record stating
  - a. Advance Directive discussed - Yes or No
  - b. Do you have a Living Will or Power of Attorney - Yes or No?
2. Stamp the front of the member's chart or provide a "sticker" on the chart with the above statements(s). Please be sure to address the above questions with the member. A number of providers have implemented the questions but they are left unanswered.

If you would like more information on health care directives, you may contact the following organizations:

- Arizona Medical Association
- Arizona Hospital Association
- Aging and Adult Administration-State of Arizona
- American Association of Retired Persons
- Arizona Senior Citizens Law Project

#### MEMBER REASSIGNMENT

Occasionally, it may be necessary for a PCP to request that a member be removed from their panel. PHP encourages PCPs to manage all members and to limit transfers as much as possible, and is willing to provide assistance. If it is absolutely necessary to request removal of a member from a panel, a written request detailing the issues must be mailed or faxed to the Member Services department. All requests must be signed by the PCP. The releasing physician is responsible for treating the member for a maximum up to thirty (30) days for emergency care and until such transition of care occurs. The following information is required to be included in the written request:

- Member's name and ID number
- Detailed explanation of circumstances
- Signature of the Primary Care Provider

#### FEDERAL HEALTHCARE PROGRAM PARTICIPATION

Important reminder, as a registered provider with the AHCCCS Administration, (Arizona's Medicaid Program), you are obligated under 42 C.F.R. §1001.1901(b), to screen all employees, contractors, and/or subcontractors to determine whether any of them have been excluded from participation in Federal health care programs. You can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE, and can be accessed at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

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